

# GROUP PSYCHOTHERAPY

*Journal of Sociopsychopathology and Sociatry*

PSYCHODRAMA

SOCIOMETRIC METHODS

ACTION METHODS

THERAPEUTIC FILMS

RE-GROUPING

RE-TRAINING

SOCIAL CATHARSIS

SOCIODRAMA

Volume IV

APRIL-AUGUST

Numbers 1 & 2

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## EDITORIAL NOTE

The twentieth anniversary of Group Psychotherapy within the American Psychiatric Association had an appropriate celebration in the symposium on Group Psychotherapy (Chairman: Dr. Winfred Overholser) on May 11, 1951, and the Round Table on Group Psychotherapy and Psychodrama (Moderator: Dr. Alan Gregg) during that Association's annual meeting at Cincinnati.

In the name of all friends of group psychotherapy and psychodrama we take this opportunity to extend thanks to the Executive Council of the American Psychiatric Association for planning to include in its annual program a Symposium and a Round Table for a number of years, until the need for a permanent Section is clearly proven. Such action is bound to raise the standards of research and practice in this field. The Program Chairman of the American Psychiatric Association, Dr. David Young, has given the first program his patient attention and advice.

We are glad to publish in this issue some of the outstanding papers of the symposium and are grateful to Dr. Clarence P. Farrar, the Editor of the American Journal of Psychiatry for his cordial cooperation in releasing them for this journal. We are also planning to present in a forthcoming issue the proceedings of the Round Table.

Committees on Group Psychotherapy and Psychodrama are being formed in every state of the union, as exchange centers for clinical experience and for the sponsoring of scientific programs. The International Committee on Group Psychotherapy is preparing the issue of its own organ, the *International Archives of Group Psychotherapy*.

We are also continuing herewith the publication of researches presented at the Ninth Annual Meeting of the Society of Group Psychotherapy and Psychodrama in February, 1951.

LABORATOIRE D'EXPERIMENTATION SOCIOMETRIQUE  
ET PSYCHO-SOCIOLOGIQUE

Ecole Pratique des Hautes Etudes  
VIe Section  
Sciences Economiques et Sociales  
Sorbonne

It will be of interest to the readers of this journal and to all workers in the field to know that a new center for sociometric research entitled Laboratoire d'Experimentation Sociometrique et Psycho-Sociologique (Laboratory of Sociometric and Socio-Psychological Research) has been established at the University of Paris.

The following statements are excerpts from correspondence received from F. Braudel, Secretary of the Sixth Section, and L. Febvre, President of the Sixth Section, addressed to the Sociometric Institute:

"J'ai le plaisir de vous informer que la VIe Section de l'Ecole Pratique des Hautes Etudes (Sorbonne) ayant pris en consideration vos propositions, a decide d'integrer dans son organisation, un *Laboratoire d'Experimentation Sociometrique et Psycho-Sociologique* qui sera controle par le Conseil de la Section.

Le laboratoire sera inaugure au debut du mois d'octobre 1951. La VIe Section lui accorde gratuitement des locaux 54, rue de Varenne, et met a sa disposition l'usage du personnel technique.

M. JEAN MAISONNEUVE sera le *secetaire-administrateur* du Laboratoire dont le travail sera guide par un Comite Scientifique qui sera probablement constitue comme suit: F. BRAUDEL (Secetaire de la VIe Section), L. FEBVRE (President de la VIe Section), G. GURVITCH, G. LE BRAS, C. LEVI-STRAUSS, J. MEYERSON, H. PIERON, POYER, H. WALLON. Secetaire du Comite: PAUL H. MAUCORPS."

"Nous avons l'honneur de vous informer que nous invitons le Dr. J. L. MORENO, directeur de l'Institut Sociometrique a service d'agent de liaison entre le Laboratoire en question et l'Institut Americain, et nous le remercions d'avoir accepte cette fonction."

Sociometric Institute, New York  
(Now Moreno Institute)

Annual Meeting of the American Psychiatric Association  
Cincinnati, Ohio—Friday, May 11, 1951  
SYMPOSIUM ON GROUP PSYCHOTHERAPY, THEORY  
AND PRACTICE  
Chairman: Winfred Overholser, M.D. (F.A.P.A.)  
Washington, D.C.  
Secretary: J. L. Moreno, M.D. (F.A.P.A.)  
Beacon, N.Y.

## SOME THEORETICAL AND PRACTICAL ASPECTS OF GROUP PSYCHOTHERAPY

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and

FRANCIS M. STEPHENS, M.D.

*Cincinnati, Longview State Hospital*

Since I have been asked to give the first paper, I am going to present certain theoretical aspects that may serve as a frame of reference for the discussion of the papers which will follow. As Dr. Moreno has pointed out<sup>1</sup>, an immediate step in carrying forward the science of group psychotherapy is to discover common terms that can be accepted by the major portion of those engaged in this kind of work. I am not asking that you accept just the particular terms that I present but I believe that the following concepts are basic and can be readily recognized as guiding principles inherent in a wide variety of approaches to group psychotherapy.

Since we are to talk about group work, let us start by considering the structure and function of the individual members of the group, and the structure and function of the group as a group. Let us start with our concepts of the person. I believe we can accept the concept that a person is composed of multiple parts and that the parts are interactive, making up a total personality which cannot be known adequately unless viewed as such totality of system. Equally basic is the principle of interaction of the whole back upon the parts.

---

\* Presenting the paper.  
(1) Moreno, J. L., M.D., "The Present Situation Group Psychotherapy, 1951," *Group Psychotherapy* III, 4, March, 1951.

This system of concepts derives from gestalt psychology. The part-whole and whole-part interaction may be portrayed as shown on the mimeographed sheet (p. 12) which each of you found in your chair. The ellipse represents the person as composed of multiple parts. As you see, this representation permits the discussion of peripheral and more central areas. I believe that in one form or another most of us in this room accept the theory of *depth* in personality structure. We, therefore, can refer to the functioning of personality at different levels.

In the second place let us look at this human system in terms of *rigidity*. If we accept systems in the individual, then we inevitably must conceive of the relative permanency of those systems. From one individual to another, we are dealing with a continuum of rigidity-fluidity. We meet in the manic a fluidity which results in loss of goal and flight of ideas. In the paranoid we meet a rigidity which militates against adaptation to environmental forces. Varying degrees and mixtures are found.

Closely associated with this is the concept of *permeability* of boundary of these systems of the self, or as we more often say in daily clinical work, accessibility of the person. Here in Figure 1, we can speak of the permeability of the outer boundary by outside forces; or the permeability of the outer boundary from within out. There may be a difference in permeability according to the polarity of the process. The catatonic takes in various sense impressions but does not allow the inner forces to become expressed through the outer boundary into the external world. The collaborator in this paper, Dr. Stephens, has been impressed by a catatonic's recounting of Dr. Stephen's greeting one year after the episode. This was especially noteworthy, since the patient appeared to be out of sensory contact at the time of greeting. In this case, the outer boundary was permeable to external stimuli, but impermeable from within out.

Impermeable boundaries, which we call barriers, may be variously located. The barrier may be at the outer boundary as we have just cited; or around the peripheral areas, cutting these off from the central areas. This is the functional state of the person who maintains a good front and shows his essentially psychotic state only when this inner barrier has been penetrated. Or, the barrier may be central and around a single system. This is conceived to be the state in cases of repressed memories.

A second system of concepts and terms picturing individual structure is the psychoanalytic system. Its partition into three areas, the id, the ego and the superego is too widely known to require discussion here.

A third system of concepts and terms picturing the structure of the individual frequently used is the sociometric-psychodramatic system. It looks at the human personality in terms of a polarity between spontaneity-productivity and conservation-sterility; it describes behavior as exhibiting an excess, adequacy, degree, loss of spontaneity (or inflexibility). It permits the discussion of personality at different levels, a central area—the *action matrix*, an intermediary area—the behavior matrix, and a peripheral area—the verbal matrix. It describes the ego in terms of the cluster of roles in which it operates.

Why should we spend time in this session on group work, discussing the structure of the individual? The answer is this: It seems important to emphasize the principle of wholeness of the person. This principle is not new to this session. I have heard reference to it in several others. I wish, however, to insure that the wholeness of man incorporates not only all the systems of man but incorporates the age represented by those systems. Let us ask ourselves honestly whether or not, in our therapeutic methods, we are contacting the full potentialities of the human being to respond. Why, for example, when we consider the position of man in the phylogenetic scale, should we assume that we can speak to the ancient man of 500 or 700 million years ago by contacting him primarily through the channel of language. Why should we suppose that this relatively newly acquired function should in itself permit adequate expression? In view of the totality of man, we are pressed to find techniques which embrace more of the expression of the whole person. The psychodramatic work of Dr. Moreno is one challenging answer to this need for modification of the therapeutic orientation of the last 40 years.

We need to reach man through the gamut of his senses. Through visual, auditory, tactile, kinaesthetic and other senses the varying layers of personality should be contacted. As a matter of fact, in the psychodrama sessions deliberate attempts are made to effect widespread involvement of the person through a breadth of stimulation.

By going back to the portrayal of the person in Figure 1, we can view the representation of the concept of *total involvement* defined as *an engaging of the breadth and depth of systems of the person* in a particular task or attitude or other personal function.

We may turn now to a consideration of the group. What is its structure? It is of course composed of individuals and the forces of the single person are part of the total matrix of forces operative in the group at any moment.

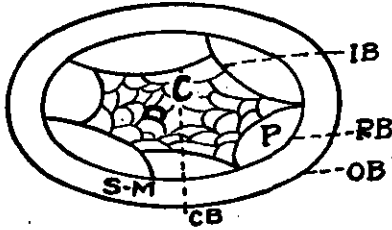


FIGURE 1: Structure of the Person

Areas:

SM—sensory-motor  
 P—peripheral  
 C—central

Boundaries:

OB—outer  
 PB—peripheral  
 IB—inner  
 CB—central

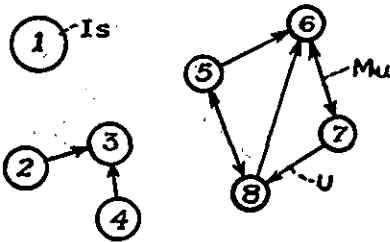


FIGURE 2: Sociometric Structure of the Group

Communication:

Mu—mutual  
 U—unitary  
 Is— isolate

I should like first to point out some broad areas that often pertain in a therapy group. Unless the therapist takes action to prevent it, the patients will come with a perception of two areas, that of the staff with the doctor as leader, and that of the patients. In psychodrama without effort to the contrary, the patients will perceive the actors in one area and the audience in another. Unless Dr. Moreno and this panel conceive of some corrective action you will be perceiving this session in terms of the audience area and the panel area. Whether or not that is a healthy structure for this group this morning, depends upon the purpose of this meeting.

The delineation of these broad areas, however, is not sufficient. We need a detailed analysis of the dynamics of inter-personal relationships within the group. Dr. Moreno, and other workers through sociometry have pointed the way for an analysis of such forces. A representation of such analysis is given in Figure 2. Sociometry gives us an operational definition of the group, in terms of interpersonal action and communication. In the Figure given, for example, each circle represents an individual of a group of 8. The vectors show the direction of the communication. Number 1 is an isolate. In the choice situation for sitting beside others for tea on a Ward in a mental hospital, this individual did not make any choice and was not chosen. Patients 2 and 4 chose number 3 but patient 3 failed to make a choice. The third subgroup

is more cohesive. Each one of the four made a choice and in turn was chosen. Patient 6 is chosen by three others, patients 5, 8 and 7. Two of the choices are mutual: patients 5 and 8, and 6 and 7. No one of the eight makes a choice outside of this cluster.

Many other types of structure of diagnostic significance exist: extraverted-introverted structure of the group; leader-centered and leaderless structure; and structure of low and high cohesion.\*

With the group as with the individual, it behooves us to consider the potentialities of the total situation. In our limited time no attempt will be made to exhaust the properties of the therapy group. I shall discuss the significance of a few outstanding characteristics. First I believe it is helpful to view the group as a social unit in which the patient can test his position. With a permissive leader he can feel increasingly free to test himself in this sample of the social world.

*He can test belonging to the group and not belonging. It is not unusual at the beginning of a new group for one or more members to sit apart against the wall, even keeping coat and hat on. Such patient can test his own satisfaction derived from participating and not participating. The so-called isolate shown in Figure 2 can test his own feelings when in this withdrawn position. Such experimentation with position in a group can proceed more easily in the social group in the Institution than in the outside world. Consequences are not irrevocable. He can experiment in any direction, and yet he need not suffer any major social change: he will not be divorced because of his actions, or lose a job, or be disinherited, or placed in jail. He can with relative impunity try out social behavior and weigh the approval or disapproval of the patient-staff group.*

The therapeutic power of the fact of belonging to a group should not be underestimated. The patient who has failed in his human relationships and has had to withdraw finds himself in a social group again. The fact of coming to a therapy room with the same group day after day is in itself a positive force. The individual who has set up a barrier between himself and the rest of the world finds himself in a situation where he is accepted as well as anyone else. This feeds the individual's need for affection, recognition and status in the group. The barrier between the person and the environment can give way in this situation of equality. The person finds that he can come in as one of the group, and that he is free to leave the group at will. He is not treated as

\* J. L. Moreno, "Who Shall Survive?" 1934.

inferior or superior, nor as majority or minority but one of equal status in the group of fellow patients and staff.

The beneficial effects of this belongingness can be measured sociometrically, but the way in which the process takes place is more difficult to demonstrate. Look at Figure 1 and in your mind's eye blacken the outside barrier to represent that the person could feel that he had withdrawn rather completely from society. Look again on your sociograms and consider the isolate of Figure 2 and listen to the statement of one of our group therapy patients who had experienced persistent loss in competing with his favored brother for the affection of his mother: "I didn't know what to do except to get sick. But it seems like I got so sick I couldn't get back." Note the patient's own expression which implies distance. His words were: "I couldn't get back." The impact of the group situation upon such person where he could discuss problems, vote with others, and thus participate in group decisions is a force in therapy not possible to attain in the individual interview.

Another process characteristic of the group and potent in therapy is that of *contagion*, that is the influence of the behavior of one or more persons on the behavior of others. It seems as though the concept of the field forces is important here. The person is not alone in a universe but has locus in a field of forces and is a unit interactive in such field.

*Reinforcement* is closely related to contagion, apparently. The impact of having two, ten, or twenty individuals moving in the same direction toward one goal, whether physically as in the dance drama, or figuratively as in the group discussion is impressive. Further research is needed to throw light on the nature of this process of reinforcement.

*Cohesiveness* of the group is another force to be recognized. Some research has been carried out already in this field. We can speak of the cohesiveness of a group in which the bonds are peripheral; and those in which the bonds are central. In any case, to the patient who has not yet experienced the stability of a group, it becomes important to experience that the group hangs together despite frank expressions of emotions, or even openly hostile attacks.

Now that we have a certain frame of reference regarding the whole-part nature of the individual, and the whole-part nature of the group, let us face the crucial question for therapy, namely: how to *loosen these structures*. We agree, I believe, that therapy is "change"—some call it "learning." The reason I was willing to spend some time on concepts of structure was to set up a com-

mon frame of reference regarding the loosening of structure. Admittedly, we cannot effect a *change*, that is, *therapy* without such loosening as will permit a "restructuring" of the individual—and the group.

Today I should like to introduce the papers which are to follow by pointing briefly to two directions of loosening, or liberating spontaneity. The one is through a heightening of individual and group action. Movement has a demonstrable effect upon such release of spontaneity. In the warming-up in psychodrama, we therefore plunge the whole group into varied movements, varied tempos. We accent the movement through music, and have them move in as many different ways as possible, and move the body in as many planes as possible. We emphasize social movement. We take hold of hands in a circle; we dance by twos, by fours, or tens. We cut in; whatever becomes structured one moment we break up the next—all for the sake of liberating spontaneity—all to set the person and the group in a state which will permit the change necessary for therapy.

The second approach for releasing spontaneity, is by relaxation. Here we wish the patients to become so quiet that rigid systems will relax and repressed memories be made accessible.

We wish to do more than to give patients an opportunity to relax; we wish to furnish a basic emotional security, a solid social relationship upon which the patient may lean while he brings painful material into consciousness. We, therefore, use the primal relation of infant and mother. The patients are asked to lie on the soft red carpet on the floor as though in a crib or cradle.

The therapist, as mother figure, walks from one infant to another and covers the child, pats it, and loves it. The lullaby improvised by Mr. Sigmund Valin, of our psychology staff at Longview Hospital, serves as background to the mother's recitation of her care and love. I will play you a sample from a record of the music and voice.

In summary, as a frame of reference, I am suggesting that we hold in mind the whole-part and part-whole system of the person and of the group; that we evaluate therapeutic procedures in terms of their involvement of the whole potentialities of the sensory and organic, as well as verbal man.

Accepting therapy as a process of change, or learning, I am suggesting that we evaluate therapeutic approaches in terms of the degree to which they bring the person and the group to a state favorable for change, namely in terms of the degree to which they liberate spontaneity.

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## THE DYNAMICS OF GROUP AND ACTION PROCESSES IN THERAPY\*

An analysis of the warm-up in psychodrama

JAMES M. ENNEIS

*St. Elizabeths Hospital*

*Washington, D. C.*

One of the primary problems facing any therapist is the establishment of channels of communication. In group psychodrama this is done through the warm-up. This is a process by which the group focuses. By the merging of varied interests, it centers on a problem area with which it is willing to be concerned during a particular session. There is an exclusion of peripheral concerns, and a crystalization of the more basic areas with which the group will deal.

Thus far we have found three major types of warm-up: (1) the Cluster Warm-up, (2) the Chain of Association Warm-up, (3) the Directed Warm-up.

In the *Cluster Warm-up* the group comes in, takes their seats, and begins discussing various topics. Each topic or discussant draws a cluster of people. These clusters of people begin to interact and there is a merger of the interests through which one topic becomes predominant. During interaction the group may arrive at a new area which has not been the topic of any one cluster. Thus the group selects the area with which it is willing to be concerned. This merging, focusing, and exclusion process may take place with a great deal of constructive discussion, joking bantering, or extreme hostility between the clusters.

For example, the group comes in, is seated, and is silent. The director maintains the silence and the tension grows within the group. Finally, one man begins talking about his relationships to one of the girls present. How he would like to date her, but he feels that this would be being unfaithful to his wife. He begins to draw a cluster around him which discusses the degree to which one should maintain faithfulness to one's spouse and the meaning of this. Another group discusses the relationship of alcohol and love. The starter or instigator for this group being a man who says that when he goes out of the hospital he will get really drunk and make love to everyone that he meets. The

\*Read at the annual meeting of the American Psychiatric Association (Symposium on group-psychotherapy). May 11th, 1951, Cincinnati, Ohio.

first cluster is discussing the disappointments of love, letters from their wives and mothers which have been discouraging to them. A new cluster begins to form around a student, a Catholic priest, who comes in. They begin talking of love and the resurrection. This moves into areas of relationships to fathers, and to dreams which have been occurring with several of them about their family relationships. These three clusters draw together on the subjects of dreams and begin describing dreams of rejection and anxiety types, dealing mostly with parental figures. Resurrection keeps coming back in as a part of this warm-up and results in a discussion of the love of fellow man. A new cluster begins to form which includes the people who have been, thus far, left out of the discussion. They talk of being wallflowers, how one feels when one is a wallflower, and what might be the underlying cause of this.

The whole group draws together on the subject of being afraid of people, then moves to expressions of love to people, saying that this is the basic difficulty. They are not able to express love or to make adequate relationships with others. The "Star" is spot-lighted by the group and with their support comes forward; this is the person in whose personality this problem area is most clearly crystalized. This person moves into action using members of the group to help him portray his psychodrama. Action serves as a further focusing mechanism which maintains the warm-up, allowing the session to contribute specifically to the groups' understanding and handling of the problem.

An example in the *Chain of Association Warm-up*: The group comes in in high spirits, joking and laughing with each other. One patient is chewing grass and says to the director, "I hope you don't mind if I chew grass." The director says, no he doesn't mind. One of the patients says, "Human's are not supposed to be herbivorous." Another member of the group says, "If you keep chewing that grass you are liable to give milk." Another one says, "If you do, come over and squirt on me." Another one brings up the subject of masturbation and they begin chattering about masturbation and their feelings about it. Then one says, "The trouble with me is that I beat my meat too much. I used to go away from home and stay away to get away from my mother and father and play with myself. I was really a son-of-a-bitch. My mother didn't like me a bit. She caught me playing with myself and that is why she didn't like me." This person becomes the "Star" of the group. The group is willing to be concerned with his problem, and with this area of the development of the personality.

The *Directed Warm-up* may be directed by the leader of the group, by some one person within the group or by the group as a whole. This type of

warm-up is commonly used in training psychodrama. Here the leader has specific information with which this particular session must deal, and therefore he warms up the group to this area, and action takes place within its limits. The patient directed warm-up, is likely to begin by a patient saying, from the group, that he has something which he wishes to do today and asking the group to allow him to be the star and to portray his particular problem. He will warm the group up to himself and perhaps to the problem area as well. There are also group directed warm-ups in which the group pushes a particular patient who has not been able to participate in action before, or one toward whom it has strong emotional feelings. The group directed warm-up usually has further integration of the group as its goal.

Once the group has selected the area with which it will be concerned, and the therapeutic person, that is, the people in whose personality the problem area is most clearly shown, action is begun. We have established, essentially, channels of communication through which the action on stage and the feelings of the group can merge into beneficial processes of catharsis, the development of insight, and relearning. Vicariously the entire group benefits from the action process through catharsis and the expansion of perceptual fields.

As the star is warmed up to the roles which he is to play in relationship to the people who are causing difficulty in his current or past life, other members of the group are selected to portray the roles of people in his environment, or social atom. These auxiliaries are selected on the basis of their need, or opportunities inherent in the situation for developing insight themselves. In other words, the auxiliary egos chosen will be people for whom the experience of taking these particular roles will be a therapeutic one.

In the action the problem is usually shown in its present status, its development, how it is affecting current relationships, and possible solutions and insights regarding this type of behavior. After this has been done on stage, the problem and the star, or the therapeutic personae, are returned to the discussion level with the group. The star and the problem come from the group and are returned to the group. Thus the problem area is worked through to a meaningful conclusion giving a sense of closure in each session.

The teles and transferences are controlled and are built primarily between the members of the group with a minimum directed toward the leader as ther-

apist. The transference-telepolarity is a vital part of psychodramatic therapy.\* The psychodramatic therapist can be more objective and realistic in handling these phenomena, as they are set up between members of the group rather than being wholly directed toward him.

*In order to facilitate the development of a climate which affords an optimum opportunity for these warm-up processes to take place, sociometry is used in selecting groups. Sociometry is a choice procedure. All potential members of the group are asked to list in the order of their preference, the people with whom they would like to work in a therapeutic setting, and to list in the order of their displeasure, the people with whom they would not want to work in such a group. This data is used to form groupings in which inhibitory influence is minimal and freedom for creative production is maximal. There is a minimum of personal threat involved in the relationships between members of the group. Therefore a maximum of productivity is achieved in a relatively short period of time. The extent to which any individual can contribute to the therapy process is limited only by his relationship to other members of the group. If he is able to feel free with them he may contribute and receive. However, if he feels a paralyzing threat from his relationship to one or more members of the group, his gain will be correspondingly limited.*

Once the group has become productive, jelled, and entered a stage in which communication is possible, we find that potential members who have been excluded before, now become acceptable. Whatever threat was involved has been resolved through catharsis, relearning, and greater objectification which has been taking place on the part of the group.

Even though the group is selected sociometrically, it is not a cohesive unit when it first meets. The processes through which the group forms itself into a cohesive unit may be roughly outlined as follows:

(1) First, the members of the group begin testing each other and the leader in order to learn the extremes and limits of behavior for themselves. They also test to obtain information regarding the limits or extremes to which other members of the group may go. This is a getting acquainted phase.

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\*Freud restricts the term transference to displacement of mental components taking place during therapeutic psychoanalysis. It is basically concerned with the displacement of matters of infantile sexuality upon the physician. (See Hinsie-Schatzky, *Psychiatric Dictionary*, p. 168.

Moreno's "Tele" is a far broader term and concept. It explores and tests the degree of reality in interpersonal and intergroup relations; it is applied to therapeutic as well as to non-therapeutic situations (See Hinsie-Schatzky, p. 167, also J.L. Moreno, *Interpersonal Therapy and The Psychopathology of Interpersonal Relations, Sociometry*, Vol. 1, 1937.

(2) Next they begin to do what they feel is expected by the other members of the group and by the leader. This is actually a further testing procedure—a sort of feeling out of the therapy setting to ascertain further delineation of purpose and goal.

(3) The group continues to function in this way until the process moves towards an interest in relationships to authority figures. At this point it enters a power struggle with itself and with the leader or director. Each individual wants to do the thing his way and be the center of attention. There is a personal transference through which each desires to express himself without regard for the group. The group, in a sense, has partially disintegrated into a number of individuals who are struggling one with another for the position which they feel will help them most. Here there is a sharing of anxiety experience and the beginning of the recognition of the group as a force.

(4) The fourth phase comes about when there is a recognition of the group process and the importance of the relationships within the group for therapy. This necessitates the modification of the behavior to fit the demands of each member of the group and of the group as a whole. The result is a jelling of the group and interpersonal communication becomes possible.

The length of time involved in this process, varies considerably and depends upon the skill of direction, frequency of meetings, size of groups, and the environment from which the group's population is drawn. Patients from the prison section of the hospital spend much more time in the testing phases than do acute and chronic patients from other sections of the hospital. Groups whose membership is constant show less fluctuation than do those in which there is a rapid turnover. Those which meet three times a week, jell in fewer meetings than do those having two meetings per week. They also hold the jell better.

It is the purpose in group psychodrama to create a climate in which there can be a maximum of catharsis, of relearning and insight gained, to stimulate therapeutic potentials within the group, and to make each patient something of a therapist in his relationship to other patients.

If we are to achieve anything approximating adequate therapeutic coverage of current patient loads, the group approach affords the only hope. Of these the action methods seem to offer more in economy of time and adequacy of achievement. Personality growth is facilitated through the closure of tension systems, development of insights and the expansion of the concept of self.

There is a continual assessment of relationships, perceptions, and motivations, which stimulate personality growth. The treatment is carried out in situations, which are as close as possible to those in which the problems have arisen. This results in a more speedy transfer of the benefits of therapy to the patient's extra-therapeutic living.

THE USE OF PSYCHODRAMA AS A TRAINING DEVICE FOR  
PROFESSIONAL GROUPS WORKING IN THE FIELD  
OF HUMAN RELATIONS\*

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Previous communications have described psychodrama as a teaching method useful in accelerating the training of psychiatric case work aides in World War II. This paper will report an extension in the utilization of the technique in the in-service training of psychiatric social workers, case work supervisors, and administrators of case work programs in hospitals. It is hoped that the content of this paper will suggest additional training areas where it is believed the technique offers means of enhancing the more rapid integration of course, content, and practice.

For those not familiar with the literature, it should be said that this particular use of psychodrama in teaching was developed at St. Elizabeths Hospital during the war by the training unit of the American Red Cross, which had prior to this time, and in other capacities, been instrumental in founding and developing the Psychodrama Theater at the hospital for the treatment of patients. Experience with the patients, with auxiliary egos, and observers both casual and formal, brought out the fact that although teaching was not the aim of the psychodramatists, nor learning the goal of the patients, a unique educative process was going on in which all learned and all taught.

Subsequently, when the need arose from wartime pressures to train hundreds of young people for Red Cross service as case aides on the psychiatric wards of military hospitals, an adaptation of therapeutic psychodrama was made and included in the formal curricula.

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\*Read at the annual meeting of the American Psychiatric Association (Symposium on group psychotherapy), May 11th, 1951, Cincinnati, Ohio.

It is of this adaptation that we must speak briefly. While holding fast to the concept of spontaneity, which is basic to Moreno's work, it was decided that the episodes upon the stage must be structured to meet several demands. It was imperative that the content be congruent with the theoretical training, clinical observations, and anticipated duties of the students. It was thought unwise to use patients as auxiliary egos for these *case-aides-in-training*. This decision was based on two factors, the first being that the patient might be hurt by inexperienced workers, and second, that the psychotic patients would introduce more variables than could be managed in the time available, either in structured episodes upon the stage, or in the discussion period following the stage action.

At the outset it was agreed that the primary goal of this type of training was that of helping the students achieve a desirable attitude toward all patients having a mental illness and a degree of ease in working with them, and that although many secondary goals, many useful by-products could be anticipated, the essential gestalt was that of appropriate emotion and behavior of the workers as they set about their unfamiliar tasks.

This realization and the problem of variables mentioned above, together with the known demands of the technique led to the simplification of the problems posed by the adaptation of the therapeutic psychodramatic technique to that of teaching. As a matter of fact, this adaptation seems to have required only a few courageous acts on the part of the group. By this we mean that the training group cast out the use of all psychiatric and social work cliches, admitted that its fundamental aim was psychological, agreed that the impact of the psychodramatic situation was, to some extent, not only dependent upon the necessity for spontaneity on the part of the worker in the face of an unknown situation and person, but that in all probability they were dealing with an art form not unrelated to that of the drama about which they knew all too little. When this latter amorphous idea was examined, it determined the choice of two auxiliary egos, a man and a woman who were gifted actors with no previous dramatic training, but who had had long experience with psychotic patients. It also alerted the training group to other artistically able personnel available in the environment, who were used in appropriate roles. In addition, the technical demands of psychodrama call for a director-discussion-leader at all times. The function of this director is unique. It differs markedly from that of a committee chairman, or that of the usual lecture-discussion-leader. It will be remembered that in 1944 there was, at least in social work circles, a fashionable form of democracy, apparently endemic, which operated through committees,

led to interminable meetings and required seven interim copies and agreement of the total group before action could be taken. This was long before Dr. Vannevar Bush delightfully observed in "Arms and Free Men" that a democracy can't be run by committees, that it has to choose leaders and let them lead, if it is to work. This is also obligatory in psychodrama. It was courageous, therefore, of this group to allow the leader to lead. This was a far reaching decision, inasmuch as this original training group was composed of psychiatric social workers with diverse training and philosophy, the analyzed and the unanalyzed, as well as psychodramatic actors with varied cultural background and professional experience and a supporting cast of helpers ranging at times from doctors to dancers. It is worth noting that this group seldom disagreed. In fact, no important final divergence of opinion can be recalled. Yet it was a creative group in which everyone, including the students, put in his pennysworth, yielded no doubt something of himself, and finally hammered out conclusions. This, together with an intensified atmosphere of reality experience and a unique sense of freedom, is believed to be implicit in the technique when utilized by knowledgeable, well chosen personnel.

These few adaptations listed above proved consistently useful in the further development and refinement of this technique which, as we stated in the beginning, has now been utilized over a period of years in the in-service training of graduate workers and of administrative and supervisory personnel. The need for in-service-training in agencies and institutions employing social workers and other ancillary personnel needs no justification to this audience, since shortages of properly trained workers exist in all categories. The lack of psychiatric social workers, supervisors and social service administrators to fill hospital and clinic jobs, for example, is painfully apparent, while opportunities for their employment in the preventive aspects of the mental health field are mounting. There are a number of important factors contributing to this bottleneck. However, one way of meeting it, the St. Elizabeths training group concluded, was to find a means of heightening, broadening and intensifying normal work experience which is an essential, but relatively slow teacher. In order that workers assume heavier responsibilities more rapidly, a method must be utilized, they decided, which would in a relatively short time give these workers a sense of form and direction in their work which it was hoped would result in a more effective use of their intelligence in the selection of goals, as well as a more efficient means of attaining them. Psychodrama again, as in wartime, seemed to offer the best means, for while concentrating upon the goals suggested above, important underlying characteristics of the workers would appear; such as, the ability to control their own disturbing emotions,

reactions to pressure situations, ability to get along with other people, freedom from impeding prejudice, ability to evoke cooperative endeavor, sense of responsibility, organizing and administrative ability. All of these characteristics, or the absence of them, have implications for the selection, placement and further training of career personnel.

It so happened that as these formulations were in process an opportunity was offered the then disbanded St. Elizabeths training group to give a demonstration of psychodrama teaching technique before an audience of 500 or more medical and psychiatric social workers in New York City. The former training group collected in New York four hours before the beginning of the demonstration. There was no time for the structuring of new situations, so that to an audience of trained, experienced workers, the group, with some diffidence, presented a series of simple situations originally used for the psychodramatic teaching of psychiatric case work aides. The roles of the patients and their relatives were taken as usual by the identical actor-auxiliary egos, and volunteer psychiatric social workers from the audience played the roles of social workers upon the stage.

The demonstration was consistent in technique with the previous experience of the training group. The accompanying psychological phenomena, such as the rapid achievement of a reasonable homogeneity of the audience, the mounting tension of audience and training staff, not unlike that of a theatre just before the curtain goes up, the hesitant first volunteer from the audience, the explanation of the director to the volunteer social worker, the instant identification of the audience with her, all were the same. What was not the same was that these sophisticated workers, with few exceptions, failed markedly to reach the level of the work achieved by many of the wartime aides.

That this was true was attested not only by the painfully conscious training staff, but by others present in the audience who had seen previous training sessions with the aides. The many immediate embarrassed rationalizations offered to explain this phenomena did not appear on analysis to be cogent. This conclusion led to an ad hoc attempt on the part of the training group and others interested to examine more critically current training methodology in psychiatric social work.

No attempt was made to review the didactic courses of the schools, but attention was focused upon the apparent inadequacy of field work in fulfilling the mission of practice in application of concepts learned. Attention was further and perhaps more fruitfully directed toward a consideration of identifiable

psychological components which contribute to the effective behavior of psychiatric social workers when confronted by a patient or client in need of the special kind of professional help the worker is trained to give.

Effective behavior in the psychiatric social work field seemed to this group to depend upon (1) the individual's ability to understand and interpret the whole situation that confronts him. In other words, he must be able to answer the question, "What does this situation hold?" (2) He must also have the capacity to recognize major and minor determining factors, must sense critical areas, must ask himself, "How is this situation probably going to turn out?" (3) He must be able, having answered these questions, to organize his behavior, simultaneously and in future projection, so as to direct it sequentially toward the desired goal. (4) He must be able also to perceive the shortest path to take to achievement and have a clear idea of resources available for the journey of himself and his patient.

There is nothing original in this formulation. Were we to ask professors of psychiatric social work if it was substantially true, they might quibble over wording, but probably would add that all case work teachers have known this since the beginning of the discipline and that field work provides an opportunity for students to test themselves out in respect to such a formulation. This we believe is only partially true. Because privacy is implicit in the case work relationship between patient or client and worker, the supervisor of student workers is dependent therefore almost entirely, as is the supervisor of graduate workers, upon the written record and the verbalization of the supervisee.

Since this is true, no opportunity now exists in present field work practice for the direct observation of either the lovely or terrible subtleties of behavior evoked by the interpersonal situation of patient and worker. It seems to the authors that a gap exists between theoretical training and reality application which accounts in part at least, for the distressing lack of appropriate feeling tone on the part of workers in dealing with patients and clients, as well as for the failure of mature workers, as evidenced in the demonstration referred to above, to grasp the gestalt presented in the familiar, simple problem situations posed upon the stage. Furthermore, many of the psychiatric social workers in these situations talked to their clients in social work clichés exactly as they talk to each other and in the language of the records they habitually wrote. This situation suggests the need for a laboratory experience for psychiatric social work students which will more closely involve theoretical lec-

turers, students and field work supervisors and which will not yield to facile verbalizations, nor to the easy deceptions and inexactitudes of recording.

The authors, both of whom have been teaching psychiatric social workers at the school and field level for a number of years, believe that the psychodrama teaching technique as utilized by the St. Elizabeths group provides for psychiatry and its ancillary personnel, and for mental health teaching in general, a laboratory experience in which experiments in vivo can be conducted, theoretical concepts tested with a high degree of objectivity, hypotheses tried out and current "best practice" examined. It is believed that this technique should have a place in the already overcrowded curricula of the schools of social work, as well as in field work and in-service training programs.

The experience in the New York demonstration was fruitful to the reconstituted St. Elizabeths training group in a number of ways. It provided convincing evidence that in-service training of graduate social workers was imperative. Furthermore, the demonstration showed conclusively that the selection of psychodramatic situations, even for sophisticated workers, should continue to be characterized by reality and simplicity and should be directed toward the working out of known difficulties which the workers at whatever level, were experiencing. In relatively small classes and after the establishment of rapport, chinks in the armor of the class and the individual are often spontaneously brought forward as problems upon which they wish to work, or weaknesses appear naturally in the course of events. In structuring situations, however, it is always important to take into account the formal course content, which in the training of experienced workers is directed toward a broadening and deepening of their understanding of human nature, normal and deviating, and of the application of this to reality problems encountered in their work at all levels. This fact is mentioned here again because it must be remembered that in the concept of the authors and of this experienced group, psychodramatic teaching is not a substitute for other types of training, but rather, represents an additional learning opportunity in which as one psychiatrist said at the conclusion of his first session as an observer, "A simple interpersonal situation can be put under a microscope so that one sees things in it one never thought of, or saw before."

The simple situation this psychiatrist was looking at was that of George Clemmens.

George is a nineteen-year-old patient admitted to the mental hospital two days previously. His aunt has called the social service office to ask if a mes-

sage can be delivered to him. She would like George to know that his valuable photographic equipment is now safely stored in her home. She rescued it from his room in his boarding house and will keep it for him until he gets well. Incident to this telephone conversation the aunt who is worried and talkative, reveals many clues and some facts about George and the immediate events leading to his hospitalization. She is also *anxious for George to know* that she will come to see him as soon as she can. The case supervisor who received this call from the aunt assigns this case to a new worker who began her work in the department immediately after graduation from school. This is the first case given to this psychiatric social worker who has been on duty only a week, during which time she has had general orientation to the hospital, and to the social service department.

The scene takes place in a ward of the male receiving building. The dramatis personae are: George, a nurse, and the social worker.

Appropriate information is given the worker by the Director-Discussion-Leader; the new worker is asked if she has any further questions before she starts to the ward on this mission and since she responds in the negative, the scene begins. The patient-auxiliary ego (one of the actors previously referred to) is already in the Day Room of the ward, and the nurse, realizing that the worker is new, brings her in after a brief conversation in the office (corner of stage) and introduces her to the patient and withdraws. The interview between George and the new worker then takes place. The scene is concluded, the participants take their places in the audience, and discussion begins.

It is regretted that the limitations of this paper will not permit a verbatim report of this session, nor do we have recordings of it. It is hoped, however, that a listing of a few of the questions evoked by it, as evidenced, in discussion will be suggestive and will show that this technique is, as has been emphasized in previous papers, a unique opportunity for teaching in the round.

The new worker, as she sits down in the audience, wipes her face and says, "I wish I had asked more questions before I went so gaily off on that mission."

"Questions like what, Kay?"

"Well, for one thing, his diagnosis. Somehow, it never occurred to me he would be catatonic. It is difficult to keep talking to a man who does not respond—who says not one word. We never got anyone in the clinic where I did field work who was as sick as that."

From this starting point a discussion lasting half an hour ensued in which everyone in the theatre took part. Here are some of the questions raised and comments made:

"You did have a diagnostic clue, Kay. The aunt told the supervisor and the director told you, that George had to come in because he wouldn't eat or get out of bed."

"He did respond. His eyes moved a little bit when you told him his camera was safe."

"She should have gone on talking some more about the camera."

"I think she stayed too long."

"Isn't that too hard a case to give a new worker?"

"I don't think the supervisor was very helpful in preparing Kay."

"Is it the function of a social service department to deliver messages like this?"

"Will it make any difference in the patient's recovery—I mean, have any real effect as to outcome if the worker's technique wasn't too smooth? Could a little thing like the worker not knowing exactly how to handle the situation without showing unease, affect the patient adversely?"

"Social workers aren't supposed to diagnose anyhow. Maybe she should have talked to the doctor first."

"What I want to know is, will George ever get well?"

In handling comments and discussion of this type the Discussion Leader utilizes the knowledge and resources of the entire group. She involves everyone in the theatre. If the psychodramatic situation has been real to the group, has hit them with emotional impact, they are already deeply involved and the involvement lasts throughout the discussion. Her function then is not unlike that of an experienced traffic cop. It is of importance that all questions to which there are known answers, be answered directly by someone, and that others be explored for the best possible answers in the light of experience and conceptual knowledge. Nor should any given episode upon the stage be sucked dry, since new situations can be readily constructed for pursuing other avenues of inquiry suggested by, but not pertinent to, the specific situation under discussion.

The teaching unit has used this simple situation of George Clemmens and his new psychiatric social worker at all teaching levels, and with many slight variations in detail, introduced usually to bring reality nearer to a particular audience. For example, George's prototype originally and actually was 17 and admitted to the hospital from boot camp. His aunt, really was his mother, and his camera was originally a dog named Lassie who had seven pups. At a demonstration for a lay audience of 600, George Clemmens was once a G.I. for no better reason than that the audience had in it individuals more identified with the Army than the Navy. As usual, George played such a convincing role that several hours later a former General sought out the Discussion Leader, explained that he had been in the audience and said, with obvious concern, "What is going to happen to George?" One interesting aspect of this conversation was that this officer was still, after several hours, in the midst of the psychodramatic situation and had to be reminded that the psychodramatic actor, Curtis Bacon, who played the role of George, was not now and had never been mentally ill. The General further said, "Of course, I have long known of this problem of the mentally ill—the psychiatric casualties in the Armed Forces, but it somehow never seemed very real before. What can be done to prevent it?"

In another teaching demonstration at the Dartmouth Conference for Professors of Psychiatric Social Work, in which our now redoubtable George appeared, the identification of the audience was complete with tears, not shed we hasten to add for George, his mother, nor yet for the lack of knowledge that will prevent catatonia or specifically cure it, *but for the young worker*, trying to help him, fumbling with her notebook, frightened and insecure, who reacted to George's silence by raising her voice as though he were deaf. This phenomena was of interest to the training group, since the worker playing the role was, in reality, fifty years old. However, she was such an accomplished actress that the youthful poignancy of her performance touched the audience profoundly. After all, the business of this audience was teaching young psychiatric social workers. The variation of technique used here, was that of the use of two actors, as an opening gambit in the first half of the demonstration, in order to reassure this professorial group, who were said to look askance at Psychodrama, so that in the second half members of the audience would willingly volunteer for appropriate roles. This they did. It is significant that the older worker playing the role of the younger, was herself a professor of psychiatric social work and a member of the conference. In this instance she was asked beforehand if she would help on the stage, and had agreed.

Another instance indicative of the impact of psychodramatic reality upon

individuals occurred by accident, when the St. Elizabeths training group was invited to give a demonstration for the American Psychiatric Association. Since the session was open to all, but appeared on the program of the section on Psychiatric Social Work, it was anticipated that many psychiatrists from State Hospitals would attend. The content, therefore, was to deal with hospitalized psychotic patients, their relatives, and the role of the psychiatric social worker in helping toward the resolution of the familiar yet difficult interpersonal problems which invariably ensue. In preparing for this demonstration, the training group came at lunch time to familiarize itself with the stage and to run through the structured situations. (There were to be no volunteers from the audience). No private place was available so that the group, not only did not see the stage, but had to use the end of a small assembly room where literature was being displayed. The Director, busy with scenes, failed to notice that a casual reader, a psychiatrist, left the literature tables and began to watch the action of the group. After a little while he touched the Director on the shoulder and said, "If it gets any worse, I can help you. These fringe, troublesome people always get mixed up with our meetings. I don't know the laws here, but I will help you get rid of that woman, even if I have to call a cop." The woman in question was playing the role of a paranoid patient in preparation for the next day's session. The psychiatrist stayed and helped, but not in the way originally suggested.

These instances have been cited because they suggest the quality and intensity of the emotional impact which psychodramatic teaching situations can, and do, produce. It is believed that this impact in itself, creates within the individuals feeling it, a readiness, an awareness, which opens their hearts and minds, to the end that the emotional and intellectual resources of the individual are at the service of the patient or client in the immediate situation. Standards of effective behavior for workers are raised, as evidenced in discussion where self-criticism and group-criticism takes on the exciting quality of a search for truth. This smacks of the laboratory, for psychodrama in a teaching situation demands the immediate spontaneous application of knowledge by an individual to a specific, controlled, reality situation, where all may see and hear at first-hand how it is we humans are proposing to treat one another in situations in which one person desperately needs help and another is learning to give it.

The success of this method of training is dependent upon the acceptance of certain already suggested assumptions as to the nature of the learning process in the field of interpersonal endeavor. It seems also uniquely dependent on the quality of the personnel utilizing the method. In considering personnel

selection, based on past experience, it is believed that Dr. Douglas Southall Freeman's address on "Leadership" to the Command and General Staff College, March 7, 1949, is curiously pertinent. Ordinarily one would not think of equating the administrators of psychiatric social work departments, the supervisors, the senior and junlor workers, nor their mentors with Army, Navy and Air Force officers and their commands, yet one is struck, on reading this profound and engaging essay, with the fact that leadership is leadership, and that the principles underlying the art are universal in applicability.

According to Dr. Freeman, the whole matter of leadership boiled down is to, "Be Simple, Know How, Have Character." In elucidating these points he says, "The first duty of a soldier training for leadership is to simplify his problems. A great leader has to be a simple person . . . has to study the simplification of his problems and the clarification of his own thinking . . . What will impress you most in their correspondence, prior to a great operation, is the simplicity and directness of their thinking . . . With simplicity has to be combined nowadays a knowledge that creates the impression that you do know. No matter what you are going into . . . it is confoundedly technical . . . You've got to know your stuff. Your men are going to find you out every single time, if you pretend . . . But no matter what a man may know in a long war that tests the souls of men, he has got to *BE*, as well as *KNOW* . . . To these essentials of simplicity and study I add, if you please, the vital qualification of Example."

This dogma of Dr. Freeman's is directly applicable to the use of Psychodrama in Teaching. Two major areas illustrative of this applicability will be discussed. (1) The first is that of the selection of personnel for the psychodramatic teaching unit, and the (2) second, that of the selection and structuring of the situations to be used upon the psychodramatic stage.

As implied throughout this paper, the wise selection of personnel for the endeavor is of primary importance. Keeping in mind the principles of leadership described above, it is obvious that the Discussion-Leader-Director sought must be a secure, warm person, who delights in all the processes of educational nurturing. This implies belief in and enthusiasm for the mission of the unit. As to professional competence or "know how," it should be pointed out that "know how" does not necessarily imply "can do." Both are essential characteristics of this leader. Good judgment is another imperative for him. The implication here is that, as Monnet has so shrewdly observed, "Agree to the fundamental idea and then work out the details to make it a reality. Technical details are no trick at all. *One of our greatest modern sins is letting tech-*

*nique become the master of judgment.*" As to character, we have already indicated certain desirable personality traits and only add here that this leader's life must habitually and continuously illustrate his own actual optimum interpersonal relationships.

The other essential team members who must be chosen are the man and woman psychodramatic actors or auxiliary egos. It is essential that they be able to play convincing roles, with no trace of ham, that their skills and knowledge be at all times subservient to the mission. They, too, must delight in human nature, normal and deviating, and further, while keeping to the selected role in a selected situation, they must be able to sustain sensitively the trainee or student by slight shifts of emphasis and variation, thus giving the unskilled or inadequate a chance to succeed as well as he can. It should be parenthetically stated that kind patients and clients often do this with inexperienced workers.

The experience of the St. Elizabeths training group suggests that such persons as have been briefly described, exist in far greater numbers in our population, professional and lay, than is generally known. Two recent memorable sessions, one a demonstration and the second a training session at the New York School of Social Work, reaffirmed this fact and indicated that such leaders and actors are readily identifiable at every fair-sized psychodramatic session.

The second area in which Dr. Freeman's dicta are of interest is that of the selection and structuring of the situations. This is content; this is also technique—in short, this is the meat of the matter of teaching by this method.

For example, the training group decided, as mentioned earlier in this paper, that all psychiatric social work cliches must be abandoned by students and staff during the training period; that plain English was the language of the month. It was not believed that authoritative announcement nor persuasive enjoinder would accomplish this. The following situation was devised:

You are a psychiatric social worker. You have been working in the psychiatric center of a Naval Hospital for 3 years during the war. You are at home—your first vacation in several years. You live in a remote country town. The time is 9 o'clock on a summer evening. You are sitting alone on your front porch in the moonlight, when an old friend drops by. Now the old friend, it developed as the scene progressed, was a young man, personable and charming, the worker had known in high school. He has been in the Navy, had active service, received a medical discharge because of a mental illness. No one in town knows this but his parents. He is engaged to Phyllis, his childhood sweetheart, and they are about to be married. Phyllis knows nothing of

the nature of his illness. He wonders whether he should tell her before the marriage. He does not want to lose her. He knows that you know all about such things. What do you think?

Again there is no time to disclose the range of spontaneous reaction evoked by this compelling situation. It has been used successfully with psychiatric social work personnel at the supervisory, administrative and staff worker level; that is, it tipped off considerations of the use of plain English versus cliches; emphasized the simplicities; brought out the emotional capacities of the workers as well as their actual knowledge and wisdom. We cannot forebear observing that more experienced workers seemed at times to hallucinate golden oak office desks, complete with green blotters, on hearing of the young man's problem, though sitting in a porch swing.

It was found among the administrative and supervisory group that personnel problems loomed large; that these workers had real difficulty in the smooth, wise handling of a situation, such as the following:

You are the Red Cross field director in an Army General Hospital. You have been on a month's vacation. At ten o'clock on the day you returned, the Commanding Officer sends for you and says that he has awaited your return, since you are the boss and he has confidence in you, to consult you about a serious problem which came to his attention during your absence. As the psychodramatic situation develops, it is disclosed that one of your best trained workers has become interested in, and deeply involved with, a young married officer, a patient on the open psychiatric ward. She is going out with him to dinner; has spent long hours in talking with him outside her office. It is rumored that they are engaged, although he is not yet divorced. Everyone, even the Corpsmen, are talking about it and the Chief Psychiatrist is furious. You, the field director, are to see that she clears the Post before retreat this evening.

There is no time to describe nor to discuss the outcome of this situation, except to point out that this one situation holds these, and other, successive psychodramatic opportunities:

1. Interview between Commanding Officer and field director.
2. Interview between field director and case supervisor.
3. Interview between field director and Chief Psychiatrist.
4. Interview between field director and worker involved.
5. Long distance call by field director to Red Cross area office.

Further or different scenes, other than those suggested, are frequently involved, as the training group work on this problem. Discussion reveals the ethical, professional and policy considerations which are implicit in such problems, together with the difficulty many psychiatric social workers experience in discovering that, *understanding* of the miscreant here involved will not, of itself, necessarily solve painful administrative decisions, nor make action easy.

It is believed that the limited but suggestive sampling of situations and the structuring suggested above indicate the opportunities psychodramatic technique offers for the simplification of problems existing in reality practice, in the solving of them, and to a unique degree, discloses those areas in a worker's practice where head and heart do or do not synchronize well. Here is a golden opportunity for helping the practitioner help others in a more perfect way.

After such enthusiasms as have been expressed throughout this paper for this particular technique, it must now be stated that the authors can produce no scientific validation of the results achieved by this method of teaching. Rating scales for such validation appear clumsy and incongruous with the subtleties of behavior exhibited in the spontaneous situations. However, as stated earlier, there was almost always general agreement as to the nature of the behavior observed by students and staff. The conclusions of the St. Elizabeths training group as to inappropriateness of rating scales tally significantly with those reached by the group whose work in a similar area has been reported in "Assessment of Men" . . . "This opportunity to observe the elusive and unique qualities of each candidate's behavior without the necessity for rating it, turned out to be the most valued aspect of this technique."

It might be said, in conclusion, that the method of teaching described is in the "testimonial period" of evaluation. Here are a few statements of the students from supervisory and administrative groups sent in six months after the conclusion of the course:

"I felt more free because I knew I was not hurting anyone and at the same time more conscious of what I was doing. My sensitivity to the subtleties of patients' responses was sharpened and carried over into later interviews with a real patient."

"I thought I would have difficulty in getting into the role because I am anxious about expressing myself in speech and behavior before a group. Almost immediately upon going on the stage, however, I became so intent on working

through the situation and using my past experience in this heightened emotional atmosphere that I became less self-conscious to a degree I would not have believed possible . . . ”

“A testing of skills in a realistic setting. I think this method would be invaluable in schools of Social Work so that we might practice casework with more warmth and feeling and increased sureness which comes from feeling into a situation, as well as knowing it academically.”

“A very vivid way of teaching, and an emotional living-through, a learning experience. The discussions following were exceptionally valuable.”

“Psychodrama has been very helpful in understanding supervisory problems and the effect of the supervisor and supervisee on each other.”

“Psychodrama has given me more confidence in my ability to handle difficult situations spontaneously. It has showed me that there is more than one way to handle a situation—not just ‘one correct way’”.

“Psychodrama is an emotional experience—a sort of reality testing which is more sharply pointed than talking can be.”

“I really feel that psychodrama leaves a more lasting impression than the other training methods because in itself it includes elements of all others. It combines the seeing, hearing, and more important, the feeling aspect of all learning situations. Even when not participating the observer projects herself into all roles, thereby benefiting from the total picture. It obtains the response of the total personality.”

“I hate to admit it but it was probably psychodrama that taught me the most. Perhaps it is because it deals with specifics. Perhaps it is because I learn best by seeing rather than just hearing. Perhaps it is the startle reaction. Of course, by pure theory we learn best from lectures and reading, and clinics, show us what we have learned. Psychodrama puts all of them into application.”

“I was completely impressed by the whole tremendously dramatic process. I felt as if the control of my conscious (and probably unconscious) feeling was lifted and projected vividly into the situation. Seeing and hearing an interview, all the steps, all the personalities involved, and the consequences, left an indelible impression. I wonder when schools of social work will incorporate this technique of teaching.”

## DISCUSSION

CARL A. WHITAKER

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The opportunity to read the papers presented this morning and then to listen to them again has been a very stimulating experience. It is difficult for me not to take up those details of each paper that intrigue me to further thinking. I am stimulated, however, to discuss with you one of the implicit vectors that seems to carry throughout all of these papers. There is no doubt in our minds but what the leader is the most significant figure in the group, yet it is interesting to note that he is regarded almost exclusively as a function and very little consideration is given to the leader as a person.

First, may I raise a question? Is the leader the therapist at all time, or at any time—if so, is he the therapist to one or each of the patients in the group or is he therapist to the group as a whole? There is a corollary of this question. When, and to what degree, is the leader only one of the individuals in the group, even though a very experienced one? One of our speakers has discussed the “contract” between the leader and the group. I think we might give considerable thought as to what the nature of this contract is, and what are the limitations of this contract. Before going on to discuss our experience with the growth of the leader, I should like to suggest that there is a second contract: That between the leader and himself. Part of that contract has to do with the recognition that any group has more potential therapeutic capacity than its leader. If this is true, we must face the fact that the group is to some degree therapist to each of its members, including the leader.

I should like to dismiss any consideration of the group process as such or the theoretical aspect of any particular type of group psychotherapy and take up on an individual level my perceptions of the development of one group leader. To be this personal would only be tolerable in an older, more experienced man were it not that the science of group psychotherapy or the art of being a group psychotherapist is in such an early stage of its development that an individual case history has, thereby, some significance. I offer you this then, in all humility, realizing that it will differ from your experience, as, indeed it does from the experience of the other members of our staff, but in the hope that it will stimulate us to think about the growth of the leader, since “The best way to help other people is to help yourself.” I think this approach is most necessary in group psychotherapy.

In general, there seems to have been two phases in my own development, the first having to do with carrying out a certain role within the group. This role had to do with certain preconceived ideas as to what a leader should be, with a certain conviction about the necessity for being a therapist to the group, that is, a catalyst to the movement taking place within the group as a whole. It may seem more clear if I say that it has resemblances to my early experience as a father which was so tied up with my fantasy of what a father should be that it was only much later that I found myself able to be more of a person and not just a stereotype of the father.

Within the role playing phase of my own growth as a group leader it seemed to me that I was first a *frightened patient*. In this I was very little different from the other patients in the group. I'm sure I need not illustrate this for you. As I become more sure of myself in the group situation it seemed rather automatic that I would protect my patient-feelings by assuming a *dominant-father* role. For example, one of my discoveries in this stage was that one could deepen the group experience and the group relationship by excluding all discussion of reality and overtly demanding that the group function in the present. The leader pushes himself and the group into a deeper experience when he denies all outside experience and all historical recital.

It seemed to me that the third stage in the growth of the leader had to do with the development of a protective nurturing affect on the part of the leader. I became the *maternal-parent-person*. This we see beautifully described in Dr. Twitchell-Allen's presentation. I should like to re-emphasize that this is the portrayal of the growth of one leader, and I'm sure that I don't have to tell you that these stages are neither serial or clear-cut. It seemed to me that the fourth stage had to do with the capacity to function as a patient among patients, to participate in the reality of the present experience on an equal basis with the other individuals in the group.

Moving now into the second phase, it seemed that in addition to all of the above, it became possible to move on from the leader status to the stage of being a *participant in group fantasies*, not only in the realities of the group experience, but in group fantasies or even to inaugurate fantasies in the group itself. For example, in my freshman medical school group psychotherapy class which meets each Monday morning at nine until the end of the Sophomore year, I discovered that I had opened several therapy hours with a risqué story and that the effect of this was to precipitate a joint fantasy. Out of that silent period there emerged a new closeness amongst us and *the next topic was apt to be very real and very personal*.

If I may be permitted to push this somewhat artificial classification a step further, it seems to me that several members of our staff have become the *demanding patient* to a new group and thereby forced the group to accept its potential as therapist. This boomerangs by making each member of the group more aware of what the group could offer him if he became a patient. Please don't infer from this that I am talking about a psychodrama type of experience. I refer to taking a specific facet of one's own growth with all the anxiety attached and demanding that the group participate with you in your free association to this facet of your own living.

Finally, it seemed to me that there is a stage in which the leader goes all out in a personal attack on someone in the group who is keeping him from participating with the group as deeply as possible. He demands that the other person in the group shall be patient to the group or that the leader and this patient-member of the group shall jointly present to the group their dissonance and demand that the group make harmony out of it.

I should like to make it clear that this is not a description of a group method, but a review of experiences as a group leader which seem to indicate that the relationship of the leader to the group is not something which is constant, but rather something which is developing and something which we may be able to implement if we can discover some more of the operational dynamics which bring it about.

May I express again my appreciation for the opportunity to discuss the excellent papers and hope that these personal experiences may be pertinent to your own thinking.

## GROUP PSYCHOTHERAPY PROGRAM AT THE SPRING GROVE STATE HOSPITAL\*

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About two years ago a group psychotherapy program was initiated in this Hospital. It was prompted by several important considerations. First was the central problem confronting most every state hospital: the chronic condition of being overcrowded and understaffed. Only a very small portion of the patients who would be suitable subjects for therapy—if the time and psychiatrists were available—could be reached through individual therapy. There was an urgent need to find ways for reaching larger portions of our patient population. *Group psychotherapy* seemed to indicate many inviting possibilities. This choice was influenced by the impressive reports about the use of this technique in the Military Services and in occasional civilian institutions. We were anxious to gain experience in this procedure. Another consideration was of a more theoretical nature: Sociology and also some psychiatrists look at mental disease as "deviant behavior." It would probably take a certain amount of mental acrobatics to apply this point of view to many conditions (e.g., psychosomatics), but looking at the problem from a state hospital viewpoint, we promptly realize that the "deviant behavior" is the most important factor in deciding whether or not a patient should be and remain hospitalized. It is only when a person's behavior becomes unacceptable to his environment that hospitalization is considered. It would seem, therefore, logical that the first goal in treatment should be to enable the patient to acquire the knowledge of the 'art' of getting along with people, an art that one would best acquire in a group setting. Of course this is only part of the task, to quote Schilder "the socialization process of the group is only a part of the psychotherapeutic task; the task demands that the individual gain insight into his social and psycho-sexual adaptation."

The material for this paper is the result both of my own experience and the experience of many members of our Staff who regularly reported at our meetings about their activities, impressions and findings.

The *groups* in operation since the beginning of our program (1949) could fit into the following categories:

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\* Read at the 9th Annual Conference of the American Society of Group Psychotherapy and Psychodrama, New York, February 16, 1951.—I wish to thank Dr. Albert A. Kurland and the other members of our Staff for their many helpful suggestions in the preparation of this paper.

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|---|-------------------------------------|
| 1. Alcoholics                                 | 6. Groups of actively psychotics    |
| 2. Relatives of alcoholics                    | 7. Groups of handicapped psychotics |
| 3. Psychodrama Group<br>(with schizophrenics) | 8. Groups of delinquent psychopaths |
| 4. Insulin-treated patients                   | 9. Groups of hospital attendants    |
| 5. Patient self-government                    | 10. Group of therapists             |

### 1. *Alcoholics.*

Our program for the treatment of the alcoholics was carried out in close cooperation with the Alcoholics Anonymous. The patients under consideration are chronic alcoholics of long duration without psychosis. Upon admission, the patient was told about the treatment program and was admitted to the group as soon as the symptoms and signs of acute intoxication had subsided and sedation was discontinued at least during daytime.

The group met three times weekly: once with a psychiatrist; twice with other members of the A. A. in a Baltimore Branch of the A. A. (transportation was provided by the Hospital). In this paper I shall discuss only the sessions with the psychiatrist.

The composition of the group was mixed, the greater portion being made up of male patients. The average size of the group was about 30; this included: actual patients, former patients, relatives and friends of patients. The duration of a session was one hour. It was an "open" group, patients being admitted to the group as soon as they were ready for treatment. The atmosphere of the sessions was kept congenial and at the time dignified. Topics for the discussions were suggested by the group or the therapist and dealt with questions like: What is an alcoholic?—Philosophy of the A. A.—What is comfortable sobriety?—Causes of relapse?—In connection herewith were discussed feeling of insecurity, frustration, need for dependency, escape from responsibilities, etc.

The therapist took an active part in the discussions pointing out the many *disadvantages* of alcoholism in terms of disrupted family life, disadvantages at work and in social status. On the other hand, he emphasized the many possibilities that alcoholics are missing and made great use of testimonials of *former patients* who adjusted well after their discharge from the hospital.

Speakers from the Social Service Department and the Maryland State Rehabilitation Service were invited in order to stimulate discussions about problems connected with these services and to clarify problems that had been raised in preceding discussions.

It is an interesting observation that in all the discussions there was no mention of sex, a phenomenon also observed by E. Mueller. It was also noted

that the patients remaining "dry" were friendly and cooperative, eager to help the ones that found it difficult to keep sober. On the other hand, the recidivists were resentful of everything and everybody and particularly of the patients remaining "dry."

About 1/3 of the members took active part in the discussions while the other 2/3 remained silent. It has not been ascertained yet which category of patients benefited more from the group sessions.

Through our close co-operation with the Alcoholics Anonymous, we were able to follow up on the discharged patients and the following excerpts from the latest A. A. report concerning our program illustrate the results:

1. 62 (45%) of those admitted have been released and are known to be with their families and their jobs and are adjusting themselves well to their responsibilities without the use of alcohol. The majority of them are remaining in Alcoholics Anonymous.
  2. 26 (19%) have not been released from the hospital; but the majority of these are attending meetings conducted at the hospital or those of the Baltimore group, or both.
  3. 27 (20%) have been released and while it is not definitely known how well they are adjusting themselves, there has been no indication that they have returned to alcohol.
  4. 13 (9%) have been released and are known to have returned to alcohol.
  5. 4 (3%) have died since their release.
  6. 6 (4%) of those committed have eloped from the hospital.
- . . . . Six patients refused to cooperate with the doctors and openly refused to accept the seriousness of their illness. They were released from the hospital as a sort of disciplinary measure . . . . 5 of *this* group have not returned to drink, have all gotten jobs and have wholeheartedly subjected themselves to the A. A. program. There is indeed much food for thought in the adjustment which these five very sick persons are making in their lives."

## 2. *Relatives of Alcoholics.*

Although the relatives of the alcoholics were admitted to the regular therapeutic sessions for the alcoholic patients, it was felt that they needed something for themselves, some support and insight which would enable them to deal more efficiently with the patient. We thought of the possibilities offered by group therapy. We sent letters to the relatives informing them of our plans and finally we organized a group composed of 5 wives, 1 mother and 1 husband of alcoholic patients. The age of the members of the group ranged from 30 to 50 years. The sessions were conducted by a psychiatric social worker. They

met once weekly for one hour. In the first few sessions the leader assumed an active role, suggesting topics and, when called upon, answering questions.

The discovery that she (or he) was not the only one facing the problem of living with an alcoholic, that the other members of the group shared the same problems, seemed to be the first step toward the alleviation of the relative's anxiety. Sex seemed to be a problem with the wives of the alcoholics. On the one hand, they were offended by their husbands' accusing them unjustifiably of being unfaithful, on the other hand they themselves were not sure of their husbands' fidelity. Again they were relieved by discovering that the other members of the group had the same experiences and by learning that those are common features in chronic alcoholism.

While the patient was in the hospital, his relative usually showed little activity in the group. The problems became more alive as soon as the alcoholic left the hospital: readjustment, job, how to deal with the discharged patient?

To illustrate the importance of treating the patient and his immediate relatives I should like to cite the case of Mr. M., a 45 year old white male who had his first attack of *delirium tremens* in 1935. He was admitted to this Hospital on February 24, 1950 and paroled in the care of his wife on March 31, 1950. Because of continued drinking, he was returned to the Hospital on May 10, 1950. At that time Mrs. M. joined the group of the relatives and came to realize the part she had in her husband's difficulties. In the past she would get up in the morning grouchy and refuse to make breakfast for her husband because of his drinking the preceding night; he in turn refused to give her the paycheck, showed no interest in the house, would stay out late at night and then come home intoxicated. Since his release from the hospital on June 12, 1950 they have been going together to the A. A. meetings and Mrs. M. continued with our group. She reported that her husband recently gave her the paycheck, the first time in 20 years. He also showed some interest in the house. She also reported with great pride the following *incident*: One evening her husband told her he was going to get a glass of beer. She said that her usual reaction would have been a *storm of anger* and quarreling. This time, however, she said: 'go ahead and don't stay too long.' She was agreeably surprised to see that Mr. M. took off his coat and remained home.

The creation and the maintenance in operation of the relatives' group were combined with many difficulties, to mention only a few:

- a. The members of this group, not being hospitalized, had to come to the hospital for the sessions and this was connected with factors such as distance, transportation, time and reluctance to come to a mental hospital for treatment.
- b. Ambivalent feelings toward the patient. We observed that the relatives genuinely interested in the patient came regularly to the meetings. The others dropped out from the group and would seldom visit the patient.
- c. In some cases, the *patient* was against it. E.g., one patient, after his re-

lease from the hospital, would get intoxicated every time his wife would go to the group meeting, until she finally dropped out.

### 3. *Psychodrama (with groups of schizophrenic patients.)*

We began in June, 1949 with a group of schizophrenic patients. The composition of the group was mixed, being made up of about an equal portion of male and female patients. The *criteria* for selection were: 1. an indication by the patient of the desire to participate; 2. ability to maintain a sufficient degree of self-control within this social setting, and 3. the recommendation of the ward psychiatrist. The number in the group was kept to a maximum of 14; as a patient left a new one was admitted to the group. At the end of 18 months, a total of 82 patients had been members of this group.

They fell into the following diagnostic categories:

Schizophrenic reactions	54
Affective disorders (Manic-depressive, Manic)	8
Psychoneurosis	3
Character disorders with psychotic episodes	17

The group met twice a week for about 75 minutes in a large room equipped with a two-step *platform-stage* on which a colored spotlight could be cast.

During a period of several months *sound recordings* were made, by tape recorder. These would be played back to the patients. At first they appeared to be deeply interested in the sound of their own voices, but after the novelty wore off it seemed to contribute very little to the situation.

Each session would usually begin with a discussion: either spontaneous *within* the group, or stimulated by the *therapist*. Some detail of the discussion would then be acted out. For example, in a discussion about hospital life, mention would be made about 'ground parole.' Various patients would re-enact their actions—while in this situation. At times it would practically amount to a period comparable to 'free association' in which a great deal of hostility toward the institution was ventilated.

Scenes re-enacted evolved about social settings in the hospital such as: a visit of a relative to a patient, a discussion of two patients on the ward; about problems they would face on leaving the hospital such as: the return home, applying for a job, meeting old friends. Quite often this gave a sharp picture of the patient's readiness to leave the hospital.

After several months of work with this kind of approach and evaluating the activities, there was much uncertainty as to what was being contributed

by this form of activity. On questioning the patients individually as to what they felt they were getting out of it, a wide variety of answers were obtained. To some patients it was an escape from the boredom of the ward; to others it was an opportunity for socializing with members of the opposite *sex*. For still others it was an opportunity to demonstrate histrionic abilities and for self-expression.

It was then decided to probe a little more deeply into emotionally-laden material. We cautiously began to employ some of the *Moreno techniques*. This was facilitated by a splendid lecture on Psychodrama<sup>3</sup> by Dr. J. L. Moreno and a demonstration of techniques during a symposium on Psychodrama, held at Spring Grove State Hospital on October 13, 1949. We were also fortunate to have two trained volunteers who had attended Doctor Moreno's Psychodrama Institute in Beacon, N. Y.

The techniques used were: (1) The substitute role technique—asking a person to act out someone else. (2) Mirror technique—the auxiliary ego taking the part of the patient and mirroring his behavior to him. (3) Acting out of a patient. (4) Reversal technique—someone else plays the role of the patient and the patient plays someone in relationship to his real self. (5) Double Ego technique—in which the patient and the auxiliary ego objectify different sides of an inner conflict.

Despite all attempts at getting into deeper emotional problems, the activities have remained limited to a level dealing with activities in the hospital setting and re-enactment of episodes in their interpersonal relations. Rarely was there ever any sexual situation brought up.

Many of the patients while attending psychodrama, were also receiving other forms of therapy such as Electro-Convulsive Treatment, insulin, other group or individual psychotherapy. There were no particular effects noted in relationship to other forms of therapy, except in three cases of character disorder, where it was felt that the dramatization activities were blocking the treatment and the patients, upon their return to individual therapy were unproductive; the three patients were dropped from psychodrama and several months later were also dropped by their individual therapists.

It was noted that dramatization has a marked effect upon the affective disorders, particularly of the *manic* type. It seemed that usually after about 20 sessions these individuals have shown a marked amelioration in their psychomotor symptomatology.

Since many of the members of this group were also receiving other forms of therapy, the benefits of psychodrama could not be evaluated statistically.

Our psychodrama unit continues in operation.

#### 4. *Insulin-treated patients.*

This group was formed in May, 1950 with a two-fold aim: on the one hand were the therapeutic aims of group therapy in general, on the other hand was an attempt to learn about the patients' individual reactions and feelings toward insulin treatment and their ideas about its effect and effectiveness.

The group consisted of female schizophrenic patients who were in, or had recently completed a course of insulin therapy. The size of the group was about eight patients; at the end of six months a total of 15 patients have been members of this group. The age of the members ranged between 17 and 39 years. Nearly all have been hospitalized less than one year.

Membership in the group was automatic on beginning of insulin treatment. Patients were allowed to continue in the group after termination of the course of insulin. Patients who *refused* to come to these group meetings were urged to express their feelings and thoughts associated with that refusal. Sessions were held twice weekly at regular intervals. The topics were not different from the ones discussed in other groups except for occasional comments about insulin therapy. Some patients objected to being used as a "guinea pig" but admitted that they felt better. Others felt that the treatment served to recall their childhood. One patient said: "it helped me to relax my tension but it really did not change any of my problems." In general, they felt that the treatment brought about a feeling of relaxation, comfort and well-being.

Although it was difficult to evaluate the results in terms of statistics, the following observations have been made: 1. there has been greater receptivity and adaptation to the insulin routine as manifested by decreased incidence of need to force the patient to take injections and also a decreased incidence of delayed insulin reactions; 2. there has been an increased socialization of the patients.

#### 5. *Patient self-government.*

We have at the present time 2 wards with patient self-government; these are: the convalescent wards for male and female patients in the admission building. This program has been in operation since March, 1950.

The government or committee was composed of five members elected by the entire group for a six-week term of office. The ward psychiatrist would

meet weekly with the committee and with the entire group, maintaining a passive, non-directive attitude, acting mainly as a liaison between the group and the hospital administration.

The accomplishments of the committee were impressive; its members showed considerable insight in the ward housekeeping and inaugurated a fair system of rotation taking into consideration personality qualifications and insisting on each patient contributing. They also accepted the responsibility for the dining room and for the establishment of respect for individual ownership.

But perhaps the most important accomplishment was the clinical reaction of individual patients to this new situation in which the patients gain the experience of working together toward a constructive goal and develop a knowledge of socialization, organization and effective group leadership. They learn to explore reality situations and analyze their own needs and handicaps.

An example will illustrate this point: An aggressive member of the committee reported to her psychiatrist that some patients reacted to her as her children did, with the only difference that the patients were also complaining about her tone of voice and her domineering manner. She began wondering if her children were reacting to her domineering attitude. After a visit home two weeks later, she reported that she was getting along better with her family and that she had been making an effort to modify her behavior. She felt that she was now better informed about things annoying other people, that she was able to be more realistic in her reaction to her family. Another patient reported that she patterned her ways of getting along in her new job on what she had learned in the hospital while participating in the work of the Patients' Self-Government Committee.

While on the subject of patient self-government may I mention that the chief obstacle in the progress was the reaction of the attendants. They experienced great anxiety because of the feeling of loss of authority and because of the fear of "becoming functionless!" The same difficulties have been reported by Hyde and Solomon<sup>4</sup> in their report on the patient self-government at the Boston Psychopathic Hospital.

#### 6. *Groups of actively psychotics.*

Since the beginning of our program, we had many groups of this type in operation. Some were discontinued, the majority, however, are in operation and new ones were created. We had groups both in the admission and the chronic services.

There is no uniform picture of the operation of these groups. However, these were the general features: (a) Each group was composed only of one

sex. (b) The size of the groups varied from 6 to 16. (c) The criteria for the selection of the patients were not uniform: some therapists made the selection on the basis of the patients' desire to cooperate; others designated their patients for group therapy more on an arbitrary basis. The patients were required to come to the meetings but then could leave the session without giving any explanation. The groups were composed mainly of schizophrenic patients and a few with affective disorders; there were always one or two 'aggressive' patients in each group "to carry the ball." Psychopaths had to be excluded because they were found to be a disruptive element.

Some groups were of the "open" type—as one patient left the group, another was admitted in order to maintain an average maximum (8 to 16). Other groups would not replace their losses and gradually be reduced to a small number (2 or 3) when they would form a new group. There was also the "open house" type of groups—their sessions were held on the ward or in a room adjoining the ward. The patients would "drop in for a cigarette" and, if interested in the discussion, they could remain.

In order to illustrate the various *methods* employed, I shall now describe briefly the functioning of some groups.

I. One group, composed of chronic, 'overtly' psychotic schizophrenic *female* patients was started with 6 patients (the number increased later to 14). The criterium for selection of patients was their desire to participate. The group met in the reception room of a ward. Cigarettes, coffee and occasionally cookies were served during the session. One patient would come only for the coffee and then leave the session; the group was indignant of this behavior and decided to exclude the patient from the group. The topics for discussion were usually furnished by the group; they included questions like: why does a patient come to a hospital? Why does a patient become disturbed? And how should she be dealt with? Why do some patients refuse to eat? Why do husbands and wives quarrel? Should we punish children? How to raise children? What kind of a husband does a girl look for? etc. There seemed to be a continuation of ideas, a carrying-over of ideas from one session to another.

The *integration* of the group seemed fairly satisfactory; e.g., they usually continued their discussion *without the therapist* after the termination of each session or on occasions when the therapist was called to the phone.

A review of the patients' *progress* revealed: one patient married an attendant after her discharge from the hospital; two patients returned home to

live with their husbands; one patient returned home to her parents and one patient was discharged against medical advice at the insistence of her husband. The remaining members of the group are still in the hospital, showing very little, if any, improvement. It may be noted that, except for two patients, the members of the group received *no other* form of therapy during a period of time covering several months preceding, and during the time of group psychotherapy. The two patients that received Electro-Convulsive Treatment concurrently with the group psychotherapy, are still in the hospital.

II. Another group was composed of 8 female patients in the admission building: 7 schizophrenics and 1 manic-depressive, depressed. This group, of a "closed" type, was meeting twice weekly with two therapists, a male psychiatrist and a female psychologist. Although the patients repeatedly *rejected* the psychiatrist's interpretation of this situation as "home with father and mother figures," they nevertheless reacted to that situation in a characteristic manner. Some patients would feel ill-at-ease and withdrawn when the psychiatrist was present at the session, but would become active and participate in the group discussions when the woman (psychologist) was the only therapist; they would refer to these sessions as "*sewing circle*."

The topics, similar to those in the other groups, were suggested both by the group and the therapists. 6 of the members of this group are known to be adjusting well at home. But it must be added that most of these patients received other forms of therapy concurrently with group psychotherapy.

III. An entirely different approach was used with a group of male catatonics in a chronic building. The leader of the group, a *music therapist*, played selected phonograph recordings and after each record he would invite a discussion of events that the particular record brought to the patient's mind. First there was no response, the majority of the patients being negativistic and mute. Recently it was observed that the tense and rigid facial expression of these patients became more relaxed; the patients were observed to tap and nod to the rhythm of the music. Although progress is very slow, there are signs of improvement.

IV. The same approach (music) was used in a group of 7 disturbed, deteriorated, schizophrenic female patients. All of them were destructive, untidy and smearing faces. We noted a *marked improvement* in their social behavior in terms of not tearing up their clothes and keeping them on; the majority also stopped smearing faces.

### 7. *Group of handicapped psychotics.*

A group of physically handicapped schizophrenic patients was formed in June, 1950. It was composed of 5 male patients in the admission building. Their physical diagnoses were: multiple sclerosis, bilateral macular degeneration of the retina, right post-traumatic hemiplegia, facial paralysis and sequelae of poliomyelitis.

The meetings were held twice weekly in the therapist's office. The therapist was passive, permissive, "just present;" occasionally he would actively participate in the discussion interpreting to the group their behavior and individual dreams. The patients' reactions to these interpretations varied from complete rejection to an expression of curiosity, asking for more detailed explanations. Psychological motion picture films were frequently used to stimulate discussions. Topics for discussions were similar to those in other groups and were suggested by the patients and the therapist.

New members, without physical handicaps, were added to this group and it operates at present as a *mixed group*.

### 8. *Groups of delinquent psychopaths.*

A group psychotherapy program was also started in our Division for the Criminally Insane. The groups were composed of 8 to 10 male patients who at one time or another during their hospital career were diagnosed as 'psychopathic personalities.' They were all committed by Court, following a criminal offense ranging from vagrancy to murder.

One group, composed of 8 to 10 psychopaths, was meeting once weekly under the leadership of the *music therapist*. These patients did not verbalize to music as well as the schizophrenic patients, always complaining that music—any kind of music—had a tendency to put them in a sad mood. A few weeks after their formation, the group decided to form a "talent club" which, with the cooperation of a local organization, organized entertainment for the patients in that building.

Another group of 10 delinquent psychopaths was organized and conducted on a discussion basis. The group was meeting once weekly. Main topics for discussion were: the situation at home, hardship in childhood, bad company, etc. Later, discouraging notes appeared in increasing quantity and the patients started asking questions: "What will I get out of it?" or "How will this help me in Court?" etc.

Due to administrative changes, the therapist was unable to continue with this group.

9. *Groups of hospital attendants.*

The introduction and the development of our entire group psychotherapy program coincided in time with profound changes in the Maryland State Hospital system. It was at that time that the famous Norton articles entitled "Maryland's Shame" appeared in the "Baltimore Sun" and awakened public opinion to the conditions in the state hospitals. There were many commissions, hearings and, above all, many rumors. Finally the changes came: new administration, new salary scale, new faces, new working hours, many hurt feelings and, with all this, a great deal of insecurity and anxiety. This state of affairs was not conducive to good relationship and cooperation among the employees and still less conducive to the creation of a good *therapeutic atmosphere* for the patients.

It was imperative to remedy this situation. The *first* objective was to dispel unfounded rumors. The Superintendent met with all the employees in order to inform them about the expected changes and progress. The heads of the departments met with their subordinates in order to discuss problems concerning their department. Finally, the doctors began to meet with their attendants to discuss and clarify problems that arose during the performance of their duties.

During these discussions it became clear that many attendants had serious misconceptions about mental illness and as a result were unable to perform their duties efficiently.

The physicians in charge of the various services organized *groups of attendants*, and the Administration co-operated to the extent of giving the attendants time off to enable them to attend the meetings. The sessions were conducted on a more or less *impersonal* basis: discussing in simple terms problems of mental illness, mental mechanisms, dynamics of patients' behavior, proper ways of dealing with patients. A session would start with an attendant complaining about a patient, relating a specific incident and the discussion would revolve around this incident and what we could learn from it. For example: an attendant complained that a patient (a 24 year old schizophrenic with hysterical trends and frequent anxiety spells) would always have his spells in the office and at a time when the attendant was busy with other patients. The discussion was steered toward a realization that the patient does not want to have these spells; but that a spell may have one or even several purposes, e.g., it may

be an attempt on the patient's part to gain the attention or the affection of the attendants. The discussion went then over to ways of dealing with this patient when he had a spell and what could be done to prevent spells.

*Motion picture films* were frequently shown at the beginning of a session and then discussed. An attempt was always made to point out, when possible, how the newly acquired understanding and knowledge can be applied to situations on the ward and also in everyday life.

#### 10. *Group of therapists.*

The therapists in our groups were psychiatrists. The clinical psychologists, the psychiatric social workers and the music therapist worked with or, at least, under the supervision of a psychiatrist. The personnel participating in the program held bi-weekly meetings where problems connected with the entire program were discussed. The various techniques, the attitudes and personal reactions of the therapists were discussed frankly. During one of these discussions, for instance, a therapist complained that he was uneasy with his group and that he felt threatened by the many demands made upon him by the individuals (patients) in his group. A closer look at the problem revealed that all the demands were of an administrative character and it was suggested that the therapist should not be the administrator of his group. In reviewing the literature, I found that Teirich<sup>5</sup> came to the same conclusion.

Some therapists felt that the group sessions were strenuous; others stated that although they felt comfortable with the group, they felt "more at home in the individual treatment setting." There were therapists who strongly identified with the patients and thus made progress impossible. Some therapists felt the need of always being the center of the group activities and were frustrated when this role was denied. These discussions were of great value in the progress of our program.

Also, there were regular weekly previews of the motion picture films and the therapists' group evaluated the films for their psychotherapeutic value with the different patients' groups. Each therapist was left free to decide whether or not he wanted to show a film to his group. Following are some examples of the films: Feeling of hostility; feeling of rejection; Palmour Street; Story of menstruation; Human growth.

Therapists would occasionally report on the activities and progress of their groups.

## SUMMARY

In summarizing this material I shall discuss some of our *observations*.

1. Criteria for *selection of patients* for group psychotherapy: in some groups (alcoholics, insulin treated patients, patient self-government, hospital attendants) membership was automatic; in other groups membership was on a selective basis: some therapists made their selection on the basis of the patient's desire to participate, others required the ability to maintain a sufficient degree of self control. Some groups were formed on the basis of the patients' diagnosis (group of catatonics, group of disturbed deteriorated schizophrenics). In connection with the selection of patients it has been observed that: (a) patients with psychopathic behavior were disruptive in a mixed (with reference to diagnosis) group and they were excluded from the sessions; (b) groups of psychopaths were therapeutically unproductive in terms of insight.

2. The group psychotherapy *setting*: our groups were conducted 1. on the wards, 2. in rooms adjoining the wards, 3. in a psychiatrist's office, 4. musical therapy room, 5. psychodrama room, 6. library, etc. There was a great difference in the physical aspects of these various locations in terms of furniture, light and air conditioning. On questioning the patients individually on that matter I received an almost unanimous opinion that the sessions should *not* be held on the ward, and many expressed the desire for a congenial and friendly atmosphere in a *comfortable and pleasant setting*. It is my belief that a special room should be set aside for group psychotherapy with adequate furniture, lighting and ventilation (also recommended by Coltharp<sup>6</sup>.) Provisions should also be made for verbatim recordings of the proceedings (stenographic or, *preferably*, sound recordings).

3. *Technique and goal in therapy*: The techniques employed in our program were: Repressive-inspirational (alcoholics), educational (attendants), sociometric (psychodrama) and non-directive-permissive with occasional interpretations of pertinent material (other groups). The presence of the therapist's understudy in the group was very valuable: he would act as a *trained observer* and could conduct the session when the therapist was not available and thus keep a regular meeting schedule. The therapist should not be the administrator of his group. The question of how "deep" one should go in treating patients in a state hospital is open for debate.

4. *Evaluation of results*: It appears very difficult to evaluate statistically the results of our program, as there were too many variable factors; e.g., concurrence of other phases of the hospital therapeutic program. Many of the patients, while attending group psychotherapy, were also receiving other forms of therapy (Electro-Convulsive Treatment, insulin, individual psychotherapy, etc.). It was noted that patients participating in group psychotherapy were generally more receptive to the other forms of treatment. In general, our observation seems to concur with that of Geller (7) who found a *qualitative* increase in the degree of improvement of individual patients leaving the hospital rather than a quantitative increase in the number of patients being discharged.

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## REMARKS ON GROUP ANALYTIC PSYCHOTHERAPY\*

by

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Group Analytic Psychotherapy is the name which the present writer has given to a particular form of group psychotherapy which he has devised and practised since 1940 in England and which has been developed ever since. This name was chosen in order to make clear three features of principal significance.

Firstly, this method is group-analytic. It is based on the *group*, and is not, for instance, psychoanalytic, which is a method based on the individual. As the individual and the group cannot be studied in isolation, it is more correct to say that Group Analysis is based on the group situation. We study and treat the individual in the group, in his relation to others and to the group as a whole, as well as with the active participation of these others and the whole group. We observe the total configuration ("Location") of any event, the different ways in which such an event reflects on the group as a whole, in the interaction of its members and "inside" each individual. At other times, as we shall see later, Group Analysis—and even Group Analytic Psychotherapy—is interested in the group itself, for its own sake, and in the individuals only insofar as they are members of this particular group. In yet other situations, the interest is equally divided and the focus of attention oscillates.

Secondly, the orientation is *analytic*, based on the psychological analysis of verbal and non-verbal communications, other intentional or unintentional contributions, and the behaviour of the group's members. What is sometimes called the "here and now" of the situation is often of central significance but has in my approach no claim on monopoly whatever. Analytic orientation in this connection is not only compatible with but also very much akin to psychoanalytic orientation, but more comprehensive. It includes views of psychological analysis as conceived by Goldstein and Gelb, and of sociological analysis in the sense of sociologists, as for instance, Karl Mannheim, social psychologists and social anthropologists.

Thirdly, the name *Group Analytic Psychotherapy* emphasizes once more

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\*The reader will be interested in this contribution by one of the leading exponents of British group psychotherapy. The author does not go into elaborations of terminology and into the history of terms here; that the basic concepts and terms of scientific group therapy and group psychotherapy emerged in the U.S.A. (Moreno, 1931) is well known.—Ed

that it is a form of psychotherapy and not a form of psychoanalysis, and further, that it is group psychotherapy as distinct from therapeutic activities of all sorts which can be carried out in groups. These may be understood in terms of group analysis or group psychology, and, if so, should be called group therapy (for instance, therapeutic social clubs, play acting, activities of all sorts, etc.)

When first reporting on this work, I used the term "Group Analysis." This was thought to be specific enough. Trigant Burrow had abandoned this term and he was the only one to have used it previously. But since that time a number of writers in the U.S.A. and some in this country have adopted it. Although their work has been influenced by group analysis to a greater or lesser degree (sometimes not recognized or readily acknowledged), their practice is very different, not only from that of the present writer, but also from each other. Indeed, frequently antithetical principles are designated by this same name of Group Analysis. As matters stand today, moreover, the term "Group Analysis" is generally used to mean group psychotherapy as an application of psychoanalysis. This is an impossible conception as psychoanalysis takes place between two people and cannot take place in a group. It is also taken to mean group psychotherapy as carried out by people who individually profess to be Psychoanalysts. There are very few of these, and whatever they may practice in groups, it is certainly not psychoanalysis.

By contrast, group analysis, or group analytic psychotherapy, as already indicated, has quite a different orientation. The theoretical concepts which it has been able to form, and which it hopes to formulate in the future, are such as are relevant in a group situation; and the therapeutic factors in which it is interested and which it intends to use are equally specific. They are "group-specific" factors. The group situation brings into play a set of forces which cannot develop in an individual situation. The individual situation can teach us little for the group situation, but the group situation teaches us a lot for the individual situation. This can be particularly well studied and utilized in what the present writer calls "the group analytic situation."

It is hoped that a number of contributions of a clinical, theoretical and technical kind can be made in the course of the next few years. The present paper is intended mainly to give some idea of this method and its conceptual background, in order to make such contributions really intelligible.

Such a group assembles at least once a week for about an hour and a half. It contains between seven and nine members, who sit in a circle facing each

other. The arrangement is quite informal and no procedure of any kind is established. There is no programme or plan as to matters discussed, which are allowed to arise spontaneously. Verbal communication and formulation are the principal, manifest occupation of the group. The members are encouraged to voice anything they wish, and indeed, insofar as possible, anything which arises in their minds. Every contribution is allowed at any time, even if it seems to have no bearing on the discussion of the moment. Soon the members also realize that they are bound only by self-imposed restraint and not by the usual social restrictions as regards any observation they may wish to make about each other and about the conductor.

The conductor's attitude and technique cannot here be described in any detail. These matters have been—at least in a preliminary way—described in my introductory book. I have described how the conductor must allow the group to make him, on a deep and primary level, into a kind of primordial leader or father figure, and then by a slow process, come gradually to earth. Thus dependence upon authority is replaced by reliance on the strength of the group itself, a crescendo move in the maturity of the group and a decrescendo move in the authority of the leader go hand in hand. All this takes place for the most part silently and in the background. On a manifest level the conductor is a participant observer. He does not as a rule lead the group actively, but follows the lead of the group. Whenever possible he lets the group speak, activates and mobilizes what is latent, helps in the analysis and interpretation of content and inter-personal relationships. He generally acts as a *catalytic* agent. By focussing on the group as a whole, the conductor furthers a process of integration. This, however, is merely used so that the group may progressively tolerate the impact of deeper and more disturbing material and the frank disclosure of inter-personal conflict, with their disruptive influences. Integration is not an end in itself in this type of group. On the manifest level, the conductor accepts his role in the reality of the situation. He is in a different position from the rest, in that he is not involved as far as his own personal problems go, but is a doctor and psychiatrist in charge of the group. From his general attitude, inevitably he promotes such features as tolerance, reason, understanding, insight, independent thinking, frankness, an open mind for new experiences, etc. In this respect he exerts by his example a strong educational influence, in the best sense, namely exerted by living emotional experience on the part of the group.

The conductor, therefore, in my technique does not pretend to be on an equal footing with the patients, or just one of them. He does not ever pretend

anything. Where the basic human experience counts, the primary and elementary foundation of human existence, he indeed is in the same situation as everyone else, which again he can truly acknowledge without any pretense at all. The conductor in my approach, therefore, acknowledges his true position and acts accordingly. A primordial leader figure on an archaic level, the power of his influence can scarcely be overrated (important for the modification of the super ego, the ego ideal of the individual and the group ideal). On a reality level he is not "one of the boys" but has a different function and responsibility from the rest. As a member of the community and on general human grounds he is on equal terms with the rest.

While accepting his true position, the conductor tends manifestly to remain in the background, almost as by camouflage, so that the group can proceed with the minimum of distortion. He does not, as appears to be the case in some other approaches, put the relationships of the members to himself almost exclusively into the center of his interpretations. Such a procedure creates, albeit may be concealed, in truth a leader-centred configuration, which is not desirable from my point of view. The attitude of the conductor in group analytic psychotherapy is very difficult to acquire and observe, also difficult to describe. I have used such terms as "participant observer," "discriminating activity," better perhaps, "reluctant activity," and "dynamic neutrality" to describe some of its facets.

It is hoped that these very unsystematic remarks have given at least some idea of the atmosphere in which the group analytic group moves. In the following section we shall direct our attention to some of the features of a group under such conditions and to some of the ways in which they are used for therapeutic purposes.

THE RELATIONSHIP OF  
GROUP PSYCHOTHERAPY TO REMEDIAL READING

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The School Guidance Center is an educational clinic in Washington, D.C., where group psychotherapy is used with children whose emotional difficulties are usually shown in their inability to maintain an acceptable learning rate in spite of their intellectual capacities.

Staff members have been trained in standard remedial methods such as kinaesthetic and auditory training, phrase reading, phonics or phonetics, and concept methods. However, since the Center gets a large proportion of children who have had remedial work under these methods and have failed to make adequate progress, these are used in a limited manner. We use audio-visual aids, but the primary emphasis is on group psychotherapy, under psychiatric supervision. Anecdotal records are kept, and these and personal observations are discussed with supervising psychiatrists.

Children are referred to the Center from a number of sources: schools (both public and private), friends, social agencies, family doctors, or directly by psychiatrists. When the child has been sent in by his own psychiatrist or psychiatric agency, contact is maintained throughout therapy with that source. Where the child has had no psychiatric contact, before he can be accepted into a group, he and both of his parents must consult a psychiatrist who then decides whether the child will benefit from our therapy. In conference with the psychiatrist, the Center places the child in a group or, if it seems indicated, has him come in for a few preliminary private sessions. No child is admitted to an existing group until the group is also prepared for his admission. The schools have been cooperative in excusing the children to come into the Center for a part of their school day. Children who are not able to attend a regular school program have been withdrawn from school and are attending the Center as many hours a day as seem advisable.

Since each child presents an individual educational and emotional problem, specialized attention is provided by limiting each group to four or five. As each child acquires a new skill, he is encouraged to help a less advanced group member. Linda made greater progress when she found that she could

willing to accept his peer as "teacher" than he was to accept the persons who represented authority. Johnnie learned to operate the film-strip projector as a means of gaining some recognition from older members of his group. Film strips, records, films, and books are used to promote discussions which span from sibling rivalry to how-it-feels-to-be-adopted.

Games, drawing, puppets, and play acting are all used to coordinate the groups. Ed, who refused to talk in school and who was believed by his teacher to be feeble-minded, visited a group who were playing a game called "Object Lotto." The group let him play without talking. Then, the student leader (a fifteen year old boy) told him he must read the names of the objects on the cards if he wanted to play a second game. Ed grinned and began to read. The therapist and the group were then able to talk with Ed about the things which kept him from talking in his regular school classroom. A year later, his school reports that he has made an excellent social adjustment.

Shortly after this session, another mother telephoned to complain that she was sending her child to the Center to learn to read, "not to play checkers." Both the father and mother were invited in for a conference. We have found teach new words to a beginning reader, and the beginning reader was more that cooperation and understanding on the part of the parents are essential. By frequent conferences and by such formal devices as parents' groups led by a psychiatrist, parents of our children are given an insight to our philosophy and home tensions are reduced.

Our groups have no formal programs, but special events are made the occasion for utilizing special techniques. Christmas brought forth a play, written and staged by a group of ten year-olds who wrote and acted parts revealing situations in which they would like to be. A valentine box was used to establish a *sociogram* reflecting the group's interpersonal feelings. An observation was made of the cards sent and received by the groups members and of their reactions as they opened the envelopes. The slowest child in the group was surprised to find that she was the most popular—and so were her parents. The other children's reasons for liking her: "she's steady"—"she works hard"—"she's pleasant."

When Nicky wrote a story about a cat, he drew a picture to illustrate it. An older boy ridiculed the drawing—and was challenged to draw a better one. Each child became interested and added to the collection of cat drawings. The pictures revealed personality differences and similarities. John, an older boy with a history of psychotic episodes but with an increasing insight into his own

difficulties, drew a very handsome 'masculine' jaguar crouched out on a tree limb. The girl who in the Christmas play had given herself the role of the princess drew a dainty black kitten wearing a large magenta bow.

Constant alertness to the primary consideration of therapy is maintained. When Nicky dictated, "Me and my brother have a cat," the therapist knowingly refrained from correcting this to "My brother and I . . .": this is one of the few times when Nicky can put himself ahead of an older brother. When Nicky is more sure of himself and his place in the family, the grammatical correction will be made. We are gratified when our students tell us we do *not act* like 'teachers,' for then we realize that we have broken the barrier of the more usual authoritative learning situation. The boy whose mother objected to his playing checkers instead of "learning to read" did not fail his grade as his school had warned but was able to skip ahead into a more advanced class where he has been able to keep up with his classmates! An eleven-year-old with a thirteen-year reading capacity, who had had a year of specialized teaching before coming to our Center and yet tested only "lower 2nd grade" in reading, was advanced to the 6th grade after one semester in a therapy group, meeting four hours each week.

Therapy, as represented by attendance at the Center,\* terminates when the psychiatrist, therapist, school, parent, and *child* conclude that the child is ready to accept the pressures and standards of a regular school and social program.

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\*School Guidance Center. Research staff: Mildred E. Berl, Director; Margaret Loeb Soares, Therapist and Remedial Specialist; Blema K. Brill, Clinical Psychologist; Katherine K. Rice, M.D., Psychiatrist.

'ROUND TABLE' GROUP PSYCHOTHERAPY  
AT THE ST. PETER STATE HOSPITAL

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Geller,<sup>1</sup> in a recent article published by this journal, has very adequately reported the general use of group psychotherapy in state hospitals as well as justified the use of this technique in situations where individual psychotherapy is impossible.

Since July, 1949, under the supervision of Donald S. Branham, M.D., the St. Peter State Hospital has been trying out various methods of group psychotherapy of the 'classical' type (group discussion, didactic, etc.) with varying degrees of success. In September, 1950, a rather distinct type of group therapy was organized, and we feel that its results, as subjectively measured, have been of sufficient intensity to warrant a description of the method. The technique is referred to as Round Table Psychotherapy. This form of group therapy is not original. Considerable use of this type of therapy has been made by McCann<sup>2</sup> at St. Joseph, Missouri, and it was through the personal observance of Dr. McCann's work that we became interested in developing something similar at this hospital.

The technique involves three separate aspects—I. A "warm-up" period; Moreno who introduced this concept and term into group psychotherapy and psychodrama literature.<sup>1</sup> II. The discussion proper; III. The "playback". The procedure can be briefly described as follows: For 2 periods a week, all the patients of the same sex in the receiving hospital are invited to the therapy session. It is applied preparatory to a session or during it, or both, as described by J. L. (One session is carried on with males, another with females.) The number of patients per individual session varies from 20 to 35. Six members of the group are seated around a table in the center of the room and are known as the Round Table Members. The remainder of the group are seated around the edge of the room and are known as the Studio Audience. A microphone is cen-

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tered on the table for the purpose of recording the interactions during the session.

The "discussion" aspect of the session is limited to 30 minutes. During this time members of the Round Table discuss the "problems" of one or more of the members. The therapist is a non-participant and serves, superficially at least, only as a recording machine operator. Upon completion of the thirty-minute discussion period, the recording is terminated, and for the next thirty minutes the patients listen to a "playback" of the discussion.

After this part of the session, the patients return to their ward.

In order to "warm-up" the patients to the discussion period, each of the six members of the Round Table is individually interviewed by the therapist. These interviews vary from ten to twenty minutes in length, and are used for the purpose of "priming" the members for the session proper. During these brief interviews, the therapist attempts to orient the group toward the discussion of one particular patient's difficulties. Although it is strongly suggested during these interviews that the patient discuss only *one* of their members during one session, the therapist in no way attempts to control the discussion once the "discussion" (therapy session proper) begins. Because we believe that non-participation of the therapist in the discussion tends to make the patients assume more responsibility, we feel the therapist should play a minimal role in the session proper.

Once the group has been organized (the original 6 members were selected by the ward physician) it operates in a purely 'democratic' way. When one of the members of the Round Table leaves the hospital, he is replaced by a member of the Studio Audience. The Round Table members *themselves* elect the replacement. *When a majority of the Round Table members feel a member of their group is ready for release*, that member is given an interview with the ward physician within 24 hours of the session. *Note: the ward physician has rarely failed to act favorably upon the recommendation of the members concerning the release from the hospital of one of their group.*

The type of group therapy just described fulfills a number of the usual claims of typical group therapy. It performs—at least a superficial—*cathartic* function in allowing the members to verbalize their difficulties and complaints. The "playback" part of the session presumably gives the patient a chance to listen objectively to his own description of his problems and observe the reactions of other members of the group to it. It is also probable that through lis-

tening to the recordings of their own interactions, a number of patients have been assisted in their attempt to face reality—a step believed to be basically requisite to a satisfactory adjustment.

During the first six months of experience with this form of group psychotherapy, 71 patients were members of the Round Table proper (for at least one session.) 82 other patients were members of the Studio Audience.

Of the 71 participating as "round table" members, 51 have been *released* from the hospital. (Thus far, 7 of these have found it necessary to return for further treatment.)

It is impossible to *objectively* evaluate the effect of this form of treatment on the number of releases from the hospital. A large number of the patients were concurrently being treated with either Electric-shock or Insulin-shock therapy.

However, it is the *subjective* opinion of both the therapist and the ward physicians that these psychotherapy sessions hastened the release of many of the patients.

#### SUMMARY

During our brief experience with 'Round Table' group therapy method, we have been favorably impressed with its fulfilling an almost unique position in the hospital therapy structure. We seriously doubt its benefits as a tool for the patient to obtain emotional insight into the dynamics of his personality disorganization. Group psychodrama e.g. group therapy combined with psychodrama fulfills this latter function much more adequately. However, we do believe that Round Table Psychotherapy fulfills at least a *threefold* function which justifies its existence.

THE CIVILIAN AND ARMY SOCIAL ATOM  
BEFORE AND AFTER\*

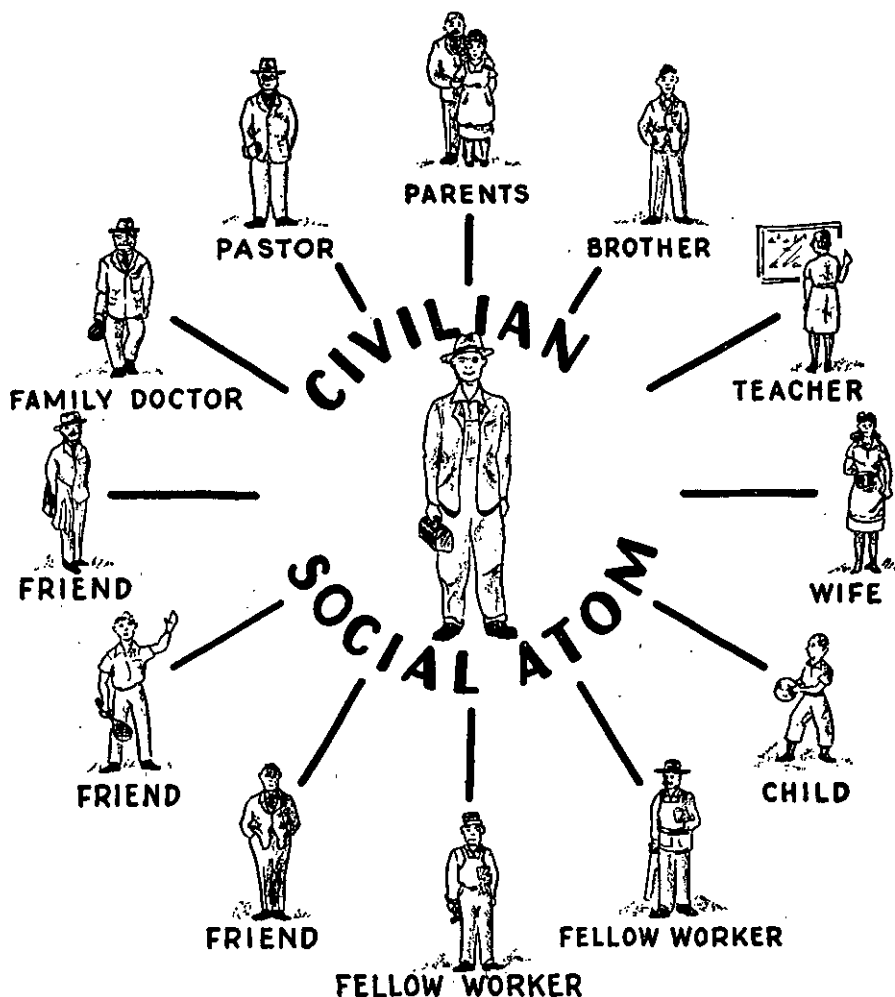
ERNEST FANTEL, M. D.

*Fort Sam Houston, Texas*

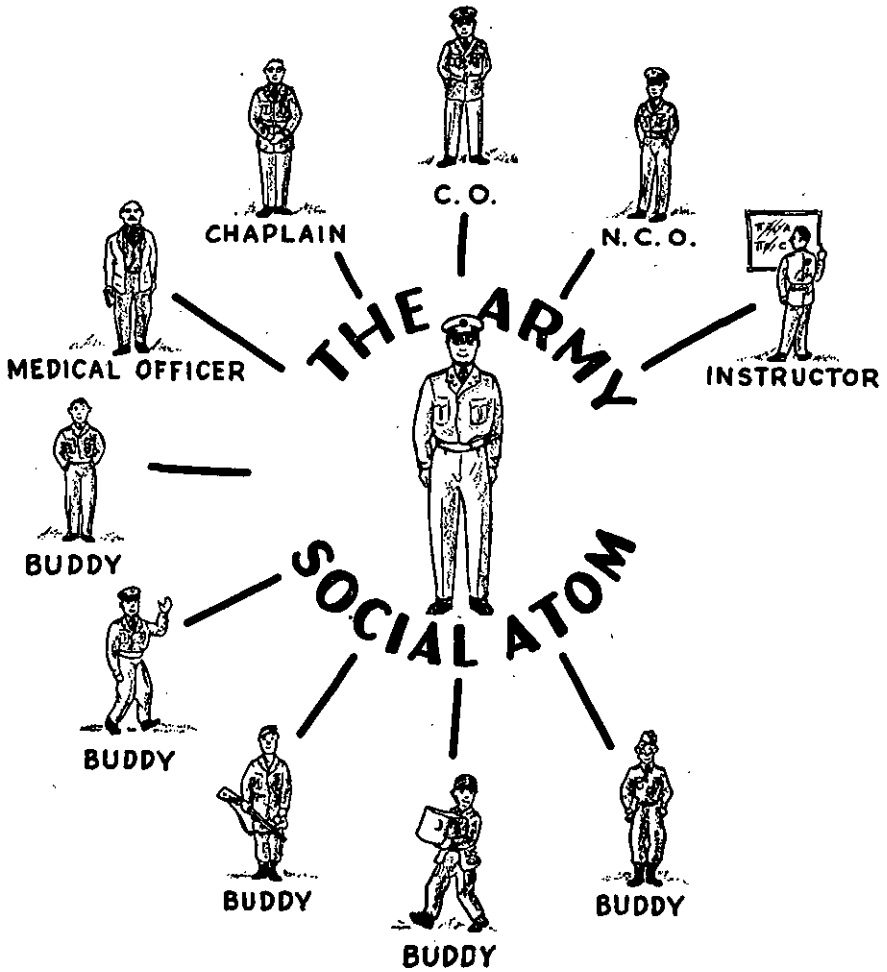
The two diagrams of social atoms supplementing this article are basic framework of interpersonal situations every individual has, the most intimate nucleus of people to whom he is related at the time. In the course of diagnosing sociometrically a large number of soldiers a certain constant pattern appears. Starting with the pattern below, the general pattern of the social atom of any individual X, a few changes may be necessary here and there according to the actual individual case. It can be made to fit particular situations. Let us start with the civilian pattern of the social atom and let us see how it fits an individual, Jack. His parents are living, instead of a brother he has a sister. He has a wife and child, he has a teacher. There is only one fellow worker who means something to him and another one who is in turn attached to him. He has three good friends, both male, and one woman friend. The family doctor is there, the pastor is replaced by a priest. In this sense the scheme of the social atom can be used for every individual, with some changes made in each case. In my classes I always start with the general framework, fill in what is missing and strike out which is wrong. By such a method I can illustrate to my students the collective as well as individual patterns of the social atom. In addition, I can point out that every individual in the social atom represents not only an attraction or a repulsion but a role, a wife, a pastor, a brother, a doctor, a teacher, and so forth, and I can point out to them the close relationship between the social dynamics and the role dynamics of that person. When Jack joins the army he ceases to be a civilian. In the new setting the old social atom is rapidly replaced by a new one. Although the setting is entirely male and the standards of living are quite different from civilian life the pattern of the civilian social atom is not entirely lost in the army social atom of that particular man. Jack's parents are now replaced by the commanding officer, at least symbolically, on the role level; if the contrast between the commanding officer and his own father is very striking and if he respected his father very dearly for his tolerance and for his personal interest in him, he may be very much upset by a cold, nasty commanding officer. He may then try to find a substitute for the father role in someone else in the new social atom; if he fails to find him he may be quite upset over that loss. Let us describe now

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\*The two drawings were prepared under the direction of the author by the Medical Illustration Division of the Medical Field Service School.



The meaning of the two pictures is simple. They tend to show how the place of the various members of a person's civilian social atom is taken over by persons in the army. Often soldiers cling to the members of their army social atom because they have a double meaning for them, and the sudden loss of members of the army social atom, such as when several buddies are lost in



action can lead to severe depressive reactions.

The social atom concept is used in this paper in its broader sense; it represents not only the attraction-repulsion-neutrality pattern around an individual (social atom in its narrower sense) but also the cluster of roles around him, the cultural atom.

the army social atom as it is for *all* soldiers: there is a commanding officer who might be used by a soldier to represent the parent, because everyone, when moving from one social atom to another, tries to replace the key individuals and carriers of significant roles to the new setting especially if the new setting is one of longer duration. He will try to find one who is like a father to him, the commanding officer, who is like a brother to him like the non-commissioned officer, who is on the religious level as much to him as the home pastor, the chaplain, whom he can call when he is sick, like his family doctor, here the medical officer; someone who is like his teacher in school, here the instructor and last but not least, all the people who represent his very good friends and fellow workers. He may try to find them represented by the buddies. Certain things he cannot find here, that is the wife and the child. This *generalized army social atom* can be altered to meet each individual case. In the diagram of the social atom I did not indicate whether the relationship to the various people is one of attraction or of hostility, or whether it is different. This remains to be filled in the course of every concrete case. Once such a frame of reference is established we can follow up the development of the social atom of Jack, as it changes from time to time, perhaps at eight week's intervals. One of his buddies has been killed in action, another buddy has been taken to the hospital, a third has been removed to another army post. What do these losses mean to him and how does he replace them? Whether these replacements are adequate or not determines to a large extent Jack's stability. In the course of time for each soldier a file of sociograms can be made which portray in a longitudinal way some of his social destiny, from the civilian social atom to the army social atom, number one, number two, number three and so on. The social atom diagrams may be the starting point, for a psycho-sociodrama which gives the psychodramatic director clues as to which problems have been particularly difficult to solve for one or another soldier or collective problems they have been unable to solve themselves.

## ON SOME AMERICAN INNOVATIONS IN PSYCHIATRY

*Annotations to Dr. John C. Whitehorn's Presidential Address, 1951*

LEONARD K. SUPPLE, M.D.

*New York, N.Y.*

Doctor John C. Whitehorn in his Presidential Address<sup>1</sup> at the American Psychiatric Association's Annual Meeting, in Cincinnati, uttered his views on the conditions, strivings, tasks and achievements of American psychiatry with such deep thoughtfulness and, indeed, engaging frankness that no American psychiatrist—in fact, no one concerned with psychiatry anywhere could afford not to study his paper. In speaking of some *newer* original accomplishments in North America in psychiatric methods, he stated: “. . . Two *general* psychiatric methods—barbiturate interviewing and group psychotherapy—have had an American origin, at least a special American development . . .”

It may be worthwhile to re-state here more explicitly why the claim that group psychotherapy originated in the United States *is* justified. Although therapeutic work within some kind of group setting had been done in some places in Europe as well as in the U.S.A. before and after World War One, it was never truly groupal (fully group-oriented), or it was carried out, in well nigh all cases, in a vague, pre-scientific form<sup>2</sup>.

The turning point came in the U.S.A. where, since 1931, sociometric methods combined with observational and inter-actional techniques, laid the foundations for 'group psycho-diagnostics' and therapy. Their *terminology* which has become household words in this field—phrases like 'group therapy,' 'group psychotherapy,' 'group catharsis,' 'group inter-action,' 'analytic and activistic forms of group psychotherapy,' also an epitome-slogan like "one patient—a therapeutic agent of the other"—were all coined here by Moreno<sup>3</sup>. Procedures

1) John C. Whitehorn, M.D.: Presidential Address—The Individual Psychiatrist and Social Psychiatry. Read at the 107th annual meeting of the American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951, in: *The American Journal of Psychiatry*, vol. 108, No. 1, July, 1951, p. 1-6, esp. p. 5 ff.

2) For surveys see among others: Meiers, Jos. I.: *Origins and Development of Group Psychotherapy* (A Historical Survey, Psychodrama Monograph Series No. 17, Beacon House, Inc., N.Y., N.Y., 1946, 44pp., 3 charts and bibliography pp. 22-24)—Also: Cottrell, Jr., Leonard S. & Ruth Callagher: *Developments in Social Psychology (1930-1940)*, Sociometry Monograph No. 1, Beacon House, Inc., N.Y., N.Y., 1941.

3) Moreno, J. L.: *Who Shall Survive?*, A New Approach to the Problem of Interpersonal Relations, with foreword by Wm. Alanson White, Washington, D.C., Nerv. & Ment. Disease Publishing Co., 1934 (now: at Beacon House, Inc., N.Y., N.Y.), 437 pp contains, e.g., the following paragraph (p. 301): “. . . group therapy treats not only the individual who is the focus of attention because of maladjustment, but the whole group of individuals who are inter-related to him in the community . . .” Further: “. . . this kind of 'group therapy' can be analytical, that is can bring to the realization of every individual of the group the harmful effects their inter-relations produce upon this or that particular individual

making interview and inter-action processes more objective and available for measurement—as recording and play-back, as diagramming inter-personal and inter-group relations in the form of the sociogram, the inter-action diagram and the movement diagram—were first and advocated established by Moreno and used in the U.S.A. between 1931 and 1934<sup>4</sup>. It was during this period that the first organized effort in behalf of group psychotherapy was made, it happened fortunately within the framework of the American Psychiatric Association.

Another approach with which Dr. Whitehorn, as he stated in his address, has been "much preoccupied," is the participant-observer method.<sup>6</sup> It may be appropriate and of interest in a historical note to establish the priority of an idea, or term, as near as possible. "Participant observer"—both method and term—seem to have been used in this country, first by Professor Eduard C. Lindemann, New York School of Social Work.

Another American innovation mentioned by Dr. Whitehorn is the *barbiturate interview*. Drugs like barbiturates are given in order to stimulate the patient to re-live and re-enact his former (traumatic) experiences. The principle of using a 'psycho-chemical starter' to stimulate spontaneous acting and re-enacting (for psychotherapeutic) had been long established in the U.S.A.—by Moreno—as a psychodramatic adjunct-device: "The warming-up process can be stimulated by bodily starters (a complex physical process in which muscular contractions play a leading role), by mental starters (feelings and images in the subject which are often suggested by another person), and by *psychochemical* starters (artificial stimulation through alcohol, for instance)."<sup>5</sup>

It may be of interest to quote Dr. Grinker here by way of comparison who wrote, almost seven years later: ". . . some patients who talk constantly throughout the session 'to their friends,' become blocked at certain points of emotional height. The therapist then plays the part of the friend stepping in, as it were, into the battle scene proper in an active role. He discusses plans of

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. . . " . . . On the other hand, group therapy can take an *activistic form through the treatment of each individual of the group who is related to the same conflict . . .* . . . "Treatment consists in the interadjustment of the individuals to another through training (see Spontaneous Therapy, p. 324) . . .

4) Moreno, J. L.: (I) "Application of the Group Method to Classification," published by the Natl. Committee on Prison and Prison Labor, New York, N.Y., 1932; republished also as Moreno, J. L.: "Group Method and Group Psychotherapy," Sociometry Monograph series, No. 5, Beacon House, Inc., N.Y., N.Y. (II) Proceedings of the American Association on Mental Deficiency, Annual Meeting, Boston, 1933; (III) in "Who Shall Survive?, A New Approach to the Problem of Interpersonal Relations" (1934)—see above footnote 3.—See also: *HinsieShatzky*, Psychiatric Dictionary, Oxford University Press, London-New York-Toronto, 1940 (-1949). Psychological organization of groups in the community.

5) See: Moreno, J. L.: "Psychopathology of Inter-Personal Relations," in: Sociometry (Journal), vol. I, page 66, 1937.

action, ways of evacuating the wounded comrades or whatever is cogent to the particular situation in order to further progress of events in hand."<sup>6</sup>

It appears that one may say, from a viewpoint of practical scientific economy of categorization, that the so-called barbiturate interview is, *mainly*—especially when conducted to its (dramatic) height—a *psychodramatic interview* in which barbiturates are used as starters. This innovation might, therefore, be put primarily or, at least, on an "equal-parts" basis on the credit list of psychodrama rather than solely to that of narcosynthesis (in this case, Dr. R. Grinker's). Dr. Grinker, while writing in the heat of the War, may well have been unaware of his (historical) indebtedness to clinical psychodrama at the time when he published his experiences.

Another war psychiatrist, Dr. Ernest Fantel who had had experience with psychodrama—with and without drug application—made the following observations: ". . . Although some of the sedated patients will readily get up and act, others will be too drowsy because of the hypnotic and will continue to lie down giving *only a verbal* account of their story. The chemically induced sleep here interferes with their acting, just as the suggested sleep is a handicap in hypnosis. Also, the fact that we might have to keep the syringe in the patient's vein to regulate the depth of narcosis interferes with the freedom of movement. We think it is far better to ask the patient directly to re-enact the traumatic experience. Although he might be resistive at first, he soon warms up and is carried away on the stage and we can re-enact the past far better than if he were half asleep from a drug."<sup>7</sup>

The phrase "inter-personal relations," interestingly enough, has been promoted by at least three exponents of inter-personal theory: William Alanson White, Harry Stack Sullivan and J. L. Moreno. The latter picked it up in the U.S.A. as a good translation of the German term "*Uwischen-menschliche Beziehung*" which he had begun to use since 1917. However, the coiner of this term "inter-personal relations" has been neither the late Dr. Sullivan nor Moreno, but W. C. Perry in his "Theory of Values," Chicago, 1927.

Dr. Whitehorn also refers in his address<sup>8</sup> to another system which tries to formulate in terms of *social role taking* and "To depict the intimately inter-personal dynamics of personality disorders." He refers here to the able en-

6) From: Grinker, Roy R., and Spiegel, J. P. "Narcosynthesis, A Psychotherapeutic Method for Acute War Neuroses," page 3, *Air Surgeon's Bulletin*, No. 2, February, 1944.—See also: Meiers, J. I.: *Origins and Developments* . . . (Footnote 3, above), page 66, ff.

7) Fantel, Ernest: "Psychodrama in an Evacuation Hospital," in: *Group Psychotherapy*, A Symposium—1945, Beacon House, Inc., N.Y., N.Y., page 125-145.

8) Whitehorn, John C., loc. cit., p. 6.

9) Whitehorn, John C., loc. cit., p. 5.

deavor of Dr. Norman Cameron (*Psychology of Behavior Disorders: A Biosocial Interpretation*, Boston, 1947). In fairness to the historical development, the credit for having applied (and described) role theory and social role taking in interpersonal dynamics of personality disorders goes to Moreno's work in this field;<sup>10</sup> this does not reduce, indeed, the value of Cameron's later contribution.

#### SUMMARY

1. Group psychotherapy—as a modern, scientific method—is an American innovation with J. L. Moreno as its outstanding leader.
2. The barbiturate interview—inasmuch as it is an *action* interview—can be classified as a psychodramatic technique.
3. The credit for having introduced term and technique of “participant observer” goes to Eduard C. Lindeman (1925).
4. The credit for having coined the phrase “inter-personal relations” goes to W. C. Perry (1927).
5. The credit for first having applied role theory to personality disorders goes to J. L. Moreno.

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10) See: Moreno, J. L.: (I) “Interpersonal Therapy and Psychopathology of Interpersonal Relations, in: *Sociometry, Journ.*, vol. I, 1937; (II) “Psychodramatic Shock Therapy,” in: *Sociometry, Journ.*, vol. II, 1939; (III) “Psychodramatic Treatment of Psychoses,” and “Psychodramatic Treatment of Marriage Problems,” and “Psychodrama and Mental Catharsis,” in: *Sociometry*, vol. III, 1940. (IV) A Case of Paranoia Treated Through Psychodrama, in: *Sociometry*, vol. VIII, 1944—See also: “Role Theory and Role Practice, p. 153-160 and “Role Tests and Role Diagrams of Children, A psychodramatic Approach to an Anthropological Problem, p. 161-175, both later in Moreno, J. L.: *Psychodrama (Collected Papers)*, vol. I, Beacon House, Inc., N.Y., N.Y., 1946.

AMERICAN SOCIETY OF  
GROUP PSYCHOTHERAPY AND PSYCHODRAMA

REPORT ON ROUND TABLE CONFERENCE ON  
NINTH ANNUAL MEETING

*Group Psychotherapy and the Treatment of Minority Problems*

February 17, 1951—11:00 A.M. — Commodore Hotel, N.Y.C.

Moderator: Nathan W. Ackerman, M.D.      Recorder: Dr. Irwin Marens

In his introduction, Dr. Ackerman pointed out that all over the world, the minority peoples are getting a beating. "The subject matter of this panel and the presence of this group attest to our common interest in the survival of the minorities. Group psychotherapy has not been applied systematically to the problem of minority attitudes and behavior. The purpose of this panel is to draw together some useful insights into minority behavior, and to examine the possible values of group psychotherapy in the amelioration of this basic problem in human relations."

Dr. Rutherford Stevens of the V.A. Regional Office in New York discussed his experience with group therapy in a mixed group of Negro and White soldiers. Therapy was conducted over a 3 year period both in the Army and at the V.A. Hospital in Topeka, Kansas. It was not the purpose of his group therapy to affect reactions to color difference. The members were largely from the middle-west and south. This was within the setting of a hospital strongly opposed to prejudice. Segregation was not tolerated there, in contrast with the attitude prevalent in the city. Dr. Stevens stated his bias is in favor of eliminating the barriers between the groups. He quoted the definition of prejudice offered by Ackerman and Jahoda as a pattern of hostility in interpersonal relations, which is directed against a whole group or the individuals within a group and which is directed toward goals of both rational and irrational benefits for the prejudiced individual. He felt that due to the high competition for acquiring material goods, even those with emotional stability would be expected to show anxiety in our society. The problem is how to best direct individuals who have a need to react in a prejudiced way. Therefore, we must continue to acquire knowledge of the dynamics of group behavior and its application to the problem of inter-group tension.

Dr. Horace Cayton, a sociologist, and author of "Black Metropolis," studied this problem by living in an inter-racial childrens' camp near Chicago. The

children came from White, Polish, Italian and Negro families within the city. There had been much racial tension in their home area, with outbursts which had resulted in setting fire to several Negro homes. He pointed out how early in life children learn prejudices, and the marked amount of fear and hostility present in these groups toward each other. He found that white girls, having to suppress their hostility, were least likely to eventually accept Negroes, whereas boys were able to act out their hostility by war-like behavior, including the utilization of suitcases for barricades, eventually becoming friendly. He found the Whites were more curious about the colored, and that curiosity reactions were first shown toward their peers. When a child did accept a Negro, there were adverse reactions in the parents, who rebuffed the child for this during their regular visits to the camp. It was agreed that inter-racial meetings are not the answer to this problem because they frequently function to diminish the guilt reactions caused by their prejudiced behavior and thereby maintain the barriers in the community. Dr. Cayton concluded with his feeling that we need more group psychotherapy with mixed groups.

Dr. Lionel Oversey of the Psychoanalytic Clinic, Columbia University, had conducted a study of the problems of Negroes, utilizing brief psychotherapy techniques. He pointed out the necessity to differentiate cast from class. Class affects all Negroes and is quantitative whereas cast affects Negroes differently and is dependent upon such factors as the individual's level of economy, his coloring, etc. With regard to cast, Negroes are a minority group and they do not have a separate culture. Cast produces two problems: (1) a low self-esteem with the self-image as reflected by the group, being derogatory and (2) various techniques for handling aggression. This may develop into an inordinate preoccupation with status and material needs, leading to anxiety and to compensatory devices of apathy, criminality or narcotic addiction. The hostility may be projected to other Negroes, disturbing the in-group relationship. Due to the fear of retaliation, which is further enhanced by reality, they must control their aggression. A preoccupation with control may then lead to submission, over-compliance, ingratiation or to chronic irritability with resultant explosive outbursts toward Whites or other Negroes. Other reactions are denial, laughter, gaiety, flippancy or chronic anxiety associated with massive repression of the emotions. The low economic status frequently results in broken families, the child feels rejected and unloved, which further operates to lower the self-esteem. There may be a further complication through reversals in the male-female roles when the male cannot provide economic security for the family.

Dr. Sol W. Ginsberg of New York City from the Committee for Mental Hygiene, discussed material from his forthcoming book concerned with the important role played by the individual's values. Values are the most important directive for goals. Influenced by shame and guilt, they reflect our personal system of integration, they are part of the ego in its functioning with the outside world, and are influenced by the cultural system. Thus, one can see the great difficulty in effecting a change in them. Values must satisfy the super-ego requirements as well as the instinctual ones; they must be distinguished from moral judgment. Values are acquired in childhood, and are a goal for the ego. Adjustment is the means of living up to these values. It is necessary, therefore, to change the values in order to change the personality. He concluded by stating that the values of the majority preserve the status quo. In reaction to this Dr. Ackerman indicated that the values of the minority may serve as a treasure house for the future. The minority in this sense preserves for posterity those values which are the essence of civilization.

Dr. Fredrick Wertham vigorously presented examples to point out the existence of prejudices toward Negroes among psychoanalysts, and felt that group psychotherapy should be first applied to those doing therapy.

Dr. Kenneth Clark discussed a typical situation at the Northside Center where the majority are Negroes, including the Director. He related an example of the hypersensitivity in a White staff member who was being supervised by a Negro and showed how this was related to unconscious anti-Negro feelings. He quoted examples from the psychiatric literature which indicated the anti-Negro prejudice present in some psychiatrists as seen in their pseudoscientific conclusions regarding Negroes. He protested against those who try to explain the Negro problem by studying the Negro as if he were the cause.

Mr. Edgar Borgatta of the Sociometric Institute was in complete agreement with Dr. Ginsberg. He felt that the problem in defining values was paramount. He emphasized that we must permit room for individual differences.

Dr. Oversey summed up his feelings, that the problem of the Negro was a socio-economic one, and that alterations at those levels of social organization are the only way the problem can be corrected.

## SCHOOLS RATHER THAN HOSPITALS

### *About Group Psychotherapy in Austria*

Report by H. R. TEIRICH, M.D., *Austria*

In his lecture, October 3, 1950, Dr. Teirich stated: Group Therapy is *not*—as is often assumed wrongly—a “product of the recent war.” As early as 1908, *Pratt* (U.S.A.) reported his “class” method in dealing with tuberculous patients. The decisive initiative, however, came from *J. L. Moreno* (formerly Vienna; then, U.S.A.), before and after World War I—he created the *concept* of “human inter-relations within the group” as part of a theoretical system and therapeutic method\*\* Teirich underscored that *group* therapy would be applicable not only to psychiatric patients, but also, e.g., for asthmatics, epileptics, stutters,\*\*\* problem children (including their mothers and for the treatment of certain groups of cases of venereal disease. He, then, described “mass-therapy” done, by him and others, with groups of 30-100 patients; further the systematic division of groups into “open” and “closed,” into kyrio-and koino-tropic\*\*\*\* groups and also the differentiation between group therapy and group *psycho*-therapy.

### *Experiences with “open” men’s and women’s groups (directed) at the Neuropsychiatric Clinic, University of Graz*

It seems that the most important result achieved by group psychotherapy is the *freeing* of the patient from the *anxiety* befalling him on admission to a *closed* psychiatric ward (“fixated shock,” Teirich).

The women’s and the men’s group differed in the following: the former was smaller in size but more homogenous (therefore could be directed more in an analytical orientation); the male group—comprising at times 16 patients—was conducted “didactically” (‘Aufklaerung’). The discussions were preceded by serious music, thus trying to relax the group-members. Then a severely psychotic would be brought into the room and, as much as possible, “intro-

\*\* J. L. Moreno: *Psychodrama* (First Volume), Beacon House, New York, 1946 pp. 429. (especially: Sect. I, II and VI).

\*\*\* In *Psychodrama*, Vol 1, p. 217-219 “Psychodramatic Approach to Stuttering.” Moreno (1937) has shown this often successful therapy—See also: Hamilton, J.L.: *Psychodrama and its implications in speech* (Editor), in: *Quarterly Journal Speech*, Vol. 29: pp. 61-67, February, 1943.

\*\*\*\* In regard to these two terms (kyrio-tropic-leader-centered, etc), see Meiers, Jos. J., “Origins and Development of Group Psychotherapy, A Historic Survey, . . . Beacon House, Beacon, N.Y., 1946, p. 10.

duced" to his fellow patients. If that psychotic case, then, could be 'de-blocked' (by insulin or Electro-shock therapy) within a relatively short time so that he was able to partake in this group, such fact would tend to work a deeply penetrating suggestion upon the fellow patients. ("Psychologische Zange,"—psycholog. 'pincer,' according to the term of C. Schneider).—The *discussions* concerned, e.g., often the significance of Electr.-convuls shock (which we in Graz, following a suggestion of *Dr. Mauz*, have come to call "E.D." = "Elektrische Durchflutung" = 'electric flooding'). Other methods, too, are discussed. Then the group therapists distributes to patients selected books (bibliotherapy).

The statement was made by many patients—a contention well known from American literature (which this writer cannot but confirm): "Group therapy helps me to recognize that I am *not* the only one who has to struggle with a certain problem; since I have come to know this, I do not feel any more so lonely." Therapeutic *results* are judged with caution ("a psychiatric clinic is no factory where, by means of counting patient-days totals, one may state 'good' or 'poor' results"). Teirich emphasizes that for the *discharged* neurotic, and no less for the psychotic patient it is important to leave with a 'positive transference.'

This group therapy work is no 'superficialized' psychotherapy; it only takes place on a different plane. Especially valuable is the combination: collective plus individual psychotherapy. To fill the leisure time during hospital stay, there is not only the just mentioned group work: there is also occupation with gymnastics ('Turnen')—through which we obtained especially good results; further, music, clay or sculpturing work, etc. We never observed any damage resulting from the above described group psychotherapy. However, the therapist must beware lest he inflict, inadvertently, any additional iatrogenic neurosis.

#### *Summation:*

1. Group psychotherapy aids in *liberating* the patient from the "shock" resulting from the *admission* to a (closed) ward.
2. In group psycho-therapy, the *inter-personal relations* are being rebuilt or/and formed anew. (activation of the "I-you" relation").
3. The group is an excellent opportunity for *observation*. The patient, at the morning rounds, put on his "face for the doctor" ('Visiten-Gesicht') whereas in the group he behaves how he 'really is.'
4. In group psycho-therapy, there is an ideal learning (training) opportunity for physicians, students, nurses.

5. The group means also a basis for individual psycho-therapy.

6. Also, a basis is formed for general 'social' (psychotherapeut.) work: as follow-up care; patients' clubs; bibliotherapy, etc.).

Teirich appealed especially to the general practitioners to form at least small 'didactic' (Aufklaerungs) or informative groups.

The lecture was closed by him with the words of L. C. Marsh that 'mental hospitals ought to become rather schools than to be asylums . . .'

## PSYCHODRAMA IN PONTIAC STATE HOSPITAL

MARGUERITE M. PARRISH

and

JACK MITCHELL

*Pontiac, Michigan*

Every Wednesday afternoon a group of fifteen to twenty patients gather in the small auditorium of the Pontiac State Hospital for Psychodrama. This group is composed of white and negro adolescent and adult men and women, single and married, ranging in age from fourteen to fifty-five, in education from the fourth grade to college graduation, in economic status from marginal to very well-to-do. Diagnostically, this group consists mostly of schizophrenics with paranoid types predominating, some affective disorders, primary behavior disorders, and psychopaths in different stages of illness, acute to chronic, overactive to very withdrawn, regressed and deteriorated. The majority of these patients reside in closed wards and are brought to the auditorium by psychiatric aides.

These weekly Psychodrama sessions, lasting for only an hour and a half, are held in the hospital auditorium which has a traditional stage.

The conductor in my approach acknowledges his true position and he acts accordingly. A primordial leader figure on an archaic level, the power of his influence can scarcely be overrated (important for the modification of the super ego, the ego ideal of the individual and the group ideal). On a reality level he is not "one of the boys" but has a different function and responsibility from the rest. As a member of the community and on general human grounds he is on equal terms with the rest.

While accepting his true position, the conductor tends manifestly to remain in the background, almost as by camouflage, so that the group can proceed with the minimum of distortion. He does not, as appears to be the case in some other approaches, put the relationships of the members to himself almost exclusively into the centre of his interpretations. Such a procedure creates, albeit maybe concealed, in truth a leader-centred configuration, which is not desirable from my point of view. The attitude of the conductor in group analytic psychotherapy is very difficult to acquire and observe, also difficult to describe. I have used such terms as "participant observer," "discriminating activity," better, perhaps, "reluctant activity," and "dynamic neutrality" to describe some of its facets.

It is hoped that these very unsystematic remarks have given at least some idea of the atmosphere in which the group analytic group moves. In the following section we shall direct our attention to some of the features of a group under such conditions and to some of the ways in which they are used for therapeutic purposes.

At present the Psychodrama staff is made up of the director and members of the Social Service Department, who initiated Psychodrama as an experimental project in group therapy in the hospital in June, 1948. Initially the staff consisted of the assistant medical superintendent, four social workers and four psychiatric aides. However, the director of the Social Service Department, who had attended a course of study with Dr. J. L. Moreno and had observed Psychodrama in St. Elizabeths Hospital in Washington, D.C., was designated the director of the project. Her direction gave impetus to the organization and safeguarded the continuity in development of the Psychodrama project. The Clinical Director and members of the Medical Staff assisted in the original selection of patients, and the former continues to serve in a consultative capacity. The operation of Psychodrama is the responsibility of the Social Service Department.

The staff was confronted early with organizational and operational problems with reference to the relationship and integration of Psychodrama in the existing hospital therapeutic program, with over-taxed personnel and facilities, limited time schedules, and typical community pressures. These factors affected the operation of and results from Psychodrama (and other therapies in the hospital) since they directly influenced the selection and availability of patients, the definition of treatment goals, the frequency and duration of sessions, the techniques used, and the composition of the psychodramatic staff itself.

In the two and a half year period to October, 1950, seventy-nine patients were selected and participated in Psychodrama for varying lengths of time. The first group was highly organized and balanced in terms of number, sex and diagnosis—eight women and seven men, ten of whom were schizophrenics and five were psychoneurotics, but shortly afterward the group became mixed and heterogeneous as patients were brought in to replace those who were discharged, placed on convalescent status or in family care. Only eight patients dropped out of the project at their own request. Of the seventy-one patients who were active in the project, consisting of twenty-nine men and forty-two women, two-thirds of whom were under thirty-five years of age, forty-three were schizophrenics, with the paranoid type constituting one half of this number; twelve

were psychoneurotics; four were manic depressives; three were involuntals; and four were primary behavior disorders. Also included were psychopaths, an epileptic, an alcoholic, and three with organic syndromes.

These patients were necessarily active in other therapies—individual therapy, convulsive (electro-shock and drug) therapy, work, Recreational, Occupational or music therapies—prior to, concurrent with, or subsequent to Psychodrama. However, one-third of this number had only Psychodrama with Recreational or Occupational Therapy. Psychodrama helps the patient to use these other therapies, or serves patients in individual therapy who were unable to handle the intensity of transference or could not relate too easily.

The treatment program of our State Hospital, into which the Psychodrama project was geared, is directed toward the release of the patient to the community—by discharge, by placement on convalescent status or convalescent work status supervised by the Social Service Department and by placement in family care supervised by a Medical and Social Service Staff—or toward an adequate, personally satisfying adjustment of the patient in the hospital, when long-term, continuous care is indicated.

The actual operation of Psychodrama consists of planning, acting or dramatic presentations, and evaluation. In the morning prior to the actual session, the Psychodrama staff meets to plan the session of that afternoon. The status of each patient in the group is discussed in terms of his illness and adjustment to his illness, to the hospital, to his family and to the Psychodrama group, and attention is focused on the patient's needs; they are analyzed and scenes are devised and cast, with staff members or patients as auxiliary egos to meet his needs.

Initially, scenes were devised which directly related to problems, situations, and individuals involved in the patient's illness. It was quickly determined that the anxiety evoked in the individual patient and in the group could not be handled by the infrequency of our sessions. It was necessary, therefore, to utilize imaginary or like-reality and even fantasy scenes in order to enlist the spontaneous participation of the patients. These scenes accorded patients the security of anonymity and allowed them to bring whatever feelings or attitudes they wished and in the amount and nature they felt able to handle without too much fear, guilt or shame. They revolve about situations over the meaning of mental illness, over commitment and hospitalization, with hospital figures of authority, over family, marital, vocational and other inter-personal relationships in a time sequence ranging from the past to the future.

The problem situations in scenes provide roles in which patients can safely express hostility, dependency or reveal psychological defenses. Care must be exercised in the selection of personnel in these scenes, not only to allow for the proper expression and gratification of the patient's needs, but also to provide the proper therapeutic atmosphere and direction for their successful enactment.

A scene is more meaningful to the individual and to the group when it is spontaneously performed. Free and uninhibited acting is particularly helpful in releasing the patient's feelings and also serves to stimulate and encourage other patients in the group. Although the Psychodrama staff is responsible for the creation and the casting of scenes, individual patients or even the group periodically create and cast scenes themselves. However, one must be alert to the meaning and the use of the patient's own material.

When the group convenes in the hospital auditorium, the director of psychodrama describes the scene and selects the participants. There is a short consultation, after which the patient-actors and auxiliary egos go on to the stage and spontaneously act out their roles. The degree of spontaneity varies from person to person, from scene to scene. There is movement in and out of roles by the patients, although the auxiliary egos maintain the integrity of the scenes and of their roles. However, when patient-actors are producing meaningful material, even if tangential to the created situation or role, the auxiliary egos follow the patient's trend.

When a patient goes on the stage, particular care is taken to support him against a sense of failure and to protect him by surrounding him with auxiliary egos who carry him along by their leadership and activity. Some preparation is always done by the auxiliary ego with the patient prior to his scene, and the smallest degree of participation is praised warmly.

The acting phase of psychodrama reveals the individual as well as the group in action. Participation is not only on the stage but in the audience as well. Periodically, "man on the street" or "polling" scenes are devised in order to enlarge the stage to encompass the entire auditorium, and there is a constant flow of communication and participation between the stage and the audience. In addition to this interplay during the scene, the group usually discusses the nature of the problem being enacted. It is by these discussions that group attention is focused on exploring the dynamics of particular feelings, and appropriate modes of behavior explained.

Following the termination of the acting session, the psychodrama staff meets to evaluate the results of the planning and acting phases. An over-all

impression of the session is crystallized and individual and group reactions analyzed. The Director, who is in strategic locations during the session, offers observations of patient-reaction in the audience to the scenes, to the patient-actors, and to the others in the audience.

By means of a variety of psychodramatic and sociodramatic techniques in these weekly group sessions, the psychodrama staff has been able to help patients (1) by resocializing them in a friendly, accepting group, (2) by re-establishing interpersonal relationships, (3) by satisfying emotional needs and diminishing anxiety in the process of role-playing and problem acting scenes and by observation in the audience, (4) by building the ego from the feeling of success deriving from overcoming imaginary problem situations on the stage and before a group of one's peers, and strengthening the ego by knowledge and acquired "know-how" from trial-and-error explorations in the safety of an accepting and guiding atmosphere, and (5) by developing emotional and intellectual self-awareness through reality testing experiences on and off the stage.

The results with the original seventy-one patients can be summarized by saying that most patients improved in their hospital and community adjustments, many patients developed insight and emotional awareness, and a few patients achieved significant personality changes. Forty-five patients are now out of the hospital either discharged, on convalescent status or in family care. Twenty-six patients are still in the hospital of which number sixteen exhibit better personal and ward adjustment and freer and greater use of other therapies and hospital facilities than previously. Only ten patients manifest little or no evidence of improvement.

## COLLABORATION OF THERAPIST AND OBSERVER IN GUIDING GROUP PSYCHOTHERAPY\*

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There is general agreement that it is notoriously difficult to convey an accurate picture of what happens in psychotherapy. One of the greatest handicaps to progress of knowledge in this field is the difficulty in reporting accurately what goes on. The problem is bad enough in individual therapy where it is hard for the therapist to participate and observe simultaneously. It is worse in group psychotherapy because of the greater complexity of the multilateral and fluctuating relationships there.<sup>1</sup> In group psychotherapy, however, it is relatively easy to add some person as observer in addition to the therapist, whereas the situational limits of individual therapy tend to preclude the presence of a third person. The addition of another person to a group of six *ordinarily changes the situation less* than the intrusion of a third person into a group of two.

In this paper we should like to discuss some of the uses of observers in group psychotherapy programs with illustrations from our experience showing some aspects of the observer's contribution to the understanding of treatment.

Although treatment of patients is the basic objective in any therapeutic endeavor, in group psychotherapy, secondary but important objectives play a major part in the program planning. In reviewing the literature, we found that *observers* are being used in a variety of ways wherever there is study of interaction between human beings.<sup>2, 3</sup> Throughout, however, the main concern centers on their skills and reliability; their ability to master various systematic techniques of recording data.<sup>4, 5</sup> In group psychotherapy a secondary goal such as research, teaching, training of young therapists or a combination of these seems to point consistently to the necessity for some kind of disciplined observation.<sup>6, 7</sup> Where young therapists are trained, for example, it is frequently the practice to use them as observers and occasionally, or as they progress in skill and ease, to have them serve as "co-therapists" taking verbal part in the sessions in cooperation with the group's designated leader.<sup>8</sup> In other

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\*\*This research is being conducted at the Phipps Psychiatric Clinic of the Johns Hopkins Hospital under the direction of Jerome D. Frank. Others on the research staff are Dr. Eduard Ascher, Mr. Joseph B. Margolin and Miss Edith Varen.

settings, the observer may be required only to write down what he sees and hears and hand it to the therapist in much the same manner as a stenographer.

In settings where the observer takes a verbally active part in the treatment situation there is probably universal concurrence that he contributes to the treatment of patients. On the other hand, when the observer is silent and merely records his observations, the implicit *assumption* is often the reverse—that he does not influence treatment at all. This, we believe, is an erroneous assumption because such a written summary is necessarily influenced by the observer's skills, selectivity and biases. If the therapist uses this summary at all, these observer-influences inevitably color his subsequent treatment.

In our work\*<sup>9</sup> the observer remains silent in the group sessions. Although the mere presence of a non-participating observer may have effects on the group members, it is not our purpose to discuss this problem at this time. The value of observers as aids in group therapy, however, lies chiefly in the fact that another person in addition to the therapist may notice events which the therapist has missed. In addition to bringing one more pair of trained eyes to the situation, the observer is also free to devote his full attention to the situation because he is not personally involved with the patients. The doctor, on the other hand, is freed of this responsibility and can devote his full effort to the patients. Since the observer is also observing the doctor's therapeutic endeavors these too are available for discussion.

#### PRE- AND POST-SESSION CONFERENCES

The *primary value* to therapy and to research has resulted from collaboration of the joint skills of doctor and observer in the *discussions* which take place before and after each session. These always concern current treatment and research problems. Between sessions the observer analyzes the meeting records in the interest of tracking down points which will be useful to the doctor in carrying out treatment or which cast some light on research problems, and brings these up at the next pre-meeting interview. Through these discussions useful interpretations come to light which neither doctor nor observer might have seen alone. Inferences and interpretation of the data are therefore the product of the full collaborative skills of doctor and observer; for example, decisions as to whether a specific maneuver had positive or negative results and the why's and wherefore's of this. These discussions are of value

\*This is a collaborative research which includes psychiatrists, social workers and psychologists who study analytically oriented group psychotherapy with neurotic out-patients. The therapists in all instances are psychiatrists and the observers are clinically trained social workers and psychologists. For detailed discussion of the duties and training of observers in this project see Powdermaker, Florence B. and Frank, Jerome D. *Group Psychotherapy—Studies in Methodology of Research and Therapy*, Chapter on "The Observer as an Instrument of Research." To be published by Commonwealth Fund.

even when *no* conclusion is reached because they direct *attention* to certain issues. It is of course, always the doctor's responsibility to select the general and specific therapeutic manoeuvre which he considers most appropriate. Although in this milieu the observer may occasionally slip into the role of a "fellow therapist" (who may make suggestions for techniques of treatment), this is never his stated or explicit role.

Following are three illustrations of observer-participation and its utility in therapy as we have seen it grow out of the kind of therapist-and-observer discussions described above.

I. Mr. Needle was a regular attender of a group of nine male patients who had met once weekly for eight meetings. He was a short, earnest looking man; an obsessional person who was preoccupied with his mother's death and funeral, and dead bodies which he saw during the war. He had a great fear of going insane. In the group, Mr. Needle addressed himself almost exclusively to the doctor, eagerly pursuing almost any lead the doctor offered about topics to be discussed. He repeatedly asked of the doctor, "Is this the way you find out what your problem is?" He seemed obsessed with "finding the answer to things." He usually spoke in a low, monotonous, affectless tone and practically overwhelmed one with circumstantial reminiscences of his childhood and his day-to-day problems of living. The doctor had focused on Needle at great length in the group because he seemed most willing to discuss intimate personal problems—at least on the surface all of Needle's discussions seemed to be quite intimate. In this manner Needle managed to retain a great deal of the doctor's interest and attention though somewhat to the resentment and irritation of the other members who were neither so facile in relating their problems nor able to associate to the things Needle said.

In the ninth meeting five patients were present but Needle had spent almost all of the first half of the meeting in an "individual session" with the doctor with only occasional, desultory participation by others. Although the members seemed bored by Needle's discussion with the doctor, none of them showed any inclination to take the focus by discussing his own personal problems. After some time, three members banded together in a separate but quite audible conversation at one end of the table. This was such an unusual occurrence in this group that the doctor noticed it and several times glanced down at that end of the table but at the same time remained focused on Needle who was talking at great length about a problem with his wife.

At the subsequent discussion between doctor and observer the latter suggested that the *group's fragmenting* might have been a reflection of the group's

intolerance of memories from Needle's personal past to which they could not associate and that it indicated their unwillingness to sit back while Needle held the floor and the lion's share of the doctor's attention. This was the first time that either observer or doctor had recognized the exclusiveness with which Needle addressed himself to the doctor. Review of the past meetings indicated this had been going on since the first meeting, although not in such a striking form.

In the tenth meeting, Needle, as usual, attempted another lengthy monologue addressed to the doctor. After a few minutes of this there was a great deal of fidgeting in the group and one patient especially kept popping in with impertinent comments. Needle persisted in trying to interest the doctor in reminiscences from his childhood while asserting, "I'm trying to go back as far as I can to find out what started this thing." The doctor suggested that part of it might be found by looking at what we do here in the group and called to Needle's attention the fact that he had been talking *almost exclusively to the doctor and only rarely including the other men in his conversation*. Needle instantly agreed with the doctor but then became constrainedly silent until almost the end of the meeting. This was followed by a prolonged period of fragmentation following which the group for the first time focused on a single patient and topic consistently. This was also the first time this latter patient had been able to give a fairly coherent account of his difficulty. Another patient supported him throughout with many questions, comments, and interpretations, and at the end of the hour told for the first time in the group's history of the pleasure and satisfaction he got out of coming to the group and that he thought he was getting better.

Thus the observer was able to see and call the doctor's attention to the fact that one patient seemed to precipitate a noxious reaction in the rest of the group by monopolizing the doctor's attention in a way that was not useful to the other members. The doctor had failed to notice this because of the *apparent* psychotherapeutic pertinence of the patient's material. His effort at the following meeting to point out what the patient (Needle) had been doing seemed at first to fail in that it temporarily caused him to become silent and the group to block. After this, however, they were able to focus for the first time on another patient with good results.

II. Mr. O'Malley was a member of a group of 11 male patients, who had met once weekly for 25 meetings. He was a big, blustery working man who suffered from anxiety attacks centering on his heart symptoms and fear of death. He was also deeply concerned with the social structure and frequently

regaled the group at great length with the rights of labor, the need for socialism in this country and the state of the nation in general. It had been noted in previous meetings that he tended to get on his "soapbox" and deliver his tirades against "injustice," etc., especially when he was anxious, e.g. over a feeling of having been rebuffed by the doctor, an issue on which he was very sensitive. At such times, Mr. O'Malley monopolized the group time, bored others by his rantings and it had been almost impossible for the doctor or other group members to get him to shift to more personal issues once he was aroused. Other patients taking issue with him generally served only to upset him further and to intensify this behavior—he would for example accuse them of not standing up for themselves as working men, etc. The doctor's efforts to intervene were countered by Mr. O'Malley's retorts which implied that the doctor as an authority figure was not to be trusted.

Matters came to a head in meeting number 27 when Mr. O'Malley was again on his "soapbox," after several meetings in which this behavior had not appeared. When one patient expressed some annoyance with Mr. O'Malley's topic, the doctor mentioned that the group was restless, while one or two were doing all the talking. This had no effect on Mr. O'Malley who kept right on; so the doctor again pointed out that "We went around in circles today and some people were dissatisfied, but anyway the feelings came out." Mr. O'M. apparently felt rebuked by this and offered to stay away from the group, since he was upsetting the others. The therapist quickly reassured him that the purpose of the group was to arouse and examine such feelings, but nothing much could be done with this issue as it was the end of the meeting.

The observer studied the records of this meeting closely and in the *conference with the doctor* preceding the next meeting pointed out the similarity of attitudes which seemed to run through most of Mr. O'Malley's generalized discussion despite the superficially varied topics he discussed. Throughout, he had shown an unwillingness to compromise. He had to be either 'all right' or 'all wrong.' This was most apparent when, in response to the doctor's remarks, he offered to stay away from the group rather than indicating any willingness to modify his behavior. It was agreed that the problem might be handled by trying to focus on this attitude in such a way that O'M. would not feel rebuffed or involved in a struggle with the doctor, which would lead to more soapbox oratory. Early in the next meeting, Nr. 28, Mr. O'M. spoke of his distress about the group's boredom with topics which interested him . . . "They thought it was a political speech . . . I was making. With eight or ten men here, when one upsets the kiboodle—he ought to get out." The doctor asked if there was

"no possibility of one changing?" and Mr. O'M. replied with finality, "I have been that way a long time—I've been that way too long." (*At this point the doctor pointed out to him the "all or none" attitude which was implicit in what he was saying.*)

Mr. O'Malley seemed to accept this and the doctor went on to note that he seemed to have had the same "all or nothing" attitude on several of the different topics he discussed last week. Mr. O'M. accepted these interpretations soberly and with great interest and he went on to recall more personal areas of his life in which he had the same attitudes, with some awareness that he was less happy because of them. For example, in contrast to his brothers who "always had a good time," after 14 years of marriage he thought that he would either have to leave his wife altogether or continue living with her and deny himself "good times and fun."

The therapist pursued this discussion of uncompromising attitudes throughout the meeting and it proved to be of concern to many of the other patients who all participated freely.

Thus, in this situation where the doctor and the group had reached an impasse with a patient, it was the *observer* who was able by careful study of the record of the meeting to cut beneath the superficial topics (which the patient wanted to talk about, but which did not seem to the doctor to be therapeutically fruitful and which bored the other members) and to infer the patient's underlying attitude. This proved to be an acceptable topic of discussion for him. It seemed to the doctor to be therapeutically relevant not only to the patient concerned but to several other members.

III. Mr. Hines was a regular attender of a group of 6 (men and women) who had met once a week for 25 meetings. He had had a prolonged psychoanalysis, interrupted when the analyst left the city and came to our clinic requesting group therapy upon the advice of a relative. In the initial interviews with him, his chief complaints were "relations with people" and "I don't know what real relations with people mean." He was obsessed with the problem of his relationship to women and his perverse sex interests. He tended to dramatize himself, frequently having tears in his voice and using highly dramatic words, such as, "crucify," "crippling," and "desperate." Toward the doctor in the group he had consistently acted the part of the good patient with much ingratiating behavior and considerable revelations of ostensibly very intimate material. He had been a stimulating and sometimes disturbing influence to other members of the group because of his oblique but penetrating hostility,

especially to the women. He had thought at first that the group could not help him because of their unwillingness to tolerate discussion of his sexual deviations, after some meetings this had ceased to matter with him. Other patients in the group had shown various reactions to Mr. H. including resentment, but chiefly admiration for his intellectual superiority and professional status, despite his *ill-concealed contempt for their "stupidity"* and his general tendency to associate himself with the doctor.

In meeting Nr. 26, Mr. Hines behaved at one point in a rather unusual way; *he put his foot on the table* as he told of advising a woman friend to take care of herself rather than mother him, saying that he liked to be considered either an equal or a superior. The doctor seemed to the observer to be repeatedly glaring at the foot and then up at Mr. Hines, who stared directly back.

In the 'doctor and observer' conference following this meeting, the observer mentioned these observations. The doctor had absolutely *no* memory of this interplay, but agreed as to its potential use if it had occurred and indicated that he would attempt to discuss it in the group at the next meeting. They raised the question of whether Mr. H. also had been unconscious of his behavior or whether his placing his foot almost under the doctor's nose had been a deliberate act of defiance.

As soon as the doctor saw an opportunity in meeting Nr. 27, he introduced the topic of Mr. Hines' putting his foot on the table during the last meeting. He informed Mr. H. that the observer noticed that *this seemed to express an un verbalized conflict between them*. Other members responded immediately by stating quite openly that they had been outraged at Mr. Hines' behavior and surprised that the doctor would let him get away with it. Some thought Mr. H. was arrogant and others accused him of thinking that he was a privileged character. The other members then went on to associate to Mr. Hines' behavior in terms of their personal experiences, expressing many of their feelings about parental figures who had tolerated this kind of behavior by others in their families in the past.

Mr. Hines' response was generally an "I don't care" attitude to the group's obvious irritation with him. He insisted that "This foot being up is comfortable for me." He did go on to explain, however, that one reason why he felt that it was comfortable was that as a youth his mother had commented favorably about a friend who could do that sort of thing so easily. Although this was the extent to which Mr. Hines could associate fruitfully in this meeting to his earlier behavior, it was noted that this event marked the *beginning* of

many rather overt gestures of defiance and hostility to the therapist in subsequent meetings. This finally culminated six meetings later in his open verbalizations of these feelings. The *observer's* primary *contribution* thus appears to have been his ability to bring into the doctor's awareness one of his "blind spots." This was important in view of the significance which the rest of the group attached to the behavior he had overlooked.

*Summary.* In this paper we have tried to show *how* an *observer*, in addition to other functions which he may have, can aid the doctor conducting group therapy by pointing out aspects of individual psychodynamics or group relationships which the doctor has disregarded or failed to notice.

The examples illustrate three possible advantages that the observer has from this standpoint. 1. Not being directly responsible for therapy, he may be more likely to notice the harmful effects of a patient's behavior on group relationships, which the doctor overlooks because his attention is absorbed by the apparent relevance of the patient's verbal content to his personal problems. 2. The observer is in a position to *discover patterns* which emerge only after careful study of meeting *records*; especially since in reviewing these records he is not influenced by the ego investment and 'blind spots' which the doctor may have when he tries to evaluate his own therapeutic efficacy in such detail. 3. Finally, he may observe some relevant behavior of the doctor, noticed also by the group members, but of which the doctor himself is unaware.

It is hoped that these examples will stimulate thinking about the methodological and treatment difficulties inherent in group therapy and the possibilities of using observers to help compensate for some of them.

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METHODS OF SOUND AND MOVEMENT AS  
AN ADJUNCT TO PSYCHODRAMA

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The Theatre in the Round of the Psychodrama setting provides the group of patients with an aesthetic milieu inviting movement and action.

In order to effect any change in a patient's body and in the corresponding psychological overtones by means of exercises and dance, a long period of time is undoubtedly required and the work must be synchronized with every other type of treatment the patient may be getting. There seems to be, in a psychotic, a general lack of physical will-to-change and often a profound resistance against any attempt to change a body position or behavior pattern. There is the difficult drawback of lack of concentration and perseverance. There is no physical desire to establish new bodily rhythms which would help to integrate and heal. An indirect approach to the body is necessary, time, and becoming acquainted with the patient well enough to catch the fleeting moments when the body attention is aroused sufficiently to *work*. Experiments at Moreno Sanitarium produced results which, I feel convinced, should be studied further under conditions of steady application, and which could be of real value for diagnosis, release and re-training.

*Percussion instruments:* The group of patients were astonishingly responsive to these instruments (gong, drums, wood-blocks, rattles, etc.) and, from the very first session, each was willing to pick out one and play on it. No one mistreated an instrument. They liked the sounds produced and particularly the gong seemed to affect them emotionally. Meaningful tones can be produced from these instruments almost at once by anyone. They are the nearest to being parts of their body, *organic* instruments; they act as extension of the player's very depths of being; they are like responsive auxiliary egos immediately at hand. They are very intriguing, beautifully made. A satisfying sound comes forth, produced by such a familiar *gesture as hitting*.

There was no disorder or chaotic pounding of the instruments. They seemed, of themselves, to induce or exercise some sort of control of the players. Mere noise-makers (glasses, pans, etc.) or over-complex musical instruments (violins, pianos, etc.) tend to excite a chaotic response; one bangs on them or

is afraid of their complexity. But it is important to note that certain, apparently "primitive," percussion instruments are *tone-makers* (not noise-makers) and their sounds can tap some intuitive, undisturbed source within a person, when shyness of cultural barriers is removed. Pianos, violins, etc. are too difficult to play spontaneously and we are all conditioned as to how they should be played and what should be played on them. This may bring on a tendency to smash them.

*Examples:* Percussion instruments are an excellent means for warm-up. They quickly stimulate group feeling; group participation and cooperativeness. Patients who are unfit to *actively* join a group *can* be active by playing an instrument. Simple rhythms led by anyone so inclined start a process of observation and are a training in cooperation and attention. The "Sociometric leader" begins a rhythm, the rest follow or improvise upon it. When the leader feels the group has done enough with it, a definite conclusion is attempted by all at the leader's signal. Most patients were able to begin such rhythms, to watch the rest chime in and to bring about an orderly finish of such "primitive" orchestration.

Different types of sound tend to stimulate a desire to respond with differing motions. For instance: sound of wood blocks is conducive for foot beats, jumps, staccato movements; while the sound of the gong inspires long sustained movements, moods, turns, swings, etc. Thus, some patients would do exercises and improvised dance sequences while the rest acted as accompanists.

Instruments had to be hit in a suitable way to produce the suitable sounds for the "dancers." The act of *bitting* an object is experienced as a constructive act, and even creative and cooperative—not the destructive expression of hitting. This alone tends to produce a helpful impression on the patient if followed through long enough, introducing a positive action where only the negative expression might have been present before.

A violent patient proved excellent in producing interesting and even complicated rhythms and sounds. She handled the instruments extremely well, was deeply impressed and moved. On several occasions when she appeared on the verge of violence, if an instrument was handed to her (such as a small open drum to be played by the hand, without a beater) she would become occupied with the playing or give vent to her feelings by the intensity of sound she could produce. On other occasions when she froze in catatonic paralysis, an instrument quietly layed on her lap and left alone as the group continued work would entice her into playing within a few minutes.

Another patient, upon hearing a simple mood-producing rhythm on the gong while some were doing exercises, suddenly stopped and said the sound reminded him so strongly of something that he wished to go into a psychodramatic session at once . . . while the gong played. He picked out his director, auxiliaries, and went into a long production of a dream.

Instruments accompanying certain kinds of psychodrama can be extremely evocative, stimulating, compelling. In such cases, however, the instruments should be played by those who are not only expert in handling them (as an electrician with lights) but also *knowing which to use and when* (as a director giving signal for certain color lights in the course of a psychodrama).

One patient was particularly interested in a dance. She was asked if she wished to go to a dance school and study seriously. Upon her approval a ballet-mistress and a school were psychodramatically produced. She applied and entered a dance class. In factual classic style, the ballet-mistress disciplined her severely, drove her on in strenuous exercises, criticized her sharply. In the middle of the "class," the patient stopped and sulkily stalked off, admitting she could not carry it through and was afraid. She was talked to quietly and finally made up her mind to return and try once more. This time another patient (a very passive, inactive one) volunteered to be another pupil because she too liked to dance. The two put up with strenuous exercises and sharp criticism for several minutes. Both did very well, even from the technical point of view, and the session was brought to a close before either of the girls got tired out. This should be a helpful means for discipline and re-training.

To move and give expression to dance-ability brings a tremendous sense of accomplishment. There are certain peaks or levels of psychodramatic action which can best be "acted" out in dance media. *Make* a dance out of your fear, your deepest sorrow, your speechless joy! Do not destroy—"dance it out!" This can be reached, perhaps most easily, through fantasy. Here sounds, lights, dance and psychodrama were combined and interwoven in such a manner that several times the patients revealed what might be seen as the most ideal and beautiful potential of themselves. The patient becomes the prophet of his own transfiguration and produces a living "art" experience in which the audience participates as "orchestra."

Another method which is definitely very useful is the integration of vocal sound and motion. To me the two are inseparable. Sound-making as part of body motion serves as a powerful instrument for focusing the personality, but a new method must first be learned in regard to "producing sound from the

body"—(Moreno's "basic language" and psychomusic) and it is very difficult to free the voice from merely vocalizing words in the accepted cultural fashion. Often there is a split between voice (emotions) and a physical act, and it takes physical, mental and emotional effort to synchronize the two. First mere sounds or tones are used; then words without meaning; finally words with meaning which can be projected into motion. It may appear easy, for instance, to say the word "run" and run across a room—but the *way* in which the word is said and the manner in which the motion carries it out are very difficult to achieve. I have never seen *anyone* do this sort of thing at once and usually there is at first a painful struggle between the verbal and actional levels, between emotion and motion.

*Saying one's own name*, accompanied by whatever gestures come forth spontaneously with the saying, is often startling. Done under proper conditions this proved a good way of concluding an outburst which threatens to go beyond all control. It also gives a most immediate and frank "picture" of the person, the image he has of himself. I have seen students, not patients, utterly unable to utter their name; and to reveal themselves completely, as the social front or mask was broken through. It must be done spontaneously and the person shown how to be truly himself without fear of the name or the gestures.

Much can be done with single words and the actions words can induce. Patients were asked to make a spontaneous choice of a word, then to get up and "move it out" while the rest said it aloud as an accompaniment. One patient picked out the word "anger." She eagerly got up and made a sequence of remarkable gestures depicting her sense of anger. She performed these motions so well, that a professional dancer might well envy this living artistry. When it was suggested to the patient that she begin to say aloud her chosen word, she began instead to scream; to move and to scream in a most intense and mad anger. The group was silent, only the gong continued being played (by director) with intensity equal to the patient's. After a few minutes it was suggested that the anger was ebbing; the gong sound became quieter and quieter and the patient began to follow the gentle sound, ceasing her screaming but still moving about angrily. She was suddenly and emphatically asked her name; there were a few moments of great effort and then she was able to answer just as emphatically and fully "herself." Such occurrences indicate that certain sounds (particularly of the gong type) can be used not only to stimulate and induce action, but to *control* and quiet.

The problem of free dance improvising with the patients was not easy to meet. Most of them demanded set steps and patterns to be shown which they

could *copy*. Once I was trying to improvise a little with a stiff and "cultured" type of patient. We were turning around, holding hands, when she stopped and began hopping up and down like a child in a tantrum, her face screwed up and in a high-pitched voice exclaiming: "Stop it, stop it! I don't *know* what I'm doing! I can't dance. This is no way to teach dancing—you have to *show* me the steps, then I could do it." This is perhaps a good illustration of what our cultural "arts" are doing to us and to our spontaneity!

There is also another aspect which should be investigated: the strong effect upon some patients of a dancer's dynamically projected movements. This is particularly dynamic if the patient participates by playing on instruments, becoming identified with the dancer or even giving the dancer verbal indications for the content of the dance. For instance, a therapeutic dancer would acquaint herself or himself with the patient thoroughly, feel out and become sensitive to the inner qualities and yearnings of the patient which the latter could not express verbally or bodily. Thus the dancer would become like the "double" of the patient's creative and living potential. At the proper time and with proper warm-up the dancer would become in action the "creating double." The patient should feel close kinship with this projection of the intensified "moving out" of himself and should direct the dancer by means of instrument accompaniment, or by words and directions. The dancer would not express or create as a dancer, but as an extension of the patient. The group also would participate as "orchestra" and anyone caught into the mood of moving should gradually have their "say."

Some of the percussion instruments can be made by patients or students and could serve as an unusual and interesting occupational therapy, closely related with the psychodramatic and psychomotion activities—instead of a distinct and separate department. Certain types of drums can easily be made; wood blocks; rattles out of gourds, etc. The instruments can be made well enough to have varying but synchronized tones. Then they can be added to the "orchestral" collection and used for actual performances, the "compositions" emerging out of real experiences, out of the "surplus-reality" of psychodrama.

Body and mind habits, patterns of automatic actions, the old crystallization which contribute to loss of spontaneity, loss of function, even loss of life-capacity, have to be broken up, eliminated or vitally changed. Gestures, mannerisms, and particularly the way in which a person performs specific exercises, do reveal the state of mind of a person. One begins to detect a certain basic

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muscular and structural "vocabulary." But it is a misleading practice to put into neat categories what each gesture reveals—there may be basic *indications*, but the interpretation varies widely depending entirely upon the capacity and the potentiality of the subject.

It may be of interest to note here that, with ordinary "normal" students, percussion instruments seem much less useful. They do find it helpful to have me play on an instrument as accompaniment to exercises and they do find the gong pleasing as a sound inducing moods and certain types of sustained movements. But I find it very difficult to make the students play on the instruments themselves. They seem almost afraid of them, or some strong cultural barriers prevent them from even trying. I have noted a real sense of fear in women of a cultured type when they try to play on a "primitive" drum—they seem afraid it will bring out or release from them the primitive emotions they would rather hide!

## PSYCHODRAMA IN A WELL-BABY CLINIC

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Psychodramatic methods have a great field of application in maternity and pediatric clinics. During a recent seminar, at a southern university hospital we (J. L. Moreno and the writer) demonstrated the use of such techniques to a pediatrician just engaged in examining a group of babies whose mother brought them to the clinic for their first check up; the infants were all between four and six weeks old.

It should be pointed out here that the psychodramatic approach is equally effective during pregnancy, when the experience of pregnancy are stirring up conflicts within the prospective mother. In such cases a trained auxiliary ego takes the part of the "psychological baby" within the mother, as a "warmer upper," to help the mother to free herself from her fears and to establish a more secure relationship to her child. At the strategic moment in the psychodrama the prospective mother herself is asked to step into action, to replace the auxiliary ego and to take the part of her own psychological baby. The psychological baby is not merely the result of this particular pregnancy, but of the entire growth process of a woman; it may have become distorted long before she reached puberty, while herself a child, playing at motherhood with or without dolls, in a psychodrama of her own making. Another approach which is frequently helpful to expectant mothers who are disturbed is to use the "double technique" in which an auxiliary ego takes the role of the mother side by side with her, co-experiencing her fears, doubts, misgivings and apprehensions. The psychodramatic method can be usefully extended to mother-infant situations with adolescent girls, long before they go through the actual experiences of marriage and pregnancy, delivery and so forth. It is well known that the psychological baby preoccupies their minds considerably. Psychodramatic techniques can help to liberate them from and correct distorted perceptions.

In the well-baby clinic to which this paper refers the only feasible approach to the babies was a group psychotherapeutic one because of the large number (several hundred) who came to the hospital at one time. Each staff member took from six to ten mothers with their babies in one group. They were seated in a circle, with their babies on their lap. The physician and I were seated among them; he asked the mother to remove the babies' outer clothing.

We had been informed that they were all colored mothers, a number of them unmarried, and that they might be confused by my clipped speech since this was unfamiliar to them. They were new to this entire process—it was their first visit with their babes in arms—and the doctor felt they might be reluctant to confide in him in the presence of a stranger. I began, therefore, to warm up to the group as if I were a part of it, just as the members of a group do in a psychodrama session. The physician first examined the babies, then interviewed each one of the mothers in turn and when the initial rapport had been established he inquired whether they had any questions to ask. One or two came forth with a few remarks about minor eruptions on the babies' skin. Some suitable medications and methods for dealing with the irritations were given. I looked around and noticed that the mothers and children were mostly of fairly dark color, with few wedding rings in evidence. There was one mother-infant pair whose skins were considerably fairer than that of the others. For lack of any better name I shall refer to this mother as Mrs. Jones. She was further more neatly and expensively dressed, had on a wedding ring, some costume jewelry and looked and acted very tense. The group's talk came around to diaper rash and this time Mrs. Jones, who had been very reticent up to that point, stated that her daughter had some eruptions she could not deal with and which might be diaper rash. The physician asked her to show them to him and as she opened the diaper of her little girl she turned away, her nose in disgust at its odor. The physician had told me that in general these mothers were extremely loving, very permissive, feeding their children whenever necessary without much attention to time or place and I did indeed see several mothers breast-feed their babies in the course of the session. Not so Mrs. Jones. Her child was examined as was each one of the others for similar difficulties. Again some suitable recommendations were made by the physician who then sat down once more, becoming a member of the group.

He looked around the circle and asked the entire group: "Do you have any feeding problems with your babies?"

Most of the mothers shook their heads: "No."

"What remarkable children, or maybe you are all remarkably fine mothers."

This double-headed dart from the physician reached its mark.

One mother, the one seated at his immediate right spoke up: "Well, I did have some trouble with her, she was spoon-fed some vegetables this week and she spit them out."

At this point the physician looked at me inquiringly and challengingly, as if to say: "What does a psychodramatist do in such a situation?"

I fell into line and *took the part of the baby*. In a very soft, rather weak but appealing voice I said: "Well, those vegetables don't taste so good after the milk. I'm not used to them yet. They're kind of rough on my sensitive mouth. I don't like them so I spit them out, I don't know what else to do with them, it hurts me to swallow them. After all, I'm only a month-old baby." The mothers looked at me, surprised at my entry into the situation and startled by this turn of events. Slowly I saw one after another beginning to smile, especially the mother who had brought up this problem.

The physician asked her: "Do you think your baby could be thinking this?"

"Yes, she could."

"Do you think she might resent you if you continue to do this?"

"Yes, she might."

"What made you start her on vegetables?"

"I did not start, it was my mother."

In the south certain feeding customs prevail and generally the grandmothers take an active part in the rearing of children, especially if the child's mother is very young and has to work.

The physician then asked: "Was it her own idea or was it someone else's, a friend of your mother, who had urged her to try to give your baby vegetables so soon?"

The mother answered: "I don't know."

"Perhaps the baby is not ready for such food yet. Maybe you had better wait a while until we tell you about solid food and what to give her."

This was met with general approval from the group and the particular mother said: "Alright, I will tell my mother not to try vegetables any more."

The ice began to break very fast now and the warming up process spread from mother to mother. Several women began simultaneously to speak of feeding problems. One said: "I don't give my baby vegetables yet, I breastfeed her and I give her very little milk at one time. And still she throws it up, you see?"

She had been feeding the child and held the baby up to the physician to show him what had just occurred.

He asked her: "Do you burp her sufficiently?"

She replied: "I think I do."

Again the physician looked at me as if he were prompting me to step into

the breach. Taking the role of the baby I said: "She puts me down too fast. I can't eat that quickly, so I bring up the milk with the burp."

The physician looked away from me at the actual child whom I represented. "Yes," he said, "it looks more like a wet burp than vomiting. (To the mother) Why don't you give the baby more time? I'm sure that is what she needs, now that I see her do it."

The mothers all smiled at this and the guilty one looked lovingly and apologetically at her baby. The physician grinned at me as if we were in cahoots and I continued, in the role of the baby: "After all, I'm not as much of a hustler as she is and besides, I have all the time in the world. She forgets, I'm still very small and helpless, it takes me some time before I can bring up a burp."

"Alright," said the mother, "I'll take it easier with you from now on." She addressed the baby and the group at one time. The mothers began to smile directly at me as if I really were their baby and the talk began to deal with another problem, that of sleeping.

One mother stated: "You know, my baby frets at night, although he sleeps beautifully during the day. But at night I don't know what to do with him, he's so fretful and restless. I have to get up early in the morning and can't always wake up and caress him and play with him during the night. I'm so sleepy I often can't hold him. Once or twice I fell asleep again before he did and I could hear him cry and fret in my sleep."

This was my cue again, especially as we saw how several mothers warmed up very much with the last speaker who was, incidentally, sitting close to me. "What's the matter with mothers," I said, again in the role of the baby, "I am a little tiny baby, I don't know night from day, whether it's early or late. All I know is that when I wake up and everything is so quiet, I'm lonely. Everyone else is asleep or dead or something and it's dark. Then I get scared and I start to cry. I want my Mummy and I want some companionship and comforting. During the day I see things and people moving and I hear voices of people or grownups or somebody and people come to me; they talk to me or smile at me or pick me up and love me. I don't feel the same way at night, only I don't know it is *because* it is night, I'm just scared to be all by myself in the world, I feel so lost."

At this all the mothers shook their heads affirmatively. The majority of them started to talk rapidly, confirming the fact that during the day their babies were quiet and happy. One mother raised her voice and said slowly: "That's true. I guess they don't know day from night."

Another chimed in: "I don't mind taking care of the baby if I'm not asleep or tired, I pick him up and make him feel good, play with him and all."

The physician asked: "Maybe you all would not mind turning night into day." Several answered him to the effect that they would not mind, "if they could only sleep during the day instead."

The mother who brought up the problem had become pensive and suddenly came out with: "You know, come to think of it, I myself feel lost at night when I'm not asleep and I wake him up to play with me."

The mothers smiled again. The physician asked them: "How many of you feel lost and alone when you wake up at night and everyone else is asleep?" Quite a large number conceded they did feel that way, although they "don't always wake up the baby to keep them company."

This discussion lasted for some time until one mother said: "Well, I understand all that, but sometimes my baby cries and I don't always know why, or what to do about it."

This was quite a challenge, so I tried to warm up again to the mother who had raised this point and to the role of her baby and said: "Sometimes I just like to cry, not because I'm unhappy, but because it makes them pay attention to me. It is not always fun to be left alone. Other times I cry because I'm uncomfortable, I want to turn over and can't do it all by myself. Or my clothes are creased and that hurts me or my diaper rubs me sore. Of course they think it is good for a baby to cry, that it helps his lungs to develop. I don't know about that, I just cry."

The physician asked the mothers: "What do you think; could that be how the baby feels when it cries and you don't know why?"

They shook their heads affirmatively, smiling at me. The whole session was now running entirely on its momentum. Unfortunately the period allotted was coming to an end. Quite unpredictably—and we know that the warming up process is responsible for this total contagion—Mrs. Jones, who had all this time remained more aloof than the other members stated: "I don't know, there have not been any babies in my family as far back as I can remember. I should feel better about her, I was a school teacher before I married, but somehow I just can't seem to get adjusted to having a baby around the house. Everything seems to be going wrong, mostly in the way I feel about her. I can't get used to her at night or by day, I sometimes have to go out for some errands during

the day and when I return everything seems to be more difficult than before I left."

At this point the physician suggested that Mrs. Jones return for an individual interview with him, when he would work out her difficulties more intensively and an appointment was made to this end.

The rest of the group now began to tell the doctor how much they had enjoyed this visit.

He asked them: "Did you learn something from this meeting?"

The mother with the night-owl baby said: "I think she (looking at me) helped us a lot. Now I, anyway, understand better why my baby acts as he does. Do you feel that way too?" She turned to her neighbors and looked around the group. They nodded their affirmation.

One mother said to me: "I hope you will be here again the next time I come."

Upon analyzing with the mothers the situations after they had been enacted it appeared that the therapeutic value of the psychodramatic dynamics consists in working out weak and distorted images which the mothers themselves have of the babies, in a more articulate and plastic way. Faced with these images in a dramatic fashion they are first startled and then they evaluate them, accepting or rejecting them. The auxiliary ego stimulates them, through a triple feeling out of what kind of mothers they are, how they perceive their babies and in what type of milieu they function. The process starts them thinking and feeling like the baby might be feeling and thinking; it is a "reversal of roles" as we say in psychodrama. Most mothers have a hazy perception of these subtle interchanges and they continue to carry around these half-formed images unless some deep action process is applied. Besides the individual experiences which a mother has of her own particular baby she has also collective experiences of babies in general. The learning which takes place in the psychodramatic situations as outlined above comes through enacting these collective experiences by trained auxiliary egos. These "action-images" and feelings may differ from culture to culture but the psychodrama is a simple and direct way of teaching them how to accept life as it is, in whatever environment, to become more relaxed in relation to their infants and to learn how to help themselves by becoming more effective auxiliary ego-mothers to their own children.

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## GROUP PSYCHOTHERAPY IN AUSTRIA

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### *Austria*

It is no easy task to speak about the development of this method in Austria, as its history is too short yet. Pupils of *Alfred Adler* were among the first to stress the importance of group work in Viennese schools. After the Great War, *Stransky* sometimes was forced by sheer lack of time to give-up single treatment in favour of group work, and found that he reached his aims much quicker in this way. Long before Alcoholics Anonymous became known, (they are still unknown in Austria even now!) *Dr. Metzel*, physician in the service of the Vienna police, tried to unite his alcoholic patients in groups.

It was not until after World War II, when *Kauders*, head of the Vienna University Psychiatric Clinic, roused a new interest in "Social Psychiatry" which of course had been badly neglected during the days of the Third Reich. After his first lecture on group treatment numerous objections against this method were made. But *Kauders* favoured it, calling it "an innovation of similar importance as the shock therapy had been." Unfortunately *Kauders* died soon after, so that many questions remained unsolved.

The first authors to publish their experiences on this topic after the last war, were *Bojsen* and *Spiel*. They reported on their groups of patients suffering from vegetative disturbances. (Problems of the vegetative nervous system were always treated with special attention by the Vienna School, of which we only need to mention the names of *Hoff*, *Potzl*, or *Schilder*.)

It was proved by electro-encephalographic records that it is possible to alter the tonus-steering with the help of an "Autogene Training" as described by *I. H. Schultz*. We can mention, by the way, that especially in Germany autogene training is considered to be a valuable instrument in the hand of the practitioner. At the Psychiatric Clinic of Tübingen regular fortnightly courses are held to teach this method, which to a certain degree already has replaced hypnosis, esp. in the form of the "fractioned active-hypnosis" inaugurated by *Kretschmer*. This method which combines exercises of relaxation and concentration became known in the U.S.A. through a paper of *Jacobson*. Practised in groups it does not only offer the possibilities of a suggestive-inspirational mesmerism, but also the "class method" of *Pratt* and *Klapman*.

When *Prof. Hoff* who had spent several years in the U.S.A., was made head of the clinic in Vienna, group psychotherapy woke up to a new life. At present *Arnold U. Schindler* works there with a group of schizophrenic women (open group, with leader), while a second group comprises the relations of these patients.

*Prof. Urban* of the clinic at Innsbruck introduced some ideas of "Social Psychiatry" already some years ago, mostly in the line of "casework." Within this frame f.e. a social worker leads a group reading stories with an emotional background to them, discussing the problems afterwards. (see also *Powell*.)

But nowhere in Austria systematic research work, f.e. about group structure, social dynamics and group tension was promoted. *Moreno's* Sociometry or Psychodrama are almost entirely unknown, the knowledge about Therapeutic Social Clubs only slowly spreads here through English literature (esp. by *Bierer*). Things are far better with the section of Psychic Hygiene where *Hoff's* plans are being realized. Here, too, group psychotherapy will have a great chance.

In 1948 the author of this article dwelled in London trying to get acquainted with the Anglo-Saxon notions of these matters. He soon realized that working with groups was no mere emergency, and did not mean to replace work-therapy, as often is believed. The author had the vivid impression that the study of books on this topic could not intimate to him the "spirit of the group" which only can be grasped through experience, by joining as many groups and as different ones as possible. When returning, the reporter was given the task of establishing an out-patient department at the clinic of Graz, and as its leader he was able to collect his first experiences with groups of men and women, comprising 290, resp. 164 patients. These open groups were meeting with their leader twice a week for more than an hour. The female group consisting of neurotics and mild schizophrenics met in the private office of the therapeutic leader where a favourable "climate for the soul" could be created. Each time between 7 and 10 patients were taking part. Here it was partly possible to interpret the discussions in an analytic way.

By way of an experiment a male group was formed without a similar selection, meeting in the psychiatric department as an "orientation group" of about 20 persons. The results here lagged considerably behind those of the female group and it was not possible to reach a similar fusion of individual and collective psychotherapy.

Besides the groups mentioned, rather unruly patients met for action methods (gymnastics), and some of *Moreno's* experiences could be verified in this group.

Our assistant *Frick* formed groups of alcoholics who were being treated with "Antabuse." His intention was to intensify the impression of the "experimental drink" in the minds of alcoholic patients. (It may be mentioned by the way, that *Frick* wrote his doctor's thesis in Italy, which was the first work on groups that ever appeared in this country.)

As mentioned above, the idea of Psychodrama (though it grew out of *Moreno's* Viennese "Stegreiftheater" and Therapeutic Theatre) is as yet unknown in Austria. Though the author tried to spread this idea in radio lectures and essays, it hardly can be expected that this revolutionary treatment will become popular soon.

At present the author of these lines is working in a country hospital for some time, in order to study conditions there; he tries to apply the experiences which he collected at the clinics. We are of the opinion that psychosomatic treatment should be applied with patients of a simple structure of mind. Thus we are trying at present to find a useful synthesis between the Anglo-Saxon idea of group psychotherapy and the idea of autogenic training. Our sessions are started with suggesting to the patients, the "feeling of warmth and heaviness" (*Schultz*), and with conjuring up in their minds some picture loaded with "affective values" (*Kretschmer; E. W. Betz; etc.*) f.e. the illusion of a river landscape, a flowering meadow in the mountains a.s.o. These group experiments always offer the cue to a conversation far more vivid than might develop in a session started ad hoc. While working at the psychiatric clinics we found that especially the problems around the shock treatment (E.C.T.) were causing anxiety in our patients (a fact which confirms the statistics of *Friedman* and *Gerhard*.) In a similar way our present patients in the hospital often feel anxious about blood pressure or blood smears and taught by experience, we make it our main point to dispel all these fears. At the psychiatric clinic it is above all "the mental shock caused by the locked doors" which we try to prevent. But we are here to avoid those "iatrogenic neuroses" so numerous in our time of technical medicine as they lately were discussed by *Frankl* in his effective way. (Female patient, after an x-ray: "My ball-shaped heart upset my stomach!")

Of course our rural population cannot overcome its distrust against "new-fangled" institutions too quickly, and often we meet with suspicion or disap-

proval. We shall not deny that sometimes we were badly disappointed. But in general people of a rather primitive mind are more thankful for this sort of treatment than the population of great cities, where the knowledge of certain psychological elements is spread at least by hear-say.

A whole, the medical world does not look upon our aims in a very friendly way. Objections are made against a certain asserted superficiality and triviality which, according to the opinion of our opponents, might be of disadvantage to psychotherapy in general. The form of "short psychotherapy" is as yet in its beginnings, the methods of *Frobman*, *Ferenczi-Rank* are hardly known at all.

It is deplorable that students of medicine hear so little in their lectures about the principles of social work and sociometry, yet the future practitioner will only be able to lead a group if he knows all about the feelings resting in the heart of every human being "the desire of being accepted, belonging to someone, a craving for inward security and peace of mind." (*H. Krauss.*)

We cannot counter the objections repeatedly made: we cannot show up our success by way of figures or curves. But let us reply that a hospital is no plant or factory where success or failure can be measured by statistics. It seems more important to us to satisfy our patients and to widen their mental outlook. The law of *Arndt-Schultz* is also available in the regions of psychotherapy: "Weak stimulants instigate the activity of life, middle ones promote it, strong ones check it."

In spite of that "collective aggression" which not even in the U.S.A. has been entirely overcome, we are convinced that group and action methods will be the methods of the future—in Austria, too. It may be necessary, though, to give our physicians and social workers the possibility of studying this subject in the Anglo-Saxon countries. Even in medicine we may suitably quote the word of *Cervantes*: "The way is better than the shelter."

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## SOME MISUNDERSTANDINGS IN THE TERMINOLOGY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

J. L. MORENO

*Beacon, N.Y.*

### 1. *Tele and Transference*

Sociometrically oriented group psychotherapy has found the term and concept "tele" useful as the agent responsible for relative adequacy in reality testing and relative strength of group cohesion. In contrast to tele transference indicates inadequate, distorted reality testing and relative weakness of group cohesion. Tele was discovered in the course of sociometric research when it was found that shared interactions in human groups deviate radically from chance and develop in proportion with their cohesion. But psychoanalytically oriented group psychotherapists—in contrast to the Freudian meaning—often use the term transference so vaguely and all-inclusively that the reader gets the impression as if all group relations are transference relations. This existing confusion will cease if the difference between tele and transference is conscientiously pointed out in our literature, and applied in every analysis of groups.

### 2. *Abreaction, Interabreaction and Interaction Dynamics*

Some psychoanalytically oriented group psychotherapists engage frequently in another misapprehension by the irregular use of the term "abreaction." Individual abreaction is one thing, a chain of connected abreactions is another. The abreactions of an individual A may provoke the abreaction of B, that of B may precipitate that of C, and so forth; from the point of view of the group they take the form of interabreactions, of a chain of influences, a series of single "atomic" abreactions merge within the group into novel patterns.

### 3. *Free Association and Spontaneity*

A third confusion derives from the inaccurate use of the term free association; the emphasis is at times upon the noun association, at other times upon the adjective free. Actually there is no free association possible. What is meant—and what psychodramatic analysis has tried to make explicit—is that therapeutic associations are (or should be) unrehearsed and spontaneous. Thus we arrive here at the relation of free association to spontaneity. Free association has, as we see, a spontaneous function but it has been limited in psychoanalytic therapy to the verbal. This limitation has crippled and frustrated the exercise of spontaneity. The dictum "say all that is on your mind" has to be logically

extended to acts and interacts. Therapeutic objectives frequently require that free association of words is augmented by free association of acts. Indeed, in situ the two can never be neatly separated. The result is that the psychoanalytic situation had to be converted into a psychodramatic situation.

#### 4. *Reality Testing and Reality Therapy*

The psychoanalytic situation is poorly suited to reality testing—as long as it remains truly psychoanalytic, that is, as long as the analyst restrains himself from becoming a live actor towards the patient, and the patient towards the analyst.

The group psychotherapy situation is better suited for reality testing than the psychoanalytic because the members of the group have, at least potentially, equal opportunities for interaction with each other. Although they do not interact within the context of a social system like the family or a work situation, they rapidly develop relations which are sociometrically meaningful. A limitation enters also here because the interactive reality is restricted to the verbal dimension and the motoric element is restricted to sitting on a chair, or standing up.

The psychodramatic group situation is the most suitable for reality testing because all situations are modeled after life itself and permit a complete living out within them. Indeed, at times they permit expression to actions in excess of what life itself would permit—"surplus" reality. In this sense psychodrama becomes not only the concrete focus for many of its potential realization aims but also a depth therapy for the group.

#### 5. *Analytic vs. Psychoanalytic Group Psychotherapy*

Analytic and psychoanalytic are frequently used as if they would have identical references. Terms and concepts like analytic group psychotherapy derived from clinical observation and the direct experimentation with groups. Its hypotheses evolved largely from sociometry and experimental social psychology. Psychoanalytic hypotheses on the other hand emphasize the point that many insights gained from the study of individual psychodynamics are also applicable to group dynamics. Until to the time that the claims made by various individual and group schools of thought are definitely demonstrated as true or false it is desirable to use the terms analytic and psychoanalytic cautiously, giving them each time their specific meaning.

EXPERIMENTS WITH THE COMIC STRIP "BLONDIE" AT  
THE PSYCHODRAMATIC INSTITUTE, BEACON, N.Y.

*The comic strip "Blondie"*, prepared by the Department of Mental Hygiene of the State of New York, represents a few standard situations which could be used in all mental hospitals—indeed in all social institutions, especially educational ones—for the accumulation of a large mass of reactions which should be interesting, coming from a great variety of groups. Such wide application might help us towards social diagnosis, differentiating abnormal from normal groups and various gradations within them. Other situations might be added to those presented in the comic strip.

*Combination of Individual and Group Techniques*

1a) Pass the comic book from patient to patient so that each one can look at it for half an hour.

1b) Afterwards they meet for a group-session and are asked for reactions to the scenes described in the comic book.

*Group Test—The text is read to the patients*

2) The patients meet in the theatre, a reader on stage reads the first scene to them, then asks for reactions for which each patient is asked directly. All four scenes are read in turn and the discussion always follows each scene immediately.

*Psychodramatic Test*

3) Every scene is enacted by a staff of auxiliary egos so that patients see as well as hear the actions and can follow the interactions taking place. The reader is now replaced by a prompter. The script is not rehearsed, the prompter sits on a chair in center of stage, visible to all. The actors take their positions for the scene to come as indicated by the prompter. Immediately after the prompter has read the part which an actor is to play, it is dramatized; the actors are permitted to ad-lib and to extend, as long as they do not fall out of the meaning of the original script and the character of the role indicated.

3b) An alternative to the above would be to let the various characters (actors) appearing in the comic strip study the strip very carefully so that they know its meaning and content well and then proceed to act it out without necessarily repeating accurately every word, but phrasing it more freely, again, maintaining the characters and the roles and the course of action and interaction. No prompter is required.

4) To replace the psychodramatic egos by dolls or puppets who are prompted by puppet director in usual fashion.

5) To make a television picture using either psychodramatic production as a format or doll or puppet figures creating a sort of psychodramatic cartoon (combining method 3 and 4).

During the production two observers in the audience watch reactions of patients, gestures, laughter, etc., and make notes of them. Immediately after each scene the director approaches the audience and asks them "what is right and what is wrong with this presentation," putting the positive question first. Also, "what is the lesson of this scene? What does it teach us?" In the ensuing discussion every member of the audience should participate and a reaction obtained from each, *before* allowing any one or two members to monopolize the discussion. A more general discussion can then take place.

These five methods can be combined, one used as a control for the other. When bed-ridden patients cannot attend the production can be staged on the ward itself. After the production the discussions should be recorded and given to a group analyst. At the next meeting of the group new versions of the four scenes can be enacted according to *instructions* coming from the *patients themselves*. Again, the reactions from the group should be recorded and collected for further study. Thus these situations can be used as a stimulus to group sessions over a long period. It would be interesting to compare the first version with the last after a period of, say, a year, and also to discover which was the most popular with the largest number of audience members.

Version 3b is particularly *recommended*.

STATE COMMITTEES OF THE AMERICAN SOCIETY OF  
GROUP PSYCHOTHERAPY AND PSYCHODRAMA (GP)

Committees are now in formation in all states, in order to secure high professional standards for group and action methods, to sponsor their introduction into hospitals, clinics, community centers and schools of learning.

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*Psychiatric State Committees of Group Psychotherapy and Psychodrama*

Such representatives of the State Committees who are members of the American Psychiatric Association are listed here again as they have a special objective, to assist in and contribute towards the programs on group psychotherapy to be presented at the annual meetings of the American Psychiatric Association. As its Executive Council has decided to consider a permanent Section on Group Psychotherapy if the continued interest of the membership warrants it, the quality and quantity of contributions will be the decisive factor.

Progress reports will be distributed among the members of the American Psychiatric Association and other groups interested in the advancement of group psychotherapy, from time to time. The next issue of this journal will list additional members and committees.

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## ANNOUNCEMENTS

### *Samuel Hamilton, M.D., 1878-1951*

We note with regret that Dr. Samuel Hamilton passed away during the month of July, 1951. He had many friends among the members of the American Psychiatric Association, and has been a sponsor of group psychotherapy and psychodrama for years.

### *Moreno Sanitarium, Beacon, New York*

The name of Beacon Hill Sanitarium, a mental hospital for the treatment of mental and nervous disorders, licensed by the Department of Mental Hygiene of the State of New York, located at Beacon, New York, has been changed to Moreno Sanitarium.

### *Presidential Election, American Psychiatric Association, 1951-1952*

The results of this election were as follows: President-Elect—D. Ewen Cameron (N) 3,008; Jacob L. Moreno (P) 440 votes.

### *In the American Psychiatric Association*

#### *An October M. H. 'Institute' Planned—Change of Address of APA*

According to the "A.P.A. Mental Hospital Service Bulletin," June issue, the Third Mental Hospital Institute of the A.P.A. is being planned for October 15-18, 1951 in Louisville, Ky. In constructing the program, the Consultants will be guided by the comments of those who attended the Second Institute, in October, 1950, in St. Louis. "Suggestions from advanced enrollees for this (3rd) Institute also will be considered in the planning.

The Washington offices of the American Psychiatric Association (including that of the Mental Hospital Service and its "Bulletin") move on July 1, inst., to: 1785 Massachusetts Ave.; N. W., Washington 6, D.C.

### *Moreno Institute, Beacon and New York, Workshops*

Sixteenth, Seventeenth and Eighteenth Workshops, 1951

## TRAINING IN HUMAN RELATIONS

Decoration Workshop   
May 26 thru 30

Independence Workshop   
June 30 thru July 4

Labor Workshop   
Sept. 1 thru 3

Psychodrama, Hypnodrama, Sociometry, Sociodrama  
Group Psychotherapy

Conferences start at 3:00 P.M. of the first Saturday

Room, Board and Tuition: \$20.00 for 1 day (or part of day); \$30.00 for 2 days; \$40.00 for 3 days; \$50.00 for 4 days.

*Enclose remittance for enrollment.*

Make reservation at least 1 week in advance.

For further information write: Moreno Institute, P.O. Box 311, Beacon, New York.

*Moreno Institute, Open Sessions*

A program of lectures and demonstrations every Friday at 8:45 P.M., under the direction of J. L. Moreno, Leona Kerstetter, Zerka T. Moreno, John Mann, G. Schauer, Robert Boguslaw. Areas: Education, Psychiatry Psychology, Business and Industry, Cultural Anthropology, Sociology, Axiology, Criminology, Sociometry, Sociodrama, Matrimonial Problems, Intercultural Relations and Tensions, Group Psychotherapy, Spontaneity Theory and Training, Role Practice, etc.

The program is flexible, no topic is set ahead of time, in order to permit the audience to decide for themselves the social, psychiatric or cultural issue they prefer. Special topics can be arranged for specific groups. For group rates inquire in advance. Individual rate: \$1.75. Telephone: Murray Hill 3-1626. Address: 106 East 41st Street (between Park & Lexington Avenues), Room 327.

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Announcing Fall Term: At 106 E. 41st Street, New York City, two 15 week courses in GROUP AND ACTION METHODS.

a) Monday, September 24, 7:30-9:30 p.m. "Basic Principles, Philosophy and Concepts of Sociometry, Sociodrama, Psychodrama and Role Playing." (Prerequisites: Courses in psychology, sociology, education).

b) Friday, September 28, 4:00-6:00 p.m. "Advanced Course, with Practicum" (Prerequisites: As above plus course a).

Fee: \$30.00 including registration; 2 points; registration on first day of class.

Important Note: New York City School Guidance Teachers will get Alertness Credit for these courses, as per arrangement with the Board of Education of the New York City Schools.

Instructors to be announced; additional courses may be opened if enrollment warrants, for Monday and Saturday afternoon.

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*International Committee of Group Psychotherapy*

We are glad to announce the formation of the Committee under the auspices of the Moreno Institute. The Committee has the following Advisory Board:

Joshua Bierer, M.D., Institute of Social Psychiatry, London; E. N. Snowden, M.D., 152 Harley Street, London, W.1; P. Senft, Ph.D., Institute of Social Psychiatry, London; Juliette Boutonier, M.D., University of Strassbourg; Jean Delay, M.D., University of Paris; S. H. Foulkes, M.D., Maudsley Hospital, London; Georges Heuyer, M.D., University of Paris; E. W. Lazelle, M.D., Denver, Colorado; Marcel Montassut, M.D., Medecin Chef des Hopitaux de la Seine, Paris; J. L. Moreno, Moreno Institute, Beacon, New York; Yves Porcher, M.D., Medecin Chef de l'Hopital Henri Rouselle, Paris; J. H. Pratt, M.D., New England Medical Center, Boston, Mass.

The *Executive Action Committee* comprises the following groups:

*French Section:* Leon Chertok, M.D., Victor Gachkel, M.D., Serge Lebovici, M.D., F. Pasche, M.D.; *English Section:* Joshua Bierer, M.D. and S. H. Foulkes, M.D.; *American Section:* J. L. Moreno, M.D., Joseph I. Meiers, M.D., Leonard K. Suple, M.D., Rudolph Dreikurs, M.D.; *Austrian Section:* Erwin Stransky, M.D. and H. Teirich, M.D.

The objectives of the Committee are: (1) To define the professional standards of group psychotherapy and to work towards a consensus of terms, operations and facts; (2) to prepare for the *First International Congress of Group Psychotherapy* in the autumn of 1952; (3) to sponsor the *International Archives of Group Psychotherapy*.

Main office for the Committee: *Moreno Institute*, P.O. Box 311, Beacon, New York; French office: c/o Mrs. L. Ostrander, 71 Rue Cardinal Lemoine, Paris, France; London offices: Dr. Joshua Bierer, The Institute of Social Psychiatry, Ltd., 9 Fellows Road, Hampstead, London, N.W. 3, England, and Dr. S. H. Foulkes, 58 Portland Place, London, W.1, England; Austrian office: Dr. Erwin Stransky, Skodagasse 1, Vienna VIII, Austria.

*Symposium of Group Psychotherapy, Theory and Practice, American Psychiatric Association, Atlantic City, Meeting May 1952*

Abstract of papers and suggestions to be sent to J. L. Moreno, M.D., P.O. Box 311, Beacon, N.Y.

*The Journal of Group Psychotherapy, Vol. 4, No. 3.*

The forthcoming issue will contain papers of the Round Table Conference on Group Psychotherapy and Psychodrama (Moderator: Dr. Alan Gregg); H. Michael Rosow and Lillian P. Kaplan, "Individuo-Group Psychotherapy"; Erwin Stransky (Vienna), "Principles of Individual and Group Psychotherapy"; other papers by Oscar Pelzman, J. H. Pratt and Paul E. Johnson, etc.

*Tenth Annual Meeting of SGP*

The tentative date of the Annual Meeting of the American Society of Group Psychotherapy and Psychodrama is *March, 1952*, the meeting place is New York City. Students who are interested in participating are invited to send abstracts of prospective papers or reports to P.O. Box 311, Beacon, N.Y.

*Group Psychotherapy and Psychodrama at Mental Hospital Institute*

An address and demonstration will be given by Dr. J. L. Moreno on October 17th, 1951, at Louisville, Kentucky under the auspices of the American Psychiatric Association.

*Conference of the Mid-West Section of SGP*

Under the leadership of Dr. Rudolf Dreikurs a mid-west section of the SGP has been formed which plans a meeting for the second half of November. For further information write to its secretary, Dr. J. W. Klapman, 8E Walton, Chicago 11.

# The Psychiatric Quarterly

NEWTON BIGELOW, M.D., *Editor*

IN THE ISSUE OF JANUARY, 1951

SOLOMON, "Treatment of the psychoses;" BEWKES, "Tribute to Dr. Richard H. Hutchings;" MICHAEL, "Impotence during electric shock therapy;" STEWART, KATZ and LANG, "The use of BCG in mental institutions;" BARAHAL, "The obstacle motif as a typical dream experience;" BRUSSEL and SCHNEIDER, "The B.E.S.T. in the treatment and control of chronically disturbed mental patients—a preliminary report;" KOENIG and FELDMAN, "Nonstandard method of electric shock therapy;" DEVEREUX, "Neurotic crime vs. criminal behavior;" CLARDY, "A study of development and course of schizophrenia in children;" STECKLER and HARRIS, "A preliminary report on antabuse therapy for alcoholism;" MATFUS, "Pain;" SIMON, HOLZBERG and UNGER, "A study of judgment in the psychopathic personality."

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SOCIAL AND BIOLOGICAL ASPECTS OF MENTAL DISEASE.

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