GROUP PSYCHOTHERAPY

Journal of Sociopsychopathology and Sociatry

PSYCHODRAMA

SOCIOMETRIC METHODS
ACTION METHODS
THERAPEUTIC FILMS

RE-GROUPING
RE-TRAINING
SOCIAL CATHARSIS

SOCIODRAMA

Volume V APRIL-JULY-NOVEMBER, 1952 Numbers 1-2-3

This Journal is the official organ of the American Society of Group Psychotherapy and Psychodrama.

Manuscripts and communications for the editors should be addressed to the Executive Committee of GROUP PSYCHOTHERAPY, Beacon, N.Y., and *not to an individual.* Unsolicited manuscripts which are not accepted for publication will be returned if accompanied by a stamped, self-addressed envelope. Entered as 2nd Class Matter, March, 1948 at the Post Office, Beacon, N.Y., under the act of March 31, 1879.

Volume V APRIL-JULY-NOVEMBER, 1952 Numbers 1-2-3

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HOW KURT LEWIN'S "RESEARCH CENTER FOR GROUP DYNAMICS" STARTED AND THE QUESTION OF PATERNITY

A Secession from the Sociometric Movement

J. L. MORENO, M.D.
Moreno Institute, New York City

The similarities between Kurt Lewin's work in action and group research and my own has been so striking that many have wondered what kind of interdependence there is between Lewin and myself. Moreover, many of Lewin's students have also been my students, writing articles published in *Sociometry* and *Sociatry* since 1938, on subjects with which I have been widely identified, sociometric methods, dynamics of group structure, sociodrama and roleplaying, psychodrama and roletraining, etc. After I had initiated them they began to write similar articles for other journals and in books, having the stamp of my thought. In consequence, group dynamics, the name which was frequently used by them, as a label covering their common interests, was considered by interested observers as a branch of the sociometric movement. My obvious support, linked with my silence may have encouraged such a view.

I have frequently been bombarded with questions about this. An illustration is the query of a French psychologist, Roger Girod, in a book on the current situation of the social sciences in the United States.

> "On peut distinguer au moins deux courants principaux au sein de la microsociologie americaine: un courant sociometrique dont l'animateur est Moreno et un courant—d'inspiration lewinienne surtout—oriente vers l'etude de la dynamique des groupes, plus particulierment des groupes dont les members sont en rapports direct les uns avec les autres out ont en commun un projet d'action precis. *Ces deux courants presentent de nombreux points communs et de nombreuses similitudes. Ils se developpent en etroite liaison mutuelle.*"* (Italics mine).
>
> "One can distinguish at least two principal currents in the center of American microsociology: a sociometric current, of which Moreno is the driving force and a current—primarily of Lewinian origin—focussed upon the study of group dynamics, more particularly upon groups of which the members are in direct contact with one another or have a specific action project in common. *These two currents have many points in common and present similarities. They are developing in close mutual relationship.*" (Italics mine).

*Roger Girod, **Attitudes Collectives et Relations Humaines, Tendances actuelles des sciences sociales americaines**, Presses Universitaires de France, Paris, 1953.

Many an idea is started by two or more individuals independently. But this is not a case of duplication of ideas. It can be shown on the basis of printed records that the leading associates of group dynamics have been in close contact with me. Theirs is not a problem of productivity, theirs is a problem of *interpersonal ethics.* In the case of duplication of ideas the carriers do not know one another, they work in different places. But the imitators sit near the one from whom they steal the eggs; they are parasites. I did not harbor ill feelings towards them, this is the reason I remained silent. I said to myself: Just as there are people who can have no children, so there are people who cannot create any ideas, therefore they adopt them. What matters is whether they fulfill their obligation and bring them up well. *It is unfortunate—and this is why I am breaking my silence now—that these students of group dynamics have not only published distorted versions of my ideas and techniques, but they are practicing them on actual people in so called research and training laboratories,* receiving large fees and research grants without being properly trained for the job.*

The first question which I shall try to clarify here is: Did I influence Lewin's ideas and methods and where and how did this take place? It should be clear that when I talk about ideas and methods I refer exclusively to group theory and group methods, action theory and action practice, that is, only to the work which Lewin had begun to do since about 1936, soon after the time that he had met me, and not to his work in Gestalt and topological psychology prior to that time.

Kurt Lewin met me for the first time early in 1935, and during that year we had several meetings. As Dr. Alfred Marrow, an intimate friend and student of Lewin's reports in the Obituary to Lewin in *Sociometry,* Volume 10, 1947, "I recall the day when I first introduced Dr. Lewin to Dr. Moreno. Both recent arrivals here, they had known of each other, but had never met. It was not long after the publication of Moreno's *Who Shall Survive?* and of Lewin's *Dynamic Theory of Personality.* Both men quickly found common ground." He was acquainted with sociometry and with some of the work I had done in Europe, especially das Stegreiftheater and had read *Who Shall Survive?* Up to that time Lewin's publications did not deal with either group or action dynamics.** For better or worse, my pioneering status in this field was already established and so I became the model for his first efforts in this for him new direction of research. He expressed in our talks particular interest in the democratic structure of groups, in contrast to their laissez faire and authoritative

*The Research Center for Group Dynamics, Massachusetts Institute of Technology; the National Training Laboratory, Bethel, Maine; the Research Center for Group Dynamics, University of Michigan, Ann Arbor.

See Bibliography in Ronald Lippitt's "Kurt Lewin, 1890-1947, Adventures in the Exploration of Interdependence," **Sociometry, Vol. 10, 1947, pp. 87-97.

structure, problems with which I experimented at that time; it happened that my report on this topic in "Advances of Sociometric Techniques" appeared in the same issue of the *Sociometric Review* (February, 1936) in which he announced the carrying on of sociometric research at the Child Welfare Research Station at the University of Iowa. His first report of this study was subsequently published, two years later, in *Sociometry*, Volume I, No. 3-4, 1938. A careful reader of my publications* up to that time who knew also of my direct, face to face contact with Lewin, must have gained the impression that he was a student of my work and under my influence, that he tried to combine his concepts and experiences in Gestalt and topological psychology with the new acquisitions. As the matter stood by 1938, I was in the circles which were interested in the new developments of action and group theory, the acknowledged leader.**

But it should be clear that I strictly separate Kurt Lewin from the group of students who attended my workshops in Beacon and in New York in the course of the last ten years. I am inclined to believe that Lewin himself was rather naive as to their astute and Macchiavellian practices, especially as these tactics did not show their true face until after his death. The journal *Sociometry* (and its journal *Sociatry* later called *Group Psychotherapy*) became one of the chief organs in which appeared a large number of their articles dealing with experiments in group and action methods. Indeed, these articles on psychodrama, roleplaying, sociodrama and other sociometric techniques, by Ronald Lippitt, Alvin Zander, John R. P. French, Alex Bavelas, Leland P. Bradford, C. Hendry, Margaret Barron, Kenneth D. Benne and others, differed little, if any, in theoretical position, description of techniques and hypotheses to be tested, from those of any other workers more closely identified with sociometry. Increasingly, I suppose, the temptation came over them to play different games on both sides of the fence, on one to appear as students of Lewin, on the other as students of Moreno, by printing the same or similar articles in the context of various publications. It was a shrewd device to plant, at least in the mind of *some* people, the idea that by sheer coincidence of circumstances the same ideas developed independently. By using a technique of quoting only each other, that is, those who belong to their clique, and not quoting any of my close associates or myself their double game became the laughing stock of connoisseurs and the initiated in this new form of "interdependence."

*Das Stegreiftheater, 1923; The Group Method, 1932; Psychological Organization of Groups in the Community, 1933; Who Shall Survive?, 1934; "Advances of Sociometric Techniques," 1936; "Interpersonal Therapy and the Psychopathology of Interpersonal Relations," 1937; "The Place of Sociometry Among the Social Sciences," 1937; "Sociometric Statistics of Social Configurations," 1938.

** For more extensive treatment of Kurt Lewin's dependence and debt to sociometry and the sociometric movement see Who Shall Survive?, revised edition, Beacon House, 1953, "Preludes to the Sociometric Movement."

However, because of gentle pressure the editors of a recent collection* of their publications Kenneth D. Benne and Bozidar Muntyan made a special acknowledgment, giving me full credit for having originated the ideas with which they were preoccupied, in *Human Relations in Curriculum Change*, published by the Dryden Press, New York, 1951:

> "The editors make special acknowledgment to Dr. J. L. Moreno, who has pioneered in the areas currently referred to as psychodrama, sociodrama, roleplaying, action dynamics, warming-up technique, group psychotherapy and sociometry, and who first introduced these terms into the literature, with some of the meanings emphasized in the present volume. To a great extent, the basic impetus for certain new trends in group and action research can be traced to the work of Moreno and his numerous associates."

The other day I was reading old protocols of psychodramatic sessions** which are now in preparation for a special volume. Among them were some of the transcripts in which these men were participating as students or protagonists before they began to write on the subject and organize workshops of their own. I still see the bright boys sitting in my classes and role-playing on the psychodramatic stages of Beacon and New York.

*Containing articles by Kurt Lewin, Alex Bavelas, Ronald Lippitt, Alvin Zander, Leland P. Bradford, etc.

**It was a challenge and a rare opportunity for the sociometrist to make a study of this group, so intimately known to us, and to determine the degree to which certain sociometric hypotheses are verified by the findings. Two hypotheses came to our mind: a) Is this a case of conscious or unconscious clique formation? or b) Is the development due to one or more influence and opinion carriers who spread the contagion to members of near or distant groups in which they participated and established a norm of behavior among them; the members generally would appear then relatively innocent. The answer came from an examination of the acquaintance diagrams and sociograms (see protocols pages 7-19 and pages 20-37) which indicate plainly that Ronald Lippitt was playing a key role and was probably the chief manipulator in the more organized efforts of the later group center.

SOCIODRAMATIC APPROACH TO MINORITY PROBLEMS

Student Participants: Ronald Lippitt and Group

Transcript of a session held *July* 30, 1943 at the Psychodramatic Institute
Directed by J. L. MORENO, M.D.

New York City

Moreno: I would like first to give you the historical background to the kind of work which we are doing. To do this we must go back 32 years. It was around 1911 when I, with a number of boys and girls in the gardens of Vienna, started a sort of movement among children, a crusade of children against adults, the machine age and all its implications. These children began to play in these gardens all kinds of social roles, taking the roles of parents, of teachers, continuing in a way what children all do when they are 2 or 3 years old, until they were stopped by their teachers because it did not seem to be the right thing to do to continue the kindergarten principle right into school. Once a child starts to attend school, life becomes serious for them, full of responsibilities, with no time for play, or at least, the playing time is drastically reduced and his time organized and disciplined for him. But *we* continued to play just the same and we thought we were revolutionizing the world. Even the police came after us and parents began to fear that I was luring their children away from them and from their homes. Around that time Stanislavski of the Moscow Arts Theatre wanted to make his actors more spontaneous. He thought that in order to be a good Romeo or King Lear, it was not enough to study one's role, he wanted his actors to learn from past experiences, to become loaded with affect and then to throw themselves into their role. Stanislavski made a fine contribution to the theatre, but it was always in the service of the "cultural conserve." He never thought of making role playing and spontaneity an aim in itself, he merely served the dogmatic drama and theatre. Many times Stanislavski is given credit for things he never did or asked for. Another contemporary development is the philosophy of Henri Bergson. In all probability the philosophy of spontaneity as we see it today would not have been possible without the inspiration which came from Bergson. However, it was the work of our spontaneity theatre in Vienna between 1921 and 1924 which made the role emerge in statu nascendi, first in a situation of dramatic structure, then when two or three individuals interacted in the process of portraying something typical for the community. Perhaps the most important aspect of this work was that it tried to combine the particular with systematic research. Spontaneity as an idea has been used by all the great educators, Pestalozzi,

Froebel, Rousseau. But the spontaneity theatre started to *study roles in vivo,* with a group of people taking an active part in it, mobilizing their own ingenuity which so developed the psychodrama theatre as we know it today.

I was wondering how to run this session in order to make it as useful as possible for this new group. There is nothing more fascinating than to see how the hidden group structure develops from scratch. How does a group view begin and how is it mobilized in order to become psychodramatically articulate? The particular variety which I will work out with you is very instructive. I would like to produce a psychodramatic situation on the stage, but I have to know how the group is structured first, in order that I may select the *right* situations and the *right* roles. It is possible *to discover the group structure in vivo.* I can assure you that I have not prepared it although at times we do prepare a group for a specific research. I would like to determine the acquaintance volume of each individual first. Is there anybody here who does not know anyone? (Proceeds to ask everyone how many people they know.)

Dr. Sobel does not know anyone. Dr. Lippitt knows 17. These seem to be extremes. Is there anyone else who knows that many people here? Nobody, well Dr. Sobel is on one end of the scale, Dr. Lippitt on the other, for this particular group, which is after all the social reality which is facing us. We can estimate a very accurate *acquaintance scale* that way. Is there anyone else who has as large an acquaintance as Dr. Lippitt or almost as many? What about you?

Audience Member: "I know only her." (Lady with him knows only him). That's fine, maybe that such a pair relationship would be interesting to study, I may come back to you later. There are probably some people here who know only one other person or two. (Miss Gersh knows almost as many as Dr. Lippitt).

Now that we have established the acquaintance scale and know the position everyone has in the group, let us determine the emotional attachment these people have to each other within the group. For this particular group Dr. Sobel is an isolate, she does not have an emotional relationship to anyone in this group. That does not mean that in any other group she may not be the center of attraction, but in this particular group she is an isolate. But she may have already an emotional relationship to me.

Dr. Sobel: I heard Lippitt speak once.

Moreno: Then you know Lippitt, but do you know the doctor?

Dr. Lippitt: No, I don't.

Moreno: In other words you do know someone Dr. Sobel, you really know Lippitt from having seen him before. Tell me, how do you feel about Lippitt?

Dr. Sobel: I think he is a very fine fellow.

Moreno: Is it a positive attraction?

Dr. Sobel: Yes.

Moreno: Dr. Lippitt, for the sake of research, is there anyone here whom you are particularly close to, to whom you have a particular emotional attachment?

Lippitt: Adams, Gersh, Brown, Balantine.

Moreno: Now we are taking the second step in determining the sociometric scale. We have found one individual who is at one end, and another who is at the other end of the sociometric scale. We are interested to know the structures which develops around this scale. I would like to know from these people how they feel about Dr. Lippitt. Is there anyone who is particularly interested in him in the particular function of doing some research with us?

Seven people are positive.

Moreno: We see that among the 17 people Dr. Lippitt knows, only 7 feel that they have a positive relation to Dr. Lippitt in this role; we see that for a person as Dr. Lippitt who has such a large acquaintance volume, only a limited number have a definite emotional relation to him. As we delve into this structure we find a very interesting depth structure and possibilities for research. The danger of running a session is working with a protaganist who is an isolate. In order to do group work, it is important to work with as large a level of appreciation as possible, so that the largest number of people in the group is reached. Now we have a sociogram with Dr. Lippitt as the center of the situation here. First we have secured the acquaintance volume; second we should establish the social atom of every individual in this group. The third step is to determine the role relations between these people, the cultural atom. The cultural atom can not be separated from the social atom except for the purpose of articulation. In the community these atoms, social and cultural, are continuously interacting. We know that every individual has a certain number of roles. We may find a person who is a flop in the service which he is trying to render to the group in a session, we may have to find another who can better fulfill the role. We would like to know in which role you like Dr. Lippitt best. In which roles do you click particularly with him? (Turns to the seven individuals who have expressed a positive relationship to Lippitt. They enumerate the role choices they have for Dr. Lippitt).

a) Friend (outside the classroom)
b) Democratic Classleader
c) Expert
d) (Same as a) or Adviser

e) Research Colleague
f) Working Supervisor
g) Youth Leader

Moreno: In what role do you like yourself best, Dr. Lippitt?

Lippitt: Democratic Classleader.

Moreno: If you would try to relate these seven people to yourself, in what role would you relate them to you?

Lippitt:

1) Having Independent Ideas
2) Rebel Against the Social Structure
3) Group Psychologist
4) Emergent Leader
5) Active Critic
6) Expounder of Theory
7) No seventh choice made

Moreno: Superimposed upon the sociogram we have also a role diagram; not only did we find the seven roles in which Dr. Lippitt is wanted by the people who chose him, but also the roles he wanted to be in with them. Now that we have developed these types of diagnostic diagrams, the acquaintance diagram, the sociogram and the role diagram, we will begin with our session. Maybe you wonder why all this is necessary. In order that this psychodramatic procedure should be a group research in vivo I have to proceed along these lines. It is one way to mobilize this group to participation and in discussing the group and working with you this way I have warmed you up for what will be presented here on the stage.

(Picks Mr. Adams to come upon the stage).

Moreno: Mr. Adams, and everyone here, this is not entertainment we are carrying out, it is a study of group relations. We can start this little experiment in many ways. We could begin with you *as a person*, the Mr. Adams everyone here knows to some extent. Maybe we could work out one of your own problems. The second possibility is to portray a social role, the role of a rebel. That relates you to millions of other people who are social rebels too. There is another way. Mr. Adams, is there anyone here in the group to whom you have a very strong relationship? Or did you see a woman or a man here with whom you would like to become acquainted? Of course, in real life you may have a hard time, but here, for a while, you may become a husband or a lover. That would be another way. I could go on suggesting starts to you, but *is there a role you yourself would like to represent?* Number 1, Adams as the social rebel, or Adams as a husband, a friend, an employer, etc. Do you have

a choice you prefer?

Adams: I choose the first.

Moreno: Alright. Do you have any situation in mind in which you can portray your role? Perhaps in a situation in which you have actually been, although you may of course work out something you have never experienced.

Adams: Such as a universal legislator?

Moreno: That is another idea. Have you ever been in the role of someone who has protested against society?

Adams: Many times.

Moreno: Against what, for instance?

Adams: Against religion.

Moreno: Would you like to work that out?

Adams: Alright.

Moreno: Do you need someone here on the stage in the role of a religious man or woman to work with?

Adams: A rabbi, an orthodox rabbi.

(Moreno picks one of the students as a rabbi).

Adams and student, Bello retire to discuss scene, to warm up to it.

Moreno: (addresses audience again) I am not entirely spontaneous in choosing Mr. Adams. I am thinking of him here in relation to Dr. Lippitt. It is perfectly permissable to let two people warm themselves up to the role they are supposed to perform. In recent years the term "projection technique" has become widely used by educators, psychologists and psychiatrists. Unfortunately, it has been made to include everything in the universe. It is permissible to use the term "projection" when, as in the Thematic Apperception Test the fantasy of one person is stimulated by pictures. Projection is also correct with Jung's Free Association test and with dolls. Freud influenced Jung, Jung in turn influenced Rorschach. But in psychodrama we are first of all dealing with *social and cultural realities.* If Mr. Adams will act the rebel for us, that is something with which he and most of us have some experience. We are introducing in the psychodramatic situation the actual world of a subject, father, mother and other necessary people. Projection techniques are too fragmentary and too unrelated to the total social situation. (Adams and Bello come up on the stage at this point).

Moreno: Ready? Please, Mr. Adams you as the subject should explain the social and physical situation to us.

Adams: I am a young man of an orthodox Jewish family. I am coming to the synagogue to talk to the rabbi at the insistence of my family. I am about—

Moreno: (Stops him) You must not tell us a story, you as the subject must

not reduce your spontaneity. We will see it here enacted on the stage. Don't give yourself away. Just explain the physical setting! In what room is it?

Adams: A plain room in a synagogue.

Moreno: Have you any particular synagogue in mind?

Adams: No, this is in the speakers hall. I am not acquainted with the physical situation.

Moreno: What do you see there?

Adams: Seats and everything.

Moreno: Is there anything of interest there?

Adams: No.

Moreno: When have you been in a synagogue last?

Adams: It is not a situation with which I am familiar.

Moreno: Who suggested the situation?

Adams: I did.

Moreno: You suggested an unfamiliar situation. And so you don't see anything of particular interest?

Adams: Table, seats, platform.

Moreno: Very well, what time of day is it?

Adams: Early evening.

Moreno: How are you dressed?

Adams: Ordinary street clothes.

Moreno: How do you feel?

Adams: Rather timid.

Moreno: Alright. When the situation begins, are you alone?

Adams: No, the rabbi is there.

Moreno: You go ahead now. You enter the synagogue from over there. (Adams goes behind the wings). The rabbi is sitting there. You try to assume the attitude of a rabbi, young man (Bello sits down, looking somewhat pompous, but serious). It is not a verbal interaction. The "role" has to be enacted as best you can. That is how you envisage that a rabbi sits?

Bello: (Shakes head affirmatively).

Adams: (Comes walking in somewhat diffidently).

Bello: (Gets up and welcomes him with outstretched hand). Hello, there you are, take a seat. (Points out seat to him after they have shaken hands, assumes fatherly air).

Adams: My parents thought I ought to talk to you about a plan of mine. I am in love with a young woman whom I plan to marry. She is not a member of the Jewish race. I have expressed my intention to my family. They are against it and claim it is not entirely up to me to make the decision. I respect

my parents but I feel that it is something beyond me to clarify the matter to them. I have the intention of carrying out my plan and the girl knows about the objections of my family. I am trying to give it serious thought before I go ahead. My family insisted that I come to talk the situation over with you.

Bello: It seems to me that you are a serious minded individual, but you think things out so far and no further. You don't understand the deeper relations we have to religion. It goes way back into history. It is not possible for Jews to change. Whenever Jews have tried to assimilate they were forced back into Judaism. It happened again and again. What about those Catholic Jews in Germany? It is not possible, and it won't help you any. There have been Hamans and Hitlers throughout our history. I tell you it won't work.

Adams: Of course, I realize and I am interested in these historic events, but I don't want to be a blind, slavish follower of all religious precepts, and laws I will be tied down to.

Bello: You are not a slave of the laws when you study the laws and understand them. It is then you realize that they make you free. When you understand the deeper meaning of the law as it was given to us through Moses you are no longer tied down by it. It gives beauty and meaning to life. Don't forget, we are the chosen people. We are chosen by God to teach others and to lead them. We must remain clean in order to be able to do so. Not that they, the "Gentiles" are not clean. One can respect them, I have many friends who are not Jews. But there is a limit, one must not overstep this limit. Later on, you will have children. Think of the conflict this will create. You will want them to be Jews and she will want them to be Christians.

Adams: You are implying that there is only one basic interpretation to this basic law, but I'm not willing to accept that.

Bello: What basic law are you referring to? (With dignity).

Adams: I am referring to a basic law of progress in a society in which we will eliminate all these segregations, in which we will not perpetuate them.

Bello: Progress is not only related to a basic law, there is something superhuman. Your life does not end in this world.

Adams: The superhuman to which you are referring does not mean the same to you as it means to me. You assume that there are these deleneations. I don't believe there are.

Bello: First of all I don't assume, I know. I have studied the Bible. That is no human work. God made us the center of the universe. You cannot go against God. Young man, I am sure that if you will sit down at home and think it over, this will be the only conclusion to which you can come.

(End of Scene).

Moreno: Thank you. Mr. Adams, are you satisfied with this rabbi, or do you want to see another?

Adams: He did a very good job.

Moreno: I am not concerned with how good a job he did. I want to know whether he was able to change your mind?

Adams: No, I knew what to expect.

Moreno: Would you, rabbi, like to see another rebel?

Bello: What shall I tell him?

Moreno: How would you like to be a rebel? *Let's "reverse the roles."*

(Bello in the role of the rebel, Adams in the role of the rabbi).

Moreno: Tell me, rebel, what kind of a situation are you in?

Bello: It would be a room, not the synagogue, because these things do not happen in a synagogue. It is the room of the rabbi. (Describes room). There are bookshelves with only religious books. There would be a bed in the same room, a simple, large, double bed, the rather old fashioned kind. Over on the right wall an oil painting of a rabbi with a long beard and earlocks. Table and chairs are here, the largest chair is for the rabbi, it gives him superiority.

Moreno: What time of day?

Bello: Afternoon.

Moreno: How are you dressed?

Bello: Day clothes, with a hat on.

Moreno: Good, what else? What's in your hand?

Bello: Gloves.

Moreno: Alright, go ahead.

Adams: (Sits down at table in meditating fashion).

Bello: Enters.

Adams: (Gets up and shakes hands, then points at seat) Young man, sit down. What is your problem?

Bello: How do you do? I don't have any problem. My parents have a problem. They have me and themselves. I have fallen in love with a girl who is not Jewish. I think she is beautiful and has everything I want in a woman, and I plan to marry her. My parents said if you can not convince me then I should go ahead and go to the devil and marry her.

Adams: It is not an unusual occurrence. I meet young people with the same sort of problem every day. You say you have fallen in love with her; what has really happened is that you succumbed simply to a physical attraction. You have not thought of your life with the young woman and you are not thinking of your very solemn obligation. After all you will have children and those children will want a very definite place in the world. These children

will not be accepted anywhere. They will not belong with your family and neither will they fit in the outside world. Experience shows that you will not fit and your children will not fit in another cultural group. These children will not have any particular culture or future in a group.

Bello: May I say something?

Adams: Certainly.

Bello: It may be true that we may face rejection. But I face rejection today. I am interested in creating a world where it won't make any difference what a man is, whether he is a Jew, a Gentile, or a Hindu. Do you want to perpetuate that kind of a world? You are justifying the continuation of that kind of a world. I don't respect those people who will reject me, I don't want to have justification for such a world. Don't you suffer from it?

Adams: Yes.

Bello: I am interested in improving this world of ours.

Adams: You want to improve the world. That's fine. So do I. But I want to work with my group. You cannot do it singlehanded. You cannot influence the world in one day. Improvement does not come by marrying a particular girl, we have to work at it and wait patiently.

Bello: (Stands up). Well, that is just the point, how long are we going to wait? It has to begin somewhere, with someone. How long are we going to put up with ignorance?

Adams: (Authoritatively) Sit down. You cannot accomplish anything alone. You are just one individual among millions of others. If you would choose a girl from among your own group you will be able to improve the world together.

Bello: If you have a beautiful painting you love, would you throw it away and look for another?

Adams: I am not suggesting you throw away this girl, but you could give up this idea of marrying her. She will get over it.

Bello: What about me? My life would be wrecked too.

Adams: I feel that if you can adjust yourself to a girl whom you could belong to already you would start off with an easier way to improve the world.

Bello: But if this girl and I did not fit to each other already then we would not love each other. Rabbi, I don't think you can help me after all. I will think it over.

Adams: Will you come and talk things over with me again before acting on this?

Bello: I will.

(End of scene).

Moreno: Thank you. Now you Mr. Adams sit on this side and Mr. Bello on the other. We have so far established *two* categories of rebels and *two* categories of a religious father. I would like to know from you with whom you identified yourself. Which of the presentations came closest to what you think you would do under the same circumstances, which of the rabbis and which of the rebels?

Let us name the categories for Bello 1 and 2, 1 rabbi, 2 rebel. For Mr. Adams 3 and 4, 3 for rebel, 4 for rabbi. (Proceeds to ask audience with which of the roles they identified themselves).

Mr. Brentano	1 and 2 (Thought it was convincing the way he acted)
Mrs. Brentano	1 and 2
S. Kosloff	1 and 2
Dr. Sobel	1 and 2
Lewin	Rejected all 4
Brown	3 and 4
Koppell	2 and 4
Gersh	1 and 2
Kaufman	1 and 3
Balantine	3 and 4
Lippitt	1 and 3
Ross	4
Emma	2 and 4 (Likes to believe in 4, but does not think he would be likely to meet him)
Brown	Indifferent to all 4
Leona Kerstetter	1 and 3
Whitman	2 and 4
Galewaith	Rejects all 4
Wechsel	2 and 4
Kathrine Freeman	1 and 2
Phane	2
Murphy	2
Helen Jennings	2
Purser	2
Zerka Toeman	2
Kern	2 and 4
Kirk	1 and 2
Judith Pomarlen	Rejects all 4
Silver	Likes all 4 with reservations

Hersch	Rejects all rebels, positive 1
Abelson	Indifferent
Pollens	Zero
Bark	Zero
Brentano	Rejects both rabbis
Mrs. Brentano	Same
Helen Jennings	Rejects Adams as rabbi
Zerka Toeman	Rejects both rabbis
Angel	Rejects all except 2

Individual comments in presentation

Lippitt: Take Adams, when I gave you the suggestion of Adams as a rebel I was expecting a future development which is just on the margin of a life situation. Mr. Adams is a supervisor of a bank and has a problem of being supervisor and conflicts with the supervisor above him. The pattern of rebellion seemed to me a real conflict of a rebel in a life situation in which I identified myself with him in the rebel role. I thought he was going into the role pretty well for his never having played the role of a rabbi, after the rebel.

Moreno: How do you feel about Bello?

Lippitt: He is a man who has had a sequel of experience of rebellion which Adams probably has not had in his own real life situation. He moved directly into the situation, he showed experience and insight in the role of the rabbi without any emotional attachment to the role.

Moreno: Fine, what did you think about their performances, Mr. Brentano?

Brentano: I thought they went into the whole thing with a completely stereotype answer, without showing any emotional interest in the people concerned in the situation, without considering how they felt about the whole thing.

Moreno: You felt that both actors did not show sufficient subjectivity for the conflict in which these people were?

Brentano: Mr. Adams was not at home in the roles, he projected himself only into certain aspects.

Moreno: That is alright; if I had said to him, "You are a rabbi, that is the role which you as a person are trying to play," then you might have seen a more subjective role. If it would have been his own problem, the situation would be different. But we are here tapping different aspects of a problem. What you say is correct, but it is not a critical consideration in the type of presentation they were experimenting with.

Emma: It seemed to me that Mr. Adams was arguing against himself when he was acting the rabbi, and also when he was acting the rebel. He did

not believe in the roles, especially that of the rabbi.

Moreno: That is, of course, important. There is the role creating on the level of your actual personality, and then there are the roles of the cultural environment. In both types of role creation, intensity of role creating is necessary for the adequacy of the role. If a person portrays the role of a judge, regardless of whether he has ever been a judge, he has to portray the intensity of the role. There was an element of disbelief, he did not sound true.

Balantine: I think he wanted to believe in himself as a rabbi, but there was a certain ambivalence, as if he were talking to himself, whereas Mr. Bello really changed himself.

Moreno: Do you feel that way about it, Mr. Adams?

Adams: I really felt more like a rebel than a rabbi.

Kaufman: Mr. Adams is a stereotype. When Mr. Lippitt tried to make him into a rebel he had to overcome this stereotype and throw himself into a situation which was foreign to him, whereas Mr. Bello has dramatic talent.

Moreno: Well, it is notable that whenever we see people who present their own fights on the stage they become so interesting and what good actors they are. There is a difference in warming up to your own role or warming up to a role you have to work yourself into. There is a great difference. You might still find a rebel in Mr. Adams.

Lippitt: Overt feeling is not always a sign of rebellion in Mr. Adam's situation. Mr. Bello was working along the lines of the European socialist rebel.

Moreno: That is correct. But in working out Mr. Adams private dimensions we would also have got into the deeper levels, using soliloquy technique, etc., seeing the hidden roles. We talk of people being "drama-genic," as we do of photo-genic.

Kaufman: I rather imagine it is the rebel in Mr. Adams which conflicts with Mr. Adams, the individualist, and the supervisor which has to supervise.

Moreno: Are there anymore comments? If we would categorize everyone here in this group we would see how everyone is focused on several categories. I establish a focus. Let us imagine we make this a closed group and we will come together again. Then we would see how this little community would grow psychodramatically. We would get a very significant picture of the group we have met today. At the same time we see that we are coming closer to the end of the session. We can see how, if all this material would be gathered together, the record of the actual role relationship, you would have a pretty good idea of the role structures of such a group. We have found a strong affinity to certain role categories. Perhaps in some groups all categories would have been rejected but I tried to avoid that because I wanted to reach everyone

in this group. There is another value in knowing role relations, that is the guidance value. We can very well visualize that a psychodramatic director of the future, over the television system of the United States, will be very interested to know from the start the role relationships of the communities he is reaching. This is how fact-finding procedures can go hand in hand with therapeutic guidance procedures and how they can be used to mobilize and to complete the guidance and therapy.

Purser: I would like to know how this work can be used for therapy, for people who are mentally disturbed. I don't mean suffering from a psychosis, but from a neurosis.

Moreno: For the treatment of mental disorders a different version of psychodrama is used. Psychodrama is a reversal of psychoanalysis. When we deal with individual problems it is called psychodrama. When it deals with social problems it is called sociodrama, for instance, the session we just witnessed.

But to come down to how we treat people who suffer from mental disorders, carefully selected psychodramatic techniques have to be used. I recall when we had here, a little while ago, a young woman on the stage. In order to present her psychodramatic world we provided her with the dramatis personae. We gave her the necessary auxiliary egos. The subject-protagonist is the only one who knows how she feels towards her mother and father. The auxiliary ego who embodies her father or mother is told by the subject how the father or mother acts, she warms them up. The auxiliary ego does not have to be an exact replica of how the father and mother act, they have only to stimulate the subject along the desired lines. In a short period of time we get a full picture of her life, the autobiography of the subject. *The function of "guidance" was zero* in the situation portrayed tonight, but in a therapeutic situation the function of guidance becomes the all important one.

SOCIODRAMA OF A FAMILY CONFLICT

Transcript of a Session at Psychodramatic Institute
March 24, 1944, Directed by
J. L. MORENO, M.D.
New York City

Moreno: One of the aims of the Psychodramatic Institute is to combine the solving of social problems with personality study. One of the most significant efforts which have been made from time to time here is the carrying out of research experiments in collaboration with a large number of people. Research has always had the stigma of being pursued only in the deserts, in laboratories away from life and from living people. That may be correct when it comes to the physical sciences, physics and other efforts in the physical sciences, but in the social sciences we are beginning more and more to become aware that research should be done in midst of people themselves, wherever people have an active part. It is this need for a realistic approach which has led the psychodramatic and sociometric procedures to try to solve problems which seemed to be unsolvable in the past. It is in psychodramatic work not the director who runs the research, but it is you all who are experimenting with me in exploring one subject or another. This "open" research experiment is something new itself, in terms of science.

You have heard the term auxiliary ego mentioned and you may wonder what that means. This term has been coined in the course of psychodramatic study and action. It often occurred in the course of psychodramatic procedure, for instance in its therapeutic applications, that a patient had to portray a problem which involved his family situation. If in that conflict he had a mother and father, people were necessary for the adequate portrayal of that conflict; we had to have someone who could take the roles of those absentee fathers and mothers. Often, with mental patients, it is not desirable to have the actual members of the family on the stage, they may be very unsatisfactory people to use in that portrayal, and they might suffer greatly if the patient expresses his hostility towards them. In the course of psychodramatic procedure we were forced to use professionally trained auxiliary egos to represent the absentee people necessary for the patient's portrayal. The patient was called the primary ego and the substitutes were called auxiliary egos. The name does not mean anything in itself, you may like something else better but that is the term which has been used in the last ten years, to express this particular situation I have just mentioned. The function of the auxiliary is a valuable one in the psychodramatic theatre. Some of my associates have worked with this theory in educational psychodrama, where people had to portray types. There is a difference in whether an auxiliary ego portrays an auxiliary role to a parent, a particular

parent, or whether he has to perform in a collective, representative role. There is a difference in concept, although the term auxilary ego is still used in both, whether it is the mother in a particular culture or a mother in the collective sense. We should always make it clear whether we mean a particular person or the representative of the collective idea of a person. I think it should be interesting to go into this concept of the auxiliary ego. After a great deal of experience with a good deal of hit or miss procedures we discovered that everyone has a certain range of roles he could take with facility. I always try to determine who is particularly effective in certain roles, mother, father, son, daughter, sadistic roles or tender roles, etc. We first categorized them and then we found that there are all *kinds* of mothers, and fathers and that the experiments must be constructed along various lines. I would like to experiment with you today, using the auxiliary ego function; we will first take the role of the father. I will construct a situation with you and we will discuss first of all which situation is of particular essence to a family situation. The majority shall determine which situation to take. We will choose a number of people to portray these roles.

(The following situations are suggested by the numbers of the group):

I The role of authority as the father towards his child, son or daughter.

II The role of the supporter—(father).

III Role of the paternal lover in the broad sense of the word. He may modify this role in any way he likes. .

Moreno: We need first of all a number of protagonists. Second, we must visualize how a father as an affectionate, loving person functions towards his family group, either towards his son or daughter or towards his wife and he may create a great deal of conflict with either his wife or his child.

I suggest the following situation: "Somewhere in a middle class metropolitan home, the father had a great many difficulties with his wife and the son or daughter has become aware of the conflict. He or she is between the two and has begun to take sides, either with the mother or the father. I don't decide upon which side, the subjects have to do that."

(The audience discusses this proposal and there is general agreement. Then three fathers are picked; the audience decides the child should be a daughter and three daughters offer their services. The pairs are told to prepare themselves by talking over the situation they will portray).

Moreno: It is perfectly permissible for two people to work out that situation first, talking about it and finally preparing themselves. It is obvious that they will put a great deal into this part which is of a collective nature, yet carries something of themselves. It is always interesting to see how they think the col-

lective idea works in the roles they will portray. You in the audience should score meanwhile, whether you would have acted this way, whether the role playing was adequate, and the degree of spontaneity with which they play their roles; this would be of value to us. Of great importance is also the dignity with which such a situation is portrayed. We have always to differentiate between the collective idea and the personal, subjective influence of the subject. (Here Dr. Ronald Lippitt as the first father, and Lee Glasser as his daughter, appear on the stage from the wings where they have been discussing their parts)

Moreno: I will interview the father, as he is in the leading role. What is your name?

Lippitt: (Gives a fictitious name, not at all like his own real name). Mr. Stanton, Mark Stanton.

Moreno: Mr. Stanton, what is your profession?

Lippitt: I am an insurance man.

Moreno: How old are you?

Lippitt: Thirty-seven.

Moreno: Married?

Lippitt: Married and still living with my wife.

Moreno: Mr. Stanton, would you describe your home to us?

Lippitt: We have a third story, walk up apartment around 116th Street on the West Side, four rooms.

Moreno: What is your educational background?

Lippitt: I have a B. A. from a small Pennsylvania College. I have a fairly good academic record, I won a scholarship, my father was a minister and they allowed a small number of scholarships for minister's sons at my college. When I was through the father of a roommate of mine helped me to get a job.

Moreno: How long are you living in this apartment?

Lippitt: About three and a half years.

Moreno: Do you carry insurance?

Lippitt: Yes, we have a pretty well balanced arrangement.

Moreno: Do you believe in insurance?

Lippitt: Oh yes, very much so.

Moreno: Why are you not drafted?

Lippitt: I am a little over age, of course 37 is just the borderline.

Moreno: Where did you live before you went to school in Pennsylvania?

Lippitt: We lived in Ohio, in a small town.

Moreno: Where did you meet your wife?

Lippitt: I met her at a dance, her college was about 10 miles from ours and we went to a dance at her school. My room mate fixed it up, it was a blind date.

Moreno: Are you a happily married man?

Lippitt: No, not really.

Moreno: Have you any outside interests?

Lippitt: Not feminine.

Moreno: What about your belief in God?

Lippitt: I believe in him in a comfortable middle class way.

Moreno: What about your political views?

Lippitt: I am a Republican but with leanings towards Mr. Wilkie.

Moreno: For whom did you vote in the last election?

Lippitt: I voted for Mr. Roosevelt, the Republican candidate did not appeal to me.

Moreno: Do you belong to any clubs?

Lippitt: Yes, we have belonged to the Rotary Club in most of the towns we have lived in.

Moreno: Is there anything you would like to add?

Lippitt: We have a small endowment policy which matures when my daughter gets through high school and which will ensure her college education.

Moreno: Fine. Now Mr. Stanton, will you describe your apartment to us?

Lippitt: (Here gives a vivid description of an average middle class home, as it might be seen in almost any town in the United States. Describes lay-out of the rooms, kitchen, dinette, etc). Here is the magazine rack in the living room, we have popular magazines in it such as Good Housekeeping and of course the Rotarian, and always one or two days back of the New York Sun. There is nearly always some part cut out, such as Dave Boon's column. Oh, and here is the bookshelf.

Moreno: Do you have any books on your bookshelf?

Lippitt: Yes, we have some Van Loon books and book of the month selections, and we have down below a 1926 six volume encyclopedia set. There is a somewhat worn blue rug on the floor, a little threadbare down the middle where the main traffic is. There is a colored plate on the wall of the architecture of my old college, and a Mary Parish print. Then, over there is a cupboard where I have to keep my clothes, the cleaning utensils are also kept there, the vacuum, etc., they share the cupboard with me. One of the pictures we have which my wife loves is of Grant Wood, Parson Weams.

Moreno: Fine. What is the situation in your home right now?

Lippitt: Well, my daughter is at home, she is in high school, about 15 years old. I am coming home from school and find her doing her homework, some English composition. My wife is at a card party.

Lee: (Sits down and pretends she is studying, Lippitt comes in).

Lee: Hya, Dad.

Lippitt: Hello there Lee, where is your mother?

Lee: (Disdainfully) Where do you think?

Lippitt: I don't know.

Lee: (Sarcastically) Well it's nice and quiet at home, is it not Dad?

Lippitt: What do you mean by that?

Lee: (Getting somewhat overheated) My deduction is that she must be out, at a card party or playing mahjong, etc.

Lippitt: (Quietly) Well, you'll be doing that in a few years.

Lee (Quickly, and more sarcastic by the minute) I hope not.

Lippitt: Do you think you will be smarter?

Lee: Dad, do you think I am precocious? Teacher says so.

Lippitt: I think perhaps you are.

Lee: Were you precocious?

Lippitt: My father says I was a good scholar. I did win a scholarship you know. I think you may get one if you work it right.

Lee: Gee I hope so, like father like daughter.

Lippitt: That's a nice idea. You know, I've never realized you are growing up so fast. We have so rarely talked to one another like this.

Lee: It's so nice to be able to talk to someone. Mother, well, I can't really talk to her about anything well, intellectual and things like that. You know, she was shocked when I took biology at school. Do you think I have a complex about you. I mean an Electra complex?

Lippitt: (Cautiously and with quiet authority) What do you mean by that?

Lee: Well, (Excitedly) I like you a lot, but I don't think there is anything very special about that, but I do get sort of irritated with mother when she fights with you. I get so angry, why is it?

Lippitt: Well, that is probably both our faults, I don't think it is good that you should split sides. We really should not fight, it is bad enough with the Republicans doing it. I hope it is not going to happen in this family.

Lee: Mother says I take your side and that you fight over me. She says that when you've been married a while things change. What does she mean by that?

Lippitt: She probably means we are different than we were when we married. You can see that you're different from your mother now, I hope your marriage will be better.

Lee: I hope so.

Lippitt: Do your classmates talk that way about marriage?

Lee: Well, they talk mostly about a great, big man who is going to carry

them off. I think they are very idealistic and of course a lot of them are free lovers, they don't believe in ties very much.

Lippitt: What do you think? I have read a great deal about the younger generation in the papers and have often wondered what you youngsters really think about those things.

Lee: I think it is a very good idea. I think it might be much better not to be tied down to a person. The whole idea of having some strange man talk to you and declare you man and wife, and all this bridal get-up, well, it's rather old fashioned. Is it necessary? (All this time she talks in a highly over-stimulated way).

Lippitt: Well, it is really more complex than that.

Lee: You mean, if there are babies?

Lippitt: Well, not only babies. It is also a matter of support of the family, and then there is insurance, that's very important, of course. It all gets so complicated if there is a break up, who gets the money, and things like that.

Lee: I'm sorry for you men.

Lippitt: Are you really? Why?

Lee: Well, you're such wage slaves and always have to support your wife and families. It is very hard, I really feel for you. I used to be jealous of boys as a child because I wanted to be a man, but now I don't think I'd care for it after all, I don't feel that way about it anymore.

Lippitt: Well, it is a pretty important problem to figure out. I hope that before you follow the advice of your classmates you will take it up with me. I hope that mother and I have not established a place that is not home for you. I don't want you to think there is no place for you here.

Lee: Dad, are you sorry you married? Truthfully.

Lippitt: No, I would not say that. If you don't mind I think I'll turn on the radio and listen to the news.

Lee: Yes, let's find out what happened in the election.

(Twelve and a half minutes)

Moreno: Fine, thank you. Now the second presentation. The problem is the same, but we expect a different version of it.

(Paul Cornyetz appears with the second girl as his daughter).

Moreno: (Interviews Paul) What is your name?

Paul: My name is Paul Jones (Note that he uses a stereotype for his last name and keeps his own first name).

Moreno: What is your profession?

Paul: I am a worker in radio research at C.B.S.

Moreno: How old are you?

Paul: 39.

Moreno: Married or single?

Paul: Married.

Moreno: College educated?

Paul: I studied advertising and allied fields.

Moreno: Where did you study?

Paul: At Columbia University.

Moreno: How many children?

Paul: One child, a daughter.

Moreno: Do you belong to any church?

Paul: I believe in a rather relaxed attitude towards religion.

Moreno: What are your political views?

Paul: Liberal.

Moreno: Do you belong to any political party?

Paul: No I don't.

Moreno: What newspapers do you read?

Paul: I read P.M. regularly and the Daily News for amusement.

Moreno: Do you believe in insurance?

Paul: Yes, a man must be practical.

Moreno: Do you carry much insurance?

Paul: I have a policy which will be worth about $10,000 in ten years.

Moreno: Do you have any hobbies?

Paul: I am mostly interested in radio research but like boating which I do in the summer. We have a little summer place in the country near a lake.

Moreno: For whom did you vote?

Paul: For Roosevelt.

Moreno: Would you vote for someone else in the next election? Or if you knew what you know now, would you do it again?

Paul: I would vote for Roosevelt again.

Moreno: Why are you not drafted?

Paul: I'm doing important work at C.B.S.

Moreno: Do you consider your marriage happy?

Paul: My marriage is a satisfactory affair, even if it has its little troubles.

Moreno: Do you read any magazines?

Paul: I read a magazine that is put out by some men in radio research.

Moreno: Do you have any outside feminine interests?

Paul: Well, I must admit I do, when someone catches my eye.

Moreno: Do you belong to a club?

Paul: No I don't. I know a group of people, we meet rather informally

from time to time.

Moreno: Where do you live?

Paul: We live between Broadway and Riverside Drive, on the side towards the Drive, on 109th Street.

Moreno: Will you describe the apartment?

Paul: It is a five room apartment. (Describes the lay-out of apartment). I have a little room, a den of my own over there, it has all my things in it. In the living room are some books, but they belong to my wife and daughter. I have little time for reading.

Moreno: What kind of books are they?

Paul: Oh, things like Women in Love and Jane Eyre, or something like that. Also some library books, I don't know what they are. We have a piano over there which my daughter sometimes makes believe she plays on. There are no pictures on the walls, they are pure, blank walls, I don't believe in pictures. (Describes the rest of the room, the furniture as comfortable, not too modern, a blue and grey mottled rug on the floor). It is now about 6 p.m. and I am home, wondering what my daughter is doing, she is not home yet. She should be home by now, school is over, must have been long ago. Well, I think I'll tune in to WQXR and listen to some decent music, something of a cultural nature.

Nancy: Hello Dad, what kind of noise do you call that?

Paul: Oh, good evening Nancy, that is good clean classical music. Where have you been so long?

Nancy: I've been at the library studying. Do you mind if I turn that dreadful sound off? What do you listen to that for? Can you explain to me what it means?

Paul: I am enjoying it, is not that enough? Why can't you listen to some music for once instead of that dreadful jitterbug stuff you're so keen about.

Nancy: Well at least it has life to it. That serious stuff makes me feel ill.

Paul: You are getting away from my first question. Do you mean to say you've been studying up till now?

Nancy: Yes I have.

Paul: In the library?

Nancy: Yes. I read up on some things I was supposed to, and now I'm through.

Paul: Do you mean to say you don't have any homework to do tonight?

Nancy: No homework.

Paul: That's impossible. How can you say you're studying without homework?

Nancy: Well, I just told you I did it at the library. Please turn that radio off I can't hear myself think.

Paul: What are you planning to do during the evening if you have no homework?

Nancy: I'm going to read some of the books I got from the candy store.

Paul: My gracious. I suppose you call that studying.

Nancy: Yes, I can study and learn things from those books too.

Paul: Such as what for instance?

Nancy: About human nature. Why won't you turn that thing off?

Paul: Where are your social graces? Why don't you learn from your mother, she has perfect social graces.

Nancy: Oh phooey.

Paul: I cannot see that you are making anything out of your life. What are your plans for the future?

Nancy: (Knocks her knuckles impatiently on the table).

Paul: What is the matter with you, stop knuckling that table.

Nancy: I'm nervous, you see, that noise makes me nervous. I can't listen to you and concentrate on what you're saying.

Paul: Nancy, I think it's about time we did a little talking about your future. Now consider your studies for example, what is the idea in studying social sciences?

Nancy: I want to go out into the world and do casework and research.

Paul: Why don't you learn something practical like stenography?

Nancy: I'd go crazy doing that all day. I'd get bored.

Paul: Do you think that stenographers all get bored, I don't get complaints from my stenographer.

Nancy: They don't tell you the truth about how they feel.

Paul: Let us not digress. What are you doing at school, let's go over these things one by one.

Nancy: I'm taking psychology, sociology, etc.

Paul: That does not make sense, psychology. Stuff and nonsense.

Nancy: You'd be surprised what I learn, especially these books I get from the candy store.

Paul: As deep as Aesop's Fables?

Nancy: I read those when I was 6 years old.

Paul: Yes, then you were a promising little girl. It's pretty disgusting, and these young men you bring home. This fellow John you know, the rug-cutter, prancing around. The way he puts the radio on, so loud I can't hear myself think.

Nancy: Can you dance to Brahms?

Paul: You can dance to Strauss. Our dances were at least dignified.

Nancy: Yes, I saw those things.

Paul: I see how you fly through the air, I don't see how they can stand up *after that.*

Nancy: They don't.

Paul: But really, I am worried about you, Nancy, it may be a long while before you do anything constructive.

Nancy: (Knocks on the table again) You don't have any faith in me.

Paul: You never give me any indication of the practical aspects of your future.

Nancy: In this atmosphere? (Whimsically) How can I become anything in this place, look at that grey and blue rug!

Paul: But you have not answered my question: What are you doing which is practical?

Nancy: I am going to college, I am studying, is not that enough?

(Here Moreno interpolates "Make a social ending.").

Paul: What are you doing to make sure of a job?

Nancy: I'll worry about that when I'm through with school. The next time I come home please don't have Brahms on the radio. I'm going out.

Paul: (Gestures with his shoulder and hand) Social ending.

(Fourteen minutes).

Moreno: Alright. Now the third father, in the third version. It is of course to be expected that everyone who is presenting his version after the first or second, will be influenced somewhat by what occurred here. From the point of view of role-testing this would not be the correct procedure, but from the point of view of clinical research this is excusable. What is your name?

Del Torto: Del is my first name, Ronny is the last. (Real name is John Del Torto, uses part of his own name as first name).

Moreno: How old are you?

Del Torto: I am thirty-eight.

Moreno: Where are you from?

Del Torto: I am from a small town in Italy, the name of it is Termuli. I am well traveled, you see.

Moreno: Do you speak your mother tongue?

Del Torto: No, I don't.

Moreno: How old were you when you came here?

Del Torto: Three months, that explains why I don't speak my mother tongue.

Moreno: Where did you arrive in this country?

Del Torto: New York, straight to the Bronx.

Moreno: Do you still live there?

Del Torto: No, I left there when I was six months old. From there I was really a vagabond in my early youth, going from the Bronx to Brooklyn, to Manhattan, etc. I did not settle down, it is a very weird story. It seems that I was a slightly precocious young man. When I was fourteen I used to wander all over the village trying to develop a new form of literature, quite revolutionary. This is really true.

Moreno: Mr. Ronny, we would appreciate it if you will concentrate on my questions, we cannot go too deeply into the background.

Del Torto: But how will you understand . . .

Moreno: You will have to cooperate with me, so just answer these few questions. Are you married?

Del Torto: I must be, we have one child, a girl.

Moreno: Her name?

Del Torto: Oh, how embarrassing . . . Ruth.

Moreno: How old is she?

Del Torto: Twenty-one.

Moreno: You must have married very young!

Del Torto: (Facetiously) I said I was very precocious.

Moreno: How old is your wife?

Del Torto: About thirty-six. I was very precocious and was considered quite a promising mathematician. In order not to disassociate myself from life I would try to steep myself into it. That's when I tried to develop a new literature at the age of 14 . . .

Moreno: Yes, we won't go into that now. What is your occupation?

Del Torto: I am a slightly emaciated college professor. I am developing a new literature in perfect counterpoint; mathematically speaking, the idea is . . .

Moreno: What are your political views? (Has to stop him from talking off the main track continuously).

Del Torto: I am an ineffectual intellectual.

Moreno: Do you belong to any political party?

Del Torto: I have a token membership in the Republican party, you know, I'm on the faculty of Columbia University and all that.

Moreno: For whom did you vote?

Del Torto: Well, I walked into the voting booth, looked at the list of candidates and walked right out again.

Moreno: Do you belong to any religious congregation?

Del Torto: No, when I was younger . . .

Moreno: What newspaper do you read?

Del Torto: Mostly abstracts.

Moreno: Do you carry insurance?

Del Torto: No.

Moreno: How much money do you earn?

Del Torto: With my side lines I make about eighteen thousand dollars a year.

Moreno: Are you sure you made no mathematical error?

Del Torto: No, I said with my side lines.

Moreno: Describe your apartment.

Del Torto: Well, I live in an apartment the mathematical propensities of which explain my personality. It is a penthouse, the first room one enters from the door is in the shape of a hyperbola, so that two people can be in it at the same time and yet be alone. The furniture is modernistic, of a modernity which carries my mathematical mania to the nth degree. Some of it is so streamlined that you have to lie down to appreciate it. Some is designed in an S. spiral so that when you sit in it you can approximate the angle of universal flexion. The floors are made of several structures. Harmonies of odors are sprayed into the room, the ceilings are very high. (Gestures with his hands towards the ceiling, the entire explanation is, in fact, accompanied with sweeping gestures). It is about 6:30 at night, I have just driven fifty mad people from my classes, all my students are mad too, you see. I am brooding over my wife, I am entering the home. I always brood silently and inwardly.

Moreno: What are you meditating about?

Del Torto: I am wondering if I can really live alone and I am thinking of the late dissolution of the relationship of my wife with me. It seems that certain atavisms of my early youth have recurred.

Moreno: Alright, you are now entering the house. Is anyone there?

Del Torto: No, I am expecting my daughter home. (Sits down and continues his silent, inward brooding).

Ruth: (Coming in) Hello Dad. Would you take that compass out of your hand for a moment?

Del Torto: Yes, darling, I was just working on the comparative merits of . .

Ruth: Don't brother, Dad, it's way over my head, I just can't follow you, so don't bother to explain to me.

Del Torto: Yes, that is what your mother always says. She is apt to get

angry at me.

Ruth: I don't only get apt to, I get very angry. This place, look at it, I lose my way when I come home at night. I wish you would get away from all these contraptions. If I could only live my own life and not worry about a father who is a genius and a mother who runs around. It's so hard to live up to you, especially.

Del Torto: I did try to curb your mother, I plotted a curb, and think I was most closely to feeling emotion then.

Ruth: When I was in school I did one thing for you, I majored in psychology and that was enough.

Del Torto: Let's have a quiet little talk. You can tell me what you think about this whole thing. Do you have any suggestions or thoughts on the subject?

Ruth: I am afraid to say them.

Del Torto: Don't be afraid.

Ruth: Oh, what's the use?

Del Torto: You don't think you started life off well?

Ruth: I tried to.

Del Torto: Did you meet Mrs. Quentin's daughter at school?

Ruth: Oh, now you're going to bring her up. Yes, I met her, we roomed together for a while, but we did not get along too well, we quarreled. After living here I could not live with anyone anymore.

Del Torto: Mrs. Quentin was a very accomplished mathematician. How is her daughter? You know Mrs. Quentin used to . . .

Ruth: Yes, I know, you told me about what she used to do!

Del Torto: Did you quarrel about her mother?

Ruth: Well, yes we did, she was a fool and well, I said she was a fool. But let's not get involved in a discussion about that. What are we going to do?

Del Torto: I am trying to plot a curb.

Ruth: (Gets up and wanders around restlessly.) Here you go again, always talking mathematics. I'm between mother and you. I hate to see you alone like this, and yet I can't live this way. I thought I'd make out alright, get a job or something, but I don't think I could go on living here, perhaps I ought to go back to school. I don't know myself, I'm torn between mother and you.

Del Torto: You are the connection between us.

Ruth: Don't you think I ought to be removed?

Del Torto: Oh no, that would make it disjunctioned. I could never plot your curb.

Ruth: Well, you are the professor, you should know something about the

answer to this problem. What are your plans? When I first came home I felt guilty because I had been away so long and I thought I could perhaps patch things up. Do you think I would be selfish if I went away?

Del Torto: Yes, you would be.

Ruth: But it is getting on my nerves, it is mostly on account of you that I worry. I am not concerned about mother so much.

Del Torto: Yes, darling. I understand that they are planning to put the A.B.C. into jazz.

Ruth: That reminds me, I have been composing something.

Del Torto: Really? Let's hear it.

Ruth: Oh, I don't think you'd be interested, we two don't get along in music.

Del Torto: Now don't say that, anything you have written must be nice.

Ruth: Would you really be interested to hear my composition?

Del Torto: (Gets up and pushes her towards imaginary piano) Let me tune it mathematically. Is there anything mathematical about it? I mean your piece?

Ruth: (Hesitantly sitting down) No, there is nothing like that about my music, it is classical. I am rather embarrassed to play before you, I am afraid of criticism. No, I don't think I will play it for you after all. I'm going out. Please think about what I have said to you. I expect a normal father to come home to. Do you think you could concentrate upon something else besides talking in circles as you always do?

Del Torto: Yes, darling.

Ruth: (Mimics him in irritated fashion. Yes, darling, yes, darling. That's all you have to say. I am going out). (Exit).

(Thirteen and a half minutes)

Analysis of three presentations by Moreno:

It is quite obvious that these father versions varied from one another to a great degree; this is especially true of number 3, compared to numbers 1 and 2. Each protagonist used about the same amount of time, between twelve and fourteen minutes. What we are first interested in is: *which of the three versions was closest to the problem given?* Let us take a vote on that. Category 1—Lippitt; Category 2—Cornyetz; Category 3—Del Torto. Choices: No. 1—37; No. 2—None; No. 3—None.

Moreno: You all agree that the first version came closest to the task assigned. Now another point: *which of the three versions is, in your opinion, most "objective," that is, most removed from the private personality of the persons involved.* We know that something of themselves is projected into the

three presentations. The task which I assigned was to have a conflict between husband and wife and how this conflict was reflected in the situation, how it affected the offspring. Paul deflected entirely from that situation. Number 1 came closest to the task. Now we want to determine *which people seemed least involved in the situation, which appeared more as a collective problem than a private one?*

Choices: No. 1—11; No. 2—30; No. 3—10.

Moreno: Number two is therefore first in objectivity. The fourth aspect of the analysis is: *from which of these versions did we learn most?* Which of these versions gave you the greatest and most valuable information about what such a situation means, such a father, living in America in such a situation; which of the versions stimulated and strengthened our learning process, our gathering of social understanding?

Choices: No. 1—38; No. 2—2; No. 3—9.

Moreno: Another aspect is *the degree of spontaneity and creativity and originality of the production.*

Choices: No. 1—2; No. 2—5; No. 3—39.

(Here Dr. Tilton raises the question: How can we know that unless we know their personal background?)

Moreno: That is a good question. A careful analysis is here in point. The audience reaction is only an impression, we do not know their private personalities. But the study of private worlds is not the purpose of this session. We have to study the objective setting as a whole and see how we think the personality of the people in it fits. It is true that you do not know the private world of the subjects. The question is whether you have the feeling that the true persons came out. You see from a patient, or any truly warmed up person, that he cannot stop his production upon the stage. It would be interesting and valuable to know *who contributed most to the construction of the plot, and to the process which went on.* Dr. Lippitt, could you tell us, did Shirley—also Lee at times—help you, or whose idea was it? Did you have anything leading up to it?

Lippitt: Our conversation was of quite different dimensions from the intended procedure. We had discussed whether it should be an Electra complex, at least, that is what Shirley suggested.

Moreno: That is interesting. We should always consider in our analysis what happened in the warm up before the scene and during the presentation. We can see how the presentation developed out of the skeleton more or less indirectly. Often we find that the plot is pedantically carried out and then again we see a variety of things which take place, unplanned. Now on this

basis, who had in *the dyad of the first category* the initiative in developing the production on the stage. Let's take votes on that.

Choices: Lippitt—29; Shirley—21.

Moreno: It is perhaps hard to dissociate one thing from another, but it did seem that, although Shirley was quite verbal, Dr. Lippitt showed his quiet strength throughout the scene which was largely carried by his initial presentation before Shirley came on. She distorted it somewhat but in the main the atmosphere was rather consistent.

What about *the dyad of the second category?* Who do you think carried the scene out there?

Choices: Paul—9; Nancy—18. (Here follows a little discussion which makes it plain that very little preparation had taken place between Paul and Nancy, Paul had just told her that she was to be a college student whose father did not approve of her studying social sciences, it not being practical. Paul did not hear the stipulation concerning conflict between the two parents, hence this problem was not carried through as it should have been).

Moreno: What about *the dyad of the third category?*

Choices: Del Torto—29; Ruth—14.

Moreno: Tell me, Del Torto, who chose the situation?

Del Torto: Ruth chose it. I deliberately let her choose the situation and roles and we adhered to it. It was her plot and she assigned the role and behavior in its broad scope.

Moreno: What Del Torto says now would give him a great deal of objectivity, far higher than we first assigned to him. Do you think she used a great deal of spontaneity on the stage?

Del Torto: No. She stuck largely to the plot arranged outside and was rather stereotype, the whole pattern was prepared.

Moreno: Even if an artist projects his whole mind into a plot, there is still a deviation from his subjective person and the actual plot. Sometimes the artist has an affinity to his product. Just the same, his work has become separated from his subjective mind. It is impossible for anyone to speak except in the vocabulary he has; however, a great deal of collective material is in it, and especially in such a performance as we see here.

Ruth: When we made our arrangements we did not say a mathematical genius. I was not prepared for a mathematical genius. I did not choose his characterization.

Del Torto: I said a college professor.

Ruth: Well, I had no idea of speaking to my father as a mathematical enigma. I did not expect a situation with such an unusual father, the emotion

I meant to express was towards a normal father, which is not the same thing at all.

Moreno: Now we see that Ruth did not construct the plot as it was played and we can thus deduct how much Del Torto contributed to it as it was portrayed. I thought that Ruth did very well, as compared with the other girls who did not do so well with Del Torto last week and were taken in by his magic.

Dr. Tilton: Well, Ruth was a little bit prepared because she saw the type of role Del Torto was taking before she appeared on the scene, while talking to you.

Moreno: She did not see him, she was behind the wings. She has never met him before and also had never been on the psychodrama stage before. Were you ever on a stage of any kind?

Ruth: I took some minor comic roles at school in school plays.

Moreno: *The warming up process back stage* is one of the most interesting and fascinating phases and would yield some wonderful research material in itself, when they plot together and interact before getting ready. Living is perhaps not so interesting in itself as getting ready for it. I think it was very interesting to see Del Torto's bizarre presentation because Ruth reacted very well. (Member of the audience: Ruth expected a normal father to talk to. Given a situation with a father who perplexes her she rejects him and walks out. He, Del Torto, presented an exaggerated version of a father who was unaware of the child's feelings. That is more so in a lower class family. Ruth reacted in a personal way).

Lippitt: It would be worthwhile to distinguish between the verbal situation and the action situation.

Moreno: That is a good point. The action skill is of course so important in this work. It seems there is often a criss-cross of atmosphere, which is just as life is itself. The other person does not always carry the same atmosphere as one feels at a given moment. (Here the discussion is led back to the contributions of the partners in category number 2. Paul told Nancy that she was a jitterbug and that he wanted her to do something practical in college. He did not present her with much of the characterization, only some of the content. Part of the name was his own, the last name was a cartoon).

Paul: I did not structure anything, simply told her that an argument would develop.

Moreno: It is often very interesting to note that when the structure of the situation is not complete, the subjects project something of their own as they warm up to the situation. A subject is more apt to do so in an uncertain situ-

ation than when a clear outline of a situation is developed backstage, because his spontaneity is aroused in no particular way, and then nothing is left except to follow his own track more or less.

Lippitt: What did you draw from the presentation?

Moreno: On and off in the course of presentation I indicated my own evaluation. I felt, honestly speaking, that none of the three tests completely lived up to the task I assigned. But there is no doubt in my mind that Dr. Lippitt's presentation was first in objectivity and meaning for the purpose of this type of research and if he would have had a more appropriate partner who may have had more affinity for the situation Dr. Lippitt tried to portray, it would have been the outstanding event of the evening.

APPLICATIONS OF PSYCHOANALYSIS TO GROUP PSYCHOTHERAPY AND PSYCHODRAMA THERAPY IN FRANCE

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A—*General Principles*

The first investigations into group psychotherapy began in France in 1945, at a time when the work of Moreno was yet very imperfectly known.

The French experiments were made by psychoanalysts and psychotherapists who tried to devise better techniques for more or less long and searching treatments. Two teams started these investigations in Paris: S. Lebovici and J. Moreau-Dreyfus in the Department of Prof. Heuyer, and Mireille Monod and E. Kestenberg at the Psycho-pedagogical Centre Claude Bernard. Very soon the two teams merged while research into group psychotherapy of adults was initiated. Some time elapsed before the American studies became better known and great differences in inspiration and the techniques employed between the American and the French workers could be noted. The French techniques closely followed the patterns of Freudian psychoanalysis and at the same time concerned themselves exclusively with treatments of mentally ill patients.

The various investigations thus initiated led to many forms of treatment, the essential elements of which invariably remain the therapeutic utilization of the group or of dramatic action.

1—*Therapeutic utilization of group phenomena*

In France, as in the Anglo-Saxon countries, these studies have borne upon group dynamics: (D. Lagache, J. Lacan and S. Lebovici)

A preliminary remark should be made regarding the meaning of therapeutic group. A group may be defined by its function. Now, what differentiates a group of ill persons from any other group is that each of its component elements pursues no other end than to recover and thus to part from the group. In the cases which we are called upon to treat, most of them being neuroses, it seemed to us that the group structured itself in a much more intense way than was justified by actual relationships and, in fact, our therapeutic action proved significant in the study of the intrinsic bonds uniting the members of the group. The relationship thus created is linked with the phantasmatic relationships of the patients, that is to say with their neurotic organization. In other words, the dynamic phenomena observed in groups of neurotics are both the motor which enables us to exert a therapeutic action and a stage of the archaic organization which must be transcended.

While holding back for a more searching study the description of the trans-

ference phenomena which seem to us essential, we wish to point out here and now two very important dynamic phenomena; they are what we have called phenomena a) of "resonance" and b) of "interference." The expression by one of the patients of an affect commonly experienced by all the individuals of the group but at different times of their history may release the direct reviviscence of the same emotion in other patients with an easy due on the one hand to a degree of emotional tension and on the other hand to an easily understandable sense of release from guilt. This is what we have called the phenomenon of resonance. c) More often, the expression or the performance of a pulsion by one of the patients sets into action in the other patients, in an elective way, the defense mechanisms of the "Ego" connected with this pulsion; it is then easy to demonstrate to the other patients the meaning of these defenses in relation to the events of their past life.

2—*Utilization of Dramatic Phenomena*

During the early experiments in group psychotherapy it became apparent very soon that playacting could be very fruitful. This is by no means new since all the investigations of child psychoanalysts, with special reference to Melanie Klein, have been centered upon the necessity of finding a means of expression for patients unable to express themselves directly by means of speech (small children for instance).

In her technique of psychotherapy, Madeleine Rambert has extended the play technique by describing very aptly the great value of personal experiences in the scenes enacted by means of puppets.

Moreno has offered a new therapeutic approach in suggesting the utilization of dramatic spontanity.

In our early experiments we stressed the therapeutic effect of what might be described as dramatic catharsis in itself. In those days we sometimes observed discharges of actual aggression. We now think that these were phenomena very similar to those of acting-out in the psychoanalytic theory and practice, and that part of our therapeutic efforts should aim at reducing them. Resorting to action is ultimately of the same value as in psychoanalytic treatments and the play must remain a fiction. Nevertheless, for many patients of any age group dramatic play is a choice means of expression for some pulsions. We should like to mention in particular the patients with obsessional neuroses who very soon act scenes in which the pulsions which they repress most severely are expressed by themselves in a clear and indisputable way; if the patients deny in the beginning that their playacting may have the least significance in relation to their personality, the inevitable repetition of the scenes against which the patient protests finally acquires for him a really convincing value. Similar-

ly, deeply inhibited patients (we have in mind primarily adolescents) come to express often violent affects in the coure of play, whereas in an analytical treatment it would be impossible for them to give the least hint of these pulsions. After six months of orthodox analytical treatment during which she had entrenched herself in obdurate silence, a girl was engaged in psychodrama by her psychoanalyst and an auxiliary actor. She was soon able to express by her acting a very intense aggressiveness towards the auxiliary actor, a less dangerous object than her psychoanalyst. Another girl, after an instalment of analysis as unfruitful as the previous, expressed, in dramatic psychoanalysis, her homosexuality and her phallic demand in a very direct way by the choice of her roles.

In the light of these examples it may already be comprehended that dramatic action is situated on a level intermediate between the lived out affect and its verbal expression. Dramatic expression is the outcome of an elaboration comparable to that of dream, and the aim of the treatment is to bring forth a verbal explanation of this elaboration which is the only possible mode of *reaching beyond behavior.*

In short, it is clear that our understanding and our handling of dramatic techniques are acutely aware of analytical experience.

Our attitude toward dramatic play, its handling and its understanding is similar to that of the analyst with regard to dreams, the fact being kept in *mind that in psychodrama the patients* have not the same possibilities as in the dream to deny their participation in the action. The dreamer does not necessarily feel responsible for the dream images in relation to which he becomes split; the neurotic undergoing psycho-dramatic treatment is directly integrated within his character and with his behavior towards the action of identified characters.

The fundamental difference between psychoanalysis and psychodrama is the concerted attitude of the therapists. The latter maintain a frustrating position which induces transference situations rather than contra-transferential attitudes (J. Lacan) and interference on the part of the analyst.

B—*Methods*

1°—Verbal methods

2°—Dramatic methods

1°—*The Verbal Methods*

They include on the one hand the methods of group psychoanalysis, and on the other hand of psycho-therapeutic interviews.

2°—*The Dramatic Methods*

They include:

a) dramatic group psychoanalysis
b) analytical psychodrama

We must now describe these different methods.

Group psychoanalysis is practiced in France by several therapists (D. Lagache, S. and R. Lebovici, S. Marcus-Blajan, J. Schweich, etc.).

In this method which tries to be a direct application of psychoanalysis we have been led to reproduce experiments such as they are conducted in England, in particular at the Tavistock Clinic (H. Ezriel).

Our personal experiment involved young adults whom we assembled in groups of 5 or 6 of both sexes.

We avoided including actual neuroses within the groups and we likewise thought that patients affected with characterized sexual perversions should be kept out.

The various members of the groups are encouraged to associate freely.

Very peculiar manifestations of anxiety are generally seen, which is expressed not only by silence like in individual psychoanalysis, but also by specific group reactions such as explosive and catching laughter.

The material brought by the patients is rather different from that usually collected in the course of individual treatments; it seems much more centered around their present life. Nevertheless, dreams can be analyzed in group. The study of dynamic phenomena of transference may be sketched as follows:

1° transference by patients on the psychoanalyst of parental images emerged in the course of infantile identifications.
2° transference from one patient on another patient.
3° the possible but in the present stage of thought in France questionable existence of true group transference.

It is none the less true that when these group psychoanalytical treatments follow a favourable course, the problems raised are the common concern of all the patients of the group.

These various dimensions of transference help to understand a phenomenon the importance of which cannot be overemphasized, namely, that resistances assert themselves owing to the fact that the patients easily project their affects onto another patient rather than onto the therapist. The interpretation must often be given in this perspective: the patient, for fear or exteriorizing his love or aggressive affects on the therapist expresses them on one of the other patients. Likewise, phenomena of resistance find their expression in very special acting-out which leads to the formation of sub-groups; for instance, the patient will have love trysts with a woman patient thus showing his resistance to therapeutic transference. The particular difficulty with these patients is of course

the approach to sexual problems in their phantasms or in their real life. In one group we were hindered by the presence of an adult who revealed that he was an active homosexual. Conversely in another group, a girl who in her childhood had experienced sexual aggression on the part of her father, gave us no trouble at all.

Thus we have observed that group study of sexual life can readily be made provided the latter does not raise problems of immediate reality.

These analysis groups which we reserve for slight neuropathic cases and behavior difficulties, for those whose analysis would be too "cold," may be followed in their evolution as in the course of a classical analytic treatment. Their own courses are marked by a progressive gain over anxiety to the detriment of secondary advances of the disease.

We have not, however, a sufficient follow-up perspective to claim that this method facilitates a real mobilization of neurotic structures and that the remote results will be as good as we should like to hope.

Another commonly used form of non-dramatic group psychotherapy is the interview psychotherapy. This form of treatment is currently resorted to for the psychotherapy of parents. It had appeared to us that in the course of individual interviews with parents, transference relationships, often very intense, were established between the psychotherapist and the patient, a transference situation which could in no case be elucidated in the ordinary set-up of interviews. It frequently happens that the patient experiences an acute guilt felling caused by this relationship and this ends up by making him reject the notions which seemed to have been accepted in the course of the interview.

On the other hand, the intolerance of parents with regard to a number of manifestations on the part of their children has led us to assemble them in a group so as to create a double deculpabilization both on the score of their relationship with their children on the one hand and with the psychotherapist on the other hand.

We pursue this end during the first sessions. We explain to the parents that the position and the disturbances of their children require particular educational attitudes on their part and that they must help us in the treatment of their children (this in order to avoid a direct attack against the narcissistic defenses inherent to parents). We then proceed to give them a general statement on the following theme: children are different from adults, yet they are more complicated than should be thought. We take good care not to give the least detail concerning the affective evolution of the child for unprepared patients could only deduce misleading notions from such developments.

In the subsequent sessions we ask the parents to set forth the situation in

the course of which they found themselves in difficulties with their child. From then on group phenomena are released either because the parents, relieved to see that their children are not the only ones to have such an attitude, speak to us with complete freedom, or because they are shocked by the exaggerated attitude of one of them which they refuse to recognize as their own. Generally we thus succeed in displacing the guilt feeling of the parents and in making them understand that their behavior toward their child cannot successfully resolve their own neurotic position. Such a result is enough in some cases to ease the atmosphere. In other cases the parents themselves ask for a deeper treatment.

Dramatic Group Psychoanalysis

This technique seems to us to offer the particular advantage of showing the transference very explicitly and so the possibilities of utilizing it.

The pattern of dramatic group psychoanalysis consists in assembling four or five patients and at least two therapists (a man and a woman). After explaining to the patients that dramatic enactment is a means of expressing what is within them but what they are unable to say, we ask them to outline a situation. They may use either recollections of personal experience, or entirely invented situations, or else dream material. When they have reached agreement, we ask each of them to choose a role and to assign that of the auxiliaries. It is understood that except for the latter everyone chooses his role freely and that in the course of the enactment to follow everyone may at any time do what suits him best even if his action does not coincide exactly with the original outline. We request the patients to act realistically and to assume attitudes corresponding to what they feel and wish. We have already seen that this way of "acting out" was regarded as quite comparable to the acting out in classical psychoanalysis.

Transference phenomena appear in the choice of roles and this confers immediately its true significance upon the chosen theme: Thus a patient suffering from asthma but free from any mental trouble apart from his disease regarded by pneumologists as being linked with affective problems, displayed the following behavior in the first session: the theme chosen by the others was that of a person falling out of a train through a window. He chose the role of a traveller who finds himself near the victim of the accident; then, when one of the psychotherapists had his role defined for him, the patient spoke again to say that the psychotherapist would wrongly accuse him of having caused the accident.

Another patient who had been told that his treatment would soon be terminated, suggested at the next session the story of a "child of 18" who would

not leave his parents to look for work. He *designated* the psychotherapists to act the role of the parents.

On some occasions the patients choose their role in relation to the psychotherapists (parental couple) disregarding the theme "I will be the son of Dr. X."

Sometimes, when the defense mechanisms are more intense, after the roles had been assigned, the patients scotomize altogether the roles of the psychotherapists. Thus, in the course of a session a patient had chosen the role of a police superintendant making an inquiry about a child ill-treated by its parents. While the roles were being assigned other patients, prompted by personal motives, took the roles of the parents which the first patient obviously intended to be played by the psychotherapists. It followed that the psychotherapists were given the role of policemen representing of course the super ego for these wicked parents. The first patient could not bear this paradoxic situation which led him to turn the psychotherapists into his subordinates. He immediately forgot the role of the latter and treated the action as altogether unimportant. He enacted the following scene: the police superintendant furious to find two intruders in his office, expels them vigorously without for a moment listening to the perfectly logical explanations which are given to him.

The behavior of the psychotherapists must be a dramatic transposition of the analytic attitude. It may seem paradoxical to quote, in order to define the position of the psychotherapists in dramatic psychoanalysis, the phrase of Fenichel "not to play the game;" yet, it is our guiding precept.

From the very beginning the patients, in a more or less direct way, ask the psychotherapists to help them. It is essential to avoid joining the play of the patients, and to deprive them as much as possible of the benefits they draw from their neurotic position.

The psychotherapists must therefore be concerned to embody the desiderata of the patients in the play while denying them the affective participation which they wish for.

Example: "Mathurin proposes the following theme: he is going to be a child who is all the time being punished by its mother for all sorts of poor reasons to which he obviously attaches no importance in themselves and which he does not emphasize in his playacting. The psychotherapist acting the role of the mother is constantly careful to refuse him the gratification he demands, so that the motive underlying the masochist situation may become explicit."

During the play the psychotherapists must therefore strike an attitude of sympathetic neutrality. But the form of this treatment imposes upon them the duty of enlivening the scenes enacted. It is obvious that inertia on the part of

the psychotherapists will automatically bring forth a similar reaction in the patients as a phenomenon of "dedramatization" which in turn disguises an intense feeling of guilt. It must never be forgotten that dramatic play has its own hedonic value: "not to play amounts to censuring."

While the patients feel so strongly the errors in the attitude of the psychotherapists, they themselves can react in a similar way. To refuse to play is a form of acting out; this manifestation has all the greater value of hostility toward the psychotherapist as it often embarrasses all the other members of the group: Thus Solange, displeased to have been moved into another group after a long absence, is very assiduous upon her return, but disinterests herself ostentatiously from everything that happens during the session. (It will be noted that this attitude is very comparable to the "acting" in the transference described in psychoanalysis).

It could have been feared that dramatic action might only allow the expression of pulsions and affects in an after all symbolical form, incapable of being turned to account by the ego. Experience has shown that dramatic group psychoanalysis permits very soon to appraise and interpret the defense mechanisms of the ego. The patient may thus become conscious of the meaning of his emotions.

We have already shown in connection with interference phenomena that defense mechanisms are set into action as soon as another member of the group proposes or acts a situation fraught with affects repressed by the first patient.

On the other hand, we frequently see a patient under treatment behave in the play in way different from that mapped out when the theme was outlined. In the course of the initial discussion a group of patients want to enact a scene in which patients complain of being badly cared for by their doctor. They choose the male psychotherapist to play the role of the doctor. One of the patients chooses the role of the father who would like to treat himself with the help of popular medical digests. Two facts should be noted during the session: the patient who is playing the role of the father gives advice to his children, but the latter do not, as had been foreseen, call on the doctor to complain about his indifference, but upbraid their father for neglecting them. At this point it is easy to show to the patients that they were unable in their play to reproach the doctor in the way they had meant to. Such a displacement to one of themselves (as a substitute) is one of the most frequent projections of the ego defenses.

The identification with the aggressor is also frequent and helps the patient not to feel his anxiety during the play.

A particular case seems to deserve to be specially mentioned. In dramatic

psychoanalysis the mechanisms of defense pertaining to obsessional structures are disclosed with exceptional clearness, but above all with great cogency for the patient himself. A group of patients affected with obsessional neurosis would regularly enact stories of violent death. They were of course convinced that the play had no significance in relation to themselves and that it was the result of a mere imaginative chance. The repetition of these scenes, however, finally annoyed them. One day upon entering the room one of the patients said: "no more violent death;" the second then noticed a chest which happened to be in the room, and said: "here is a trunk." "It is the bloody trunk" added the others. "It's you, doctor, who will be the corpse in it, but you will have died from natural death; I will be the doctor." It turned out that this doctor had never in his lifetime had anything to do with the character thus supposed to be dead, was unable to make the diagnosis of the apparent demise or to say what the patient had died from; finally he managed to have an imaginary laboratory say that the patient had died from digitalin poisoning; this implicated of course the character of the doctor who had prescribed the drug. This series of cancellations made the patient still more annoyed and he had to admit the reality of his wish for death which he expressed continually throughout many sessions.

Cancellation mechanisms even more glaring are frequently observed, generally around violent aggressive pulsions. A patient will be playing the role of the murderer who runs away, then "motu proprio" he will take the role of the policeman and demonstrate in perfect good faith that the murderer is one of the psychotherapists. The amazement of the patient when, at the end of the session, it was pointed out to him that he himself had played the role of the murderer, was not stimulated and the experience was useful to him. It is remarkable to see how easily obsessional patients play and express with violence their most aggressive pulsions. Occasionally, however, they resort to a particular defense mechanism: that of the play within play (the patient imagines that he is in a theatre and that he is acting a play or turning a film). The action therefore frequently offers an aspect very different from analysis, and one may wonder whether dramatic action is not specially indicated for patients whose too far-reaching rationalizations and excessively tight defenses paralyze analytical action or prevent the patient's feeling the affects in the course of his treatment. We lack, however, sufficient follow-up time and experience to answer this question.

It follows from what we have just said that the evolution of treatment is apparent both in the expression of transference and in the choice of the theme. We find successively the explosion of anxious situations, the regressions

which they entailed and the defense mechanisms which they mobilized. The explanation of these elements enables the patient to go beyond his initial positions and favors the appearance of more satisfactory identifications and cathexis.

It is also clear that to the extent to which play is an elaboration whatever its abreactive value, the final stage of treatment is nevertheless the verbal conceptualization of the unconscious phantasms and their integration within a system of conscious and rational thoughts which alone allows to transcend them. It is therefore necessary to interpret their defense to the patients and then to give them the crucial interpretation or interpretations. We generally give the interpretations immediately after the session. While it is true that during the play we occasionally stress a definite import, either by materializing it by our own play, or by recording it, it is our habit to give the interpretations, when they are necessary, after the session, but before the whole group, so as not to create a symbolized censorship.

There is a difficulty in connecting the expressed affects with the actual anamnesis of the patient. We are facing here a problem similar to that arising in certain children's treatments since in both cases the patient gives no catamnestic information as he would in a classical analysis. However, in the course of these interpretations or during the elaboration of the theme for the following session, the patients readily relate recollections connected with the material expressed. Sometimes they ask for an individual interview to recount a given recollection, and we grant it in order not to distort the character of the sessions. If on this occasion the patient brings a new element, we advise him to use it as a theme for the following sessions. It is also imperative to keep in mind the most accurate anamnesis of each patient and the pattern of his past and present family situation.

Such treatments are practiced with adults. The indications of this therapy are strictly the same as those of classical psychoanalysis and are most useful in the cases in which it can be presumed that classical analysis would prove too cold or impossible because of material difficulties. (The frustration attaching to group treatment cancels the usual difficulties of hospital analysis). We eliminate, however, unbalanced patients (psychopathic personalities) and, in a general way, all those whose ego seems too weak to benefit by such a treatment.

Few alterations have to be made to adjust these techniques to children. It is, however, striking to see that the handling of dramatic group psychoanalysis with children is ofen more difficult. The phenomena of resonance connected with homosexual passivity of patients at times considerably hinders the expression of individual positions.

On the other hand, dramatic play presents the inconvenience of requiring total and unparcelled objects and this tends to make the patient uneasy in the expression of primitive conflicts, introjection and rejection mechanisms. This is why we keep these treatments in store for children experiencing oedipian conflicts and in whom the primitive positions have but a regressive value. In a general way, we mostly utilize the dramatic group analysis for children over ten years of age; that is to say, at the end of the latency period, during puberty and adolescence. During these periods the child can no longer express himself by means of drawing, and even less so through the manipulation of more archaic material, while he is not yet remote enough from his pulsions to record them directly. Dramatic play seems therefore the ideal mode of treatment for that period.

III—Analytical Psychodrama

This technique has been used in France in two ways: *individual* and *collective.*

A.—*Individual Analytical Psychodrama*

The team of therapists includes a leader and a few auxiliary actors. The leader takes the attitude of the psychoanalyst. He intervenes only to interpret or comment what is going on. He must, moreover, organize the scene by asking the patient to associate, and by suggesting to him some material means of enacting the proposed schemes with the help of auxiliary characters. The auxiliary actors* enact what the patient has prepared and help him to transpose his affects dramatically. Such help is the more valuable the fuller the transposition, that is to say the more it embraces all that the patient has expressed, even when this exceeds his conscious intentions.

The leader asks the patient what he wishes to play, makes him associate upon events of his present and past life. Each enacted scene is short. The leader interrupts the play at his own discretion to ask the patient what he thinks of it, and it sometimes happens that the patient has a scene re-enacted several times with variants, without for that matter finding a satisfactory scene.

The chosen theme may be either a present or a past occurrence of the patient's life, or a phantasm expressed under various forms, or else a dream.

The general technique of intervention and of interpretation is similar to that of psychoanalysis, and the patient goes through the same stages.

A detail of technique peculiar to this method is the utilization of the mir-

*We prefer this wording to that of "auxiliary ego" employed by Moreno, the latter term being liable to confusion in view of the very definite meaning of "ego" in psychoanalysis.

ror technique (Moreno), one of the auxiliary actors playing either directly the role of the patient, or that of a character "who resembles him like a brother" and whose behavior is strictly similar to his. It happens that certain patients refuse to play for a more or less extensive period; this compels us to have played before them scenes enacting the affects which they express. It is in these cases that the looking glass play becomes indispensable. The study of transference is more complex in the previous form. It is obvious that the leader is the main object of transference relations, but the patient serves himself of the auxiliary actors as objects of displacement, since it is with them that he fulfils his phantasms in the play. What has been expressed with regard to the auxiliary actors, must be constantly brought back to the leader so as to establish in due course its repetitive value.

This method is very efficient but remarkably expensive. It must be kept in store for serious cases in which classical or dramatic psychoanalysis does not seem indicated. It is the choice method for highly inhibited patients or for older adolescents with character disturbances. For the latter, the acceptance of the treatment is often only partial, and this method alone allows to overcome their initial oppositions. According to Moreno, the looking glass play seems to be of remarkable value for the patients in whom a psychotic organization is suspected, especially in the case of a paranoid structure.

These very different patients are all characterized by their narcissistic defenses which would prevent any true analytic relationships and any integration within a therapeutic group.

B—*Collective Analytical Psychodrama*

It entails a comparable technique, but is applicable to a large number of patients. It has been described in a hitherto unpublished report of Dr. Favreau presented at the Second Day of Collective Psychotherapy (Paris, 1950). The trials which we have made were carried out with lying-in patients in the presence of the medical and nursing staff. They purported to create a global psychotherapic atmosphere in a hospital service and to humanize the relations between the patients on the one hand and the doctors and nurses on the other hand. Thus sheltered by the fiction of the play, the patients were able to express the affects peculiar to their condition of lying-in patients. It was even possible for some patients to situate the reactions to hospitalization in the history of their conflicts.

A theme is played by patients and possibly by auxiliary actors. It is discussed by the entire audience.

Other experiments pursued a more definite purpose: to prepare the exit of depressed patients not daring to separate themselves from the hospital.

Dr. Pasche is carrying on experiments of the same type at the clinic for mental and brain diseases of the Paris Faculty of Medecine. All these sketchily described methods rest upon the elucidation of the phantasmatic relationships which keep the patient in a dependent position. They must be distinguished on the one hand from methods of libidinal cathexis, and on the other from methods of social re-education (such as have been described by Dr. Daumezon in his practice of the psychiatric hospital). Practically all the methods assume that the patient has kept a certain place within the community and is more or less satisfactorily fitted in real social groups. It is, as a matter of fact, a valuable test of recovery to see the patient detach himself from the therapeutic group while his relationships become normal within the natural groups to which he belongs.

GOALS OF GROUP PSYCHOTHERAPY

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The goal of group psychotherapy, as I see it, is not a fixed one but a progressive one, changing to meet the needs of society.

In my experience, group psychotherapy has been an evolutionary development in relation to human behavior. That is, my first experience in this field of therapy was at a mental hospital, where most of the participants were suffering from psychosis. The particular method which I have used was originated by one of the other doctors on the staff, and called by him "the non-verbal approach." By the use of this technique many withdrawn psychotics were stimulated to an emotional response, sometimes an extreme one. For instance, I recall a mute catatonic suddenly and forcefully verbalizing protestations against being disturbed. As this other doctor and I proceeded with this method, that of writing the letters of the alphabet upon the black board as a type of test situation, the use of words was introduced more frequently, and more discussion ensued in regard to the meaning of the emotional responses.

After the mental hospital, I next was engaged in therapy in the Community Clinic, where former patients of this hospital were seen. I introduced group psychotherapy to this clinic with a high degree of success. Some of the patients I had known formerly, while there were others who were glad to find a group waiting for them immediately after leaving the hospital; particularly, since under the usual setup, the patient was not contacted by either doctor or social worker until one month after departure. Besides the active participation of these patients in the group, where most of them were able to talk freely about their problems, there was another benefit to them. I mean that many of the social workers assigned to particular patients attended the meetings, and in this way gained considerable insight into their patients' psychological needs. Also, by participating in the group themselves, they were able to become aware of some of their own psychological blocks which might have handicapped them in doing their best work with the patients.

In this extramural clinic, socialization of the patient was emphasized. He we reminded that he was part of a group working for mental health. It was pointed out that frequently people fear their own emotions, and feel that they are the only ones who have such problems. Within the group, they had an opportunity to feel less isolated and more secure amongst others who also had problems. Constructive criticism was encouraged on the ground that in an understanding group the person so criticized becomes less sensitive. In this way, the goal of the therapy in this group became one of desensitizing, destigmatizing, and socializing the individual. It should be added that this ABC method

of group psychotherapy enables the patient to gain not only emotional response on a superficial level, but does more. Similar to psychological projective techniques such as the Rorschach test, it reaches or stirs deeper levels in the emotional area of the personality, and in a similar manner reveals these emotions unconsciously. Knowing that the release of emotions may be dynamite, the therapist must be trained in restraining and guiding into constructive channels, emotions so released.

During this same period of leading the group psychotherapy class in the extramural clinic, I also had a demonstration class for student nurses at the Illinois Neuropsychiatric Institute. Here it was learned that the so-called "normal" individual had responses similar to those of the post-psychotic and others with severe mental or emotional disturbances. In this class was demonstrated a variety of those defense mechanisms which are used at times, as when under emotional stimulation, by any of us. Particularly, *anxiety under pressure* and *frustration under delay* were revealed. Other important reactions were fear of ridicule in writing such a simple exercise as the ABC's, or embarrassment over being called as demonstrator for a group, and also resentment, and even confusion, in being a part of what seemed to the individual as a strange situation.

The next period of development of this group psychotherapy class was in an out-patient clinic of a hospital for women and children. Here, the character of the personnel of the class changed. Most of the patients were those with psychosomatic complaints, largely on a functional basis. A few of the members of the class of the extramural clinic attended, and it was found that these individuals who continued in the group were basically neurotic, and their hospitalization had been on the basis of either an acute psychotic episode or a personality disorder. These particular persons became assistants to the therapist in taking attendance, writing notes of the meetings, and similar tasks. At times, considerable resistance was encountered by patients in the acceptance of a non-organic basis of headaches, heart palpitations, backaches, gastro-intestinal ailments, etc. However, frequently one or the other patient would admit that she had "a nervous stomach," or "my head hurts when I get mad," or "my stomach gets tight when I'm afraid." Utilizing such expressions by class members, considerable interpretation was achieved over a period of a number of months.

Two points of great merit have been illustrated, that is, identification and spontaneity. Through identification, various patients are able to help each other, and accomplish more at times than they can through the therapist. Spontaneity is encouraged. In fact, except for a brief introductory remark, the entire subject of discussion for the class period is derived from material presented by the

patients themselves. Other problems came to the fore in this class, outstanding among which was sibling rivalry. Often strong accusations against the therapist of favoritism were voiced. These problems were vital to the particular individuals involved. In spite of heated discussions, the group unity remained; and, despite the wide variance in age, education, economic status, and the continually changing personality of this group, many of its members have made remarkable progress in the relief of their physical symptoms, and many have gone into their deeper problems.

Based on this brief resume of my experience with a class in group psychotherapy over a period of ten years—first in a mental hospital, then in a community clinic, also with undergraduate nurses on psychiatric duty, and finally with patients in an outpatient clinic in a hospital for women and children—it has been learned that all persons have emotional response to certain stimuli. Also, it has been emphasized that in a group psychotherapy class, everyone is there to learn more about his own emotions so as to be able to handle them more profitably in the particular life situation in which he finds himself. Although stated simply, attainment of this criterion is not simple. It includes the idea of attitudes and prejudices, which, in my opinion, are often stumbling blocks, not only in interpersonal relationships, but also in intergroup relationships in society. With this in mind, group psychotherapy now has an opportunity to help develop better attitudes and to break down the barriers of prejudice in so-called "normal groups." This use of group psychotherapy seems to be the trend of today and, we hope, the goal of tomorrow.*

*Paper presented at the meeting of the American Psychiatric Association, Round Table on Group Psychotherapy and Psychodrama, Atlantic City, May, 1952.

AN EVALUATION OF THE GROUP PSYCHOTHERAPIST'S ROLE IN THE THERAPEUTIC PROCESS*

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I

To begin, let us consider an illustration from a therapy group composed of six adults seeking help with their personal problems. This group met together with a psychotherapist for two hours once a week. In the group were a husband and wife, a recently married young woman, two men, University students, and a young single woman.

The illustrative incident concerns an interaction between the wife and the young married woman and occurred during the ninth meeting of the group. I'll refer to the wife as Mrs. John Brown and to the young married woman as Stella.

Mrs. John Brown had participated only occasionally in the discussions of the previous eight sessions. She had confined her infrequent comments to supportive and reassuring responses to her husband's exploration of his problems. Stella, on the other hand, participated vigorously and related to each member with little hesitation. Stella offered suggestions, made interpretations and related her own experience to others in an active effort to make the group a therapeutic success.

During this session, the ninth, Mr. Brown had contrasted himself with his wife and others of her sort, who feel they have no problems. He was especially puzzled by this attitude of his wife's since she had suffered some years ago from what he referred to as a "nervous breakdown." This led Mrs. Brown to speak for the first time about herself to the group. Very tentatively, she told the group of her feelings about this experience and how she now considered herself in relation to it. Her attitude toward her nervous breakdown was mainly one "Oh, yes, I was tired or fatigued at the time but it really wasn't anything—really nothing at all."

Stella apparently welcomed this opportunity to relate to Mrs. Brown and was pleased that Mrs. Brown's personal difficulties had finally been brought before the group. Stella, it seemed to the therapist, was literally diving in, full of good intentions, sincerity, and with a mission to explain Mrs. Brown to herself and to get Mrs. Brown to see her tendencies toward dependence and self-denial.

For the purposes of this paper I would like to focus our attention not on whether or not such a situation should have occurred, nor on how it should be

*Paper presented at the second Institute on Group Psychotherapy and Psychodrama of the Midwest Section of the American Society, Chicago, June 7, 1952.

handled, but rather I would like to focus on the feelings of the therapist. Through this I hope to come to a fuller understanding of the role of the psychotherapist in the therapeutic process.

II

The therapist felt anxious. This was a situation which struck him with its immediacy and its particular reality. The particular personalities and dynamics of this situation confronted him in such a way that no familiar schema did them justice and no clear and desirable action was predicated. Yes, this situation had elements in common with others in the therapist's experience, but even so, the therapist was confronted with the situation's *immediate, existential uniqueness*. No formulae for dealing with situations *like* this one seemed appropriate to this *particular* one.

The familiar categories into which the situation arranged itself involved concepts of an enthusiastic, momentarily insensitive person and a hesitant and vulnerable person. But this in no way accounted for the total reality of this unique situation involving the persons *Mrs. Brown* and *Stella*. When confronted with Mrs. Brown and Stella, not with the categories which abstract and partially represent them, I believe the individual human organism, in this case the psychotherapist, experiences tension or anxiety. Psychotherapy, it appears to me, is a process of new and concrete experiencing for the therapist as well as for the client. And the process of new and concrete experiencing confronts the human organism with tension or anxiety and also with an occasion of choice.

The process of new experiencing or the encounter with the full reality of the existential moment, is, I believe, crucial to an evaluation and understanding of therapy and of the psychotherapist's role. For us to really understand or appreciate the psychotherapist's role in a therapeutic interaction, I believe we must understand the process of new experiencing and its concomitants. Two concomitant phenomena of the process of new experiencing are an *experience of anxiety* or tension and an *occasion for choice.*

III

Anxiety, as I understand the phenomena, is present in man as a natural concomitant of the new reality which continually confronts him. I cannot with serious consideration believe that anxiety or decision-making are things the therapist with training or experience does or should out-grow. Psychotherapy is not like a golf-swing, because the ball is never in the same place twice. The behavior of the psychotherapist never becomes that much part of his organism that he can be mechanical about it, and I suspect this is also true of a good golf player. To different degrees, perhaps, both must be acutely sensitive to the unique reality of the immediate situation.

There are some situations in which the occasion of choice is confronted in a very explicit, deliberate or conscious way. Other situations seem easy to the organism, and are confronted primarily with the total organism and only secondarily with the intellect. On the other hand, situations, perhaps, like the incident with Mrs. Brown and Stella, are difficult and decision-making is confronted deliberately or self-consciously. Anxiety may be mobilized in such a situation. But in other situations choice is implicit and action seems to follow almost as a matter of course. These are situations of less consciously perceived anxiety. But both situations are occasions of choosing and experiences of tension or anxiety at some level.

Let us consider another brief illustrative situation. Early in the first session of a new therapy group, a member leans forward and directs himself to the therapist, "We have no experience in this sort of thing; I was hoping that you would sort of show us what to do here." Actually the therapist, here, too, is confronted with a new situation—it is a particular person, a particular group and a particular moment. The fact that it may strike a familiar cord to many group therapists and consequently mobilizes little anxiety may distinguish it from the first illustration. But nevertheless, both illustrative situations exist as unique and concrete in their full existential reality. Both confront the individual organism with concomitant experiences of anxiety or tension and with occasions of choice.

In this illustration of the young man, the therapist may perceive the situation as a request of the group member for expert leadership. On the other hand, another therapist might perceive this situation as an insecure male's attempt to ingratiate himself with the authority figure in the group. Either perception and either structure for the experience might be a denial at the moment of the full existential reality. It is not simply a question of which therapists' perception was more valid or which conceptual structure was more appropriate to the reality. As I understand the requirements of the therapeutic process, it is a question of openness to the unique and immediate existential reality. Either situation may be perceived through familiar categories to the exclusion of their full existential reality. Either situation, on the other hand, may be perceived with openness to the full integrity of the moment.

We have characterized encounters with existential reality, as involving concomitant anxiety. In fact we have considered that an encounter with the full particularity of the existential moment involves acute anxiety. The interaction with Mrs. Brown and Stella serves as an example. Other encounters with the existential reality will often be attended to by an internalized wisdom and accumulated know-how of the individual organism—one just seems to act ap-

propriately without consternation, deliberation, or nail biting. We have also distinguished between a ritualistic or rigid adoption of either mode of encounter and an actually living and creative encounter in which the organism fully confronts the integrity of the existential reality.

I do not mean to recommend one mode of encounter with existential reality in preference to another. The deliberate and intellectual or self-conscious encounter may be an appropriate and creative response to some situations and not necessarily a symptom of an anxious and insecure personality. Likewise another mode of encounter which may be characterized by its ease or by its lack of intellectualizing may be in some situations the repression of anxiety or resistance to facing difficult situations. The important thing is the integrity to the full and concrete experiential reality.

IV

I believe this integrity to the existential reality involves more than structural flexibility or conceptual appropriateness. Adequate structures within which to arrange the elements of our new experience are doubtless important and helpful to the human organism's security. It seems to me that in anticipation of a really disturbing encounter with the existential reality, the organism perfects or prepares itself. And in our current state of cultural anxiety, it seems to me, we are unusually fearful of an encounter with the existential reality. As I understand it, it is against the frequent occurences of such encounters which are likely to mobilize considerable anxiety, that we human beings intend by theory construction and the invention of procedures for decision-making, to secure ourselves.

I believe that much of our professional theorizing, analyzing and also our research may be understood as attempts to deal with the occasion of choice and its component of anxiety. Not only the individual therapist at the individual moment of his decision in the face of a new and disconcerting existential reality, but also professionally we seem to be engaged in a vast enterprise of structure-manufacturing. It is as though we human beings hoped to manufacture pre-fabricated conceptual or perceptual structures, techniques, of behaving, procedures of decision-making, etc., which we might then store up against the moment of our next encounter with the immediate and full reality of the existential moment.

Ready-made decisions and available structures within which we might arrange the elements of a dynamic experiencing of reality would make the role of the therapist an easy one. It would be Utopian if our decisions could be factory-made or science-engineered for us. Unfortunately, perhaps, it at least has been my experience that no procedures, no research findings and no theoretical

formulation serves to make decisions for me. Each occasion of choice, it seems to me, must be confronted in its subjectively full uniqueness as well as in its categorical familiarity. To confront dynamic experiencing of reality with a ready-made structure is to run the risk of experiencing the reality only partially. To confront the occasion of choice with a pre-fabricated decision in the hope that anxiety may be avoided is to run the risk of denying the integrity and particularity of reality. To perceive the new situation through the blinders of a theoretical construction or to take action in terms of a description of the "desirable" therapeutic behavior would be to lose for one's self the *impetus vital creativity*, the reality of the immediately unique.

But lest I be understood, let me again emphasize that I am recommending that psychotherapists as scientists stop seeking appropriate and differentiated structures or models for our experience. I am, however, reminding us that the *experiencing comes before the model* and that the scientific model is slave to the experience and *not vice versa.* Also I do not intend to recommend that we individually curtail conceptualizing and analyzing our experiences, but let us remember that *the experience, not the concept* is the *reality.*

The psychotherapist, perhaps more than many other human beings, is in a position to be acutely aware of his inability to imitate life or to manufacture creativity. I think this is so, because the psychotherapist is one, who, by the very character of his role, exposes himself to existential reality and to a process of new experiencing. And yet because he also experiences the concomitant anxiety, he is particularly tempted to try. His role is such that the psychotherapist is particularly vulnerable to a kind of placing of experience in categories—a placing of full existential reality is some old familiar straitjackets.

It is his encounter, however, with a fuller existential reality which motivates the psychotherapist to be both a *scientist*, in the sense that he must seek appropriate abstractions and valid conceptual models for existence and also an artist who must express an ever-new encounter with the concrete reality of existence itself.

A NOTE ON ROLE PLAYING IN AN INDUSTRIAL SETTING

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In a recent experience with a client I used role playing in a situation which was of great interest to me and may be of value for record.

First let's consider briefly the background of this problem. The client has a base of operations in Chicago and two manufacturing centers outside the city. (To avoid embarrassment, I will try to keep away from identifying locale or personnel).

At the Chicago base activities consist of selling, warehousing and distribution. At the manufacturing sites which we shall identify as Largeville and Smallville, several variations of a basic product are fabricated.

Largeville identifies the larger of the two manufacturing facilities not only in terms of size of plant but also number of personnel and long years of experience in the field. Smallville identifies the second and smaller of the two manufacturing operations, which has been in production about a year.

The people we are concerned with at the Largeville plant are the president of the manufacturing plant at Largeville, whom we shall call Mike, and the works manager, whom we shall call Kurt. At the smaller operation in Smallville, we are concerned with the plant manager, whom we shall call Paul.

In a meeting at Chicago the following people participated—The Big Boss of the organization, some of his associates in his office, and Mike from Largeville. The conversation seemed to center about criticism of Paul and the poor results of the Smallville operation. Some of the criticisms were—operations were continuing at a loss; erratic production problems at Smallville; apparent inability of Paul to keep production promises and schedules. Plainly, the inference was that Paul should be fired and a new plant manager installed at Smallville since the operation had been in this state for three or four months.

Shortly thereafter I visited the Largeville plant and the Smallville operation and had an opportunity to meet with Mike, Kurt and Paul and familiarize myself with their operations. Geographically, the Largeville and Smallville plants were only fifteen miles apart and it was understood that Mike and Kurt, with their longer experience and know-how, had undertaken to help Paul with the more recent plant as much as possible.

However, my conclusions were that Paul was suffering from a typical case of "by-pass-itis." In other words, it was becoming increasingly common for Kurt to visit the Smallville plant and give orders directly to production foremen on the floor, thus by-passing the plant manager, Paul. In addition, it was quite apparent that production scheduling and production goals were

being set up at Largeville without the active participation of Paul as to whether these goals were realistic or not. Then when Paul did not perform up to the schedules set up, he was criticized for poor results.

These are only some of the highlights of what I found and I believe give you a fair idea that the main difficulty was really a breakdown in communication and a lack of cooperation rather than poor supervision on the part of the plant manager, Paul, at Smallville. Having reached this conclusion, I was faced with the problem first of communicating this information to the men involved, and secondly, taking some steps which would have reasonable assurance of success, to change the behavior of the persons concerned.

I was in the position where time pressure was operating—I could only spend a few days on this assignment. Therefore, I had to make use of whatever opportunities presented themselves. This may explain in part why I first spoke of some of my conclusions to Mike. This took place one night at dinner when we were comfortably relaxed and after we had talked about some things of mutual interest and concern. As it happened, we were alone and it was not difficult to make the transition to my reactions to what I observed. As it happens, Mike, is, of course, the most prestigeful of the three at Largeville and Smallville and also happens to be the better educated of the three, with a degree in engineering, which made it easier to discuss the problem in familiar terms. Mike's reaction to my observations was that perhaps he and Kurt had been at fault in not supporting Paul but instead had directly and indirectly tended to hinder the improvement of that operation. It was quite apparent that our discussion had given him a lot of food for thought. At this point, however, I was faced with how to do something to implement a change in this setting. Although I felt strongly that the basic difficulty was the lack of team work between Paul and the liaison person or Kurt, I also felt that just a discussion alone would give little or no assurance that any change in attitude or behavior would take place. I also felt that it was necessary for the men to test the reality of my suggested solution to their problem. It seemed to me that an opportunity for reality testing was really the goal I had in mind and would offer some assurance that there would be a change in the amount of action taken.

Looking at it from this viewpoint, it seemed four role playing scenes were required. (1) The first scene: Kurt as Mike, and I as myself. The scene would be the discussion after dinner, as previously described. The content would consist of my analysis and observations as I had made them to Mike. (2) The second scene: Mike as Kurt and Kurt as Mike. In this scene it's the morning af-

ter the dinner previously described and Mike has called Kurt into his office to discuss the consultant's report and findings. (3) The third scene: Kurt as Paul and Paul as Kurt. This setting is in Paul's office at Smallville and Kurt has come over this afternoon to discuss the events of the morning and yesterday with Paul. (4) The fourth scene: Mike as the consultant and the consultant as Mike. This would be in the form of an evaluation session in Mike's office with Mike expressing some of the vague doubts and fears as to the continuing success of the results of what had taken place.

I have just given you the strategy which I worked out that night after having had dinner with Mike. The next morning we used Mike's private office at Largeville and we put on the first role playing scene as described. I asked Mike to act as an observer of the scene and to insure that no important points of my exposition of the previous night were forgotten. The role playing scene went off very smoothly and I could sense the drama of Kurt as Mike actually talking about himself as the person who had made such a poor contribution to the cooperative effort of the two plants. This went on for about twenty minutes when I cut the scene.

Then I explained to the two men that now the three of us had the same understanding of how I felt about the present situation. Now I suggested it was time for Mike and Kurt to take the next step. The next step was for Mike to do something as a result of the information now at hand, and reversing the roles, they went into the second role playing scene smoothly. The action consisted of Mike calling Kurt into his office the morning following our supper together to discuss what had taken place and arrive at some conclusions for action to be taken. The action in this scene also was quite dramatic and although I have seen this kind of thing many times, I was again impressed with how spontaneously the roles were played to the hilt.

The second role playing scene ended our mornings work.

I had arranged previously for Paul to join us about lunch time at Largeville and the four of us had a chance to warm up a bit to each other over some food.

After lunch we returned to Mike's office. I pointed out to the men that we now seemed to have a better understanding of the problem and what the action steps should be to reach the agreed upon production goal. But since the production goal concerned the Smallville operation, the question arose as to how relationship between the two plants was going to be improved. To test out the method I now set the scene in Paul's office at Smallville with Kurt as Paul and Paul as Kurt. The time was this afternoon and Kurt had come over to Smallville to discuss the events of this morning and yesterday with Paul. Mike and

I moved over against the wall to observe the action. This scene was really the most dramatic of all. Of course, it was also, in my opinion, the most important because I felt that the success of any future steps was completely dependent on an improved and better working relationship between Kurt and Paul.

I might disgress for a moment and tell you that Kurt is the younger of the two men and is physically a large man with considerable initiative and drive, based in part on long years of experience in the field. Paul, on the other hand, is older and tends to be a more compliant and reticent type of individual who simply does not talk and act as fast as Kurt. In a way, therefore, they are two opposite personalities but what was amazing to the observers was the way in which Paul as Kurt seemed to clothe himself in Kurt's typical kind of aggressiveness and manner. It was surprising to see Kurt's kind of reaction and mannerisms coming out of Paul. I felt strongly that a great deal of insight was gained by each of them into the other's role, personality and problems.

Now I would like to comment briefly about the fourth role playing scene. Perhaps it was for myself that I needed some kind of assurance that the things that had happened would continue to happen and grow in the same direction. I kept thinking about some evaluated judgment which ought to be made. And I felt the person who should make it would be that person who, more than any other, would be held accountable for results. Of course, this was Mike. Therefore, I suggested to the three men that if any criticism of results was to be made by the Chicago headquarters, it certainly would be directed to Mike and therefore he had more at stake in a way than either of the other two. Therefore, it seemed important to examine some of Mike's concern and worry about what had happened.

To do this I set the scene again in Mike's office and reversed roles with Mike. As Mike, I voiced some of the doubts and questions which I felt pertinent to what had happened. As a matter of fact, I tended to be somewhat hostile to the consultant but it was quite reassuring to have the consultant come back without any glowing promises but with statements which seemed to be backed with complete confidence and assurance that results were going to continue on a satisfactory basis.

Now I have discussed the four role playing scenes which took place in one day. You may be interested in hearing a bit of the aftermath.

The role playing scenes took place on a Friday and I returned to Chicago on the week-end. On Monday I reported to top management in Chicago. During the report I casually asked the liaison person in Chicago if he had noted anything of significance with regard to Paul, with whom he talked daily. It was gratifying to hear that he had talked to Paul that morning and felt strongly

that he was talking to a completely new personality—a plant manager who spoke confidently about information which he seemed to have at his fingertips. More important, the liaison person reported that instead of the usual reaction of promises from Paul, he was surprised to hear Paul reserve judgment as to a special delivery requirement, with a promise to advise when he had more accurate data. This whole conversation with Paul was so different that the liaison person wondered what had happened at Smallville.

For myself, I feel that role playing was put to very effective use in bringing better understanding and deeper insight to inter-personal relations. From a consulting standpoint, I know of no other method which could have accomplished so much in so little time. This is another example of how important this approach can be to the solution of management problems.

GROUP ANALYSIS AS AN ADJUNCT TO LONG LASTING PSYCHOANALYSIS

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In this experimental stage of group psychotherapy like in early years of psychoanalysis research cannot be based on statistics. Single cases of groups in treatment are of value. In reporting on highly selected cases in private practice the speaker could not expect statistical figures in many years to come.

This report will refer to two groups of neurotics in private practice consisting of 5-6 patients each, of both sexes, and selected according to three principles: 1) similar diagnosis (one group consisting of cases of chronic anxiety neurosis, the other of character neurosis); 2) individual analysis lasting from 2-5 years although at a rate of only three to one sessions per week; 3) a phase of stagnation and lack of productivity in treatment since a few months associated in most cases with stagnation and even regression in their mode of life. Most cases had been in addition to it treated previously for various periods of time by other analysts. One case in each group was purposely chosen among patients who did not stagnate at the time.

I will bring the therapeutic conclusions first. The introduction of infrequent sessions of group analysis at the rate of two and sometimes even one per month in addition to the otherwise unchanged individual analysis proved to be of great value in overcoming the resistant unproductive stage of the analytic process. In no instance was this process disturbed or damaged by the introduction of group sessions. It is obvious that this will partly depend on the right preparation of the patient as well as analyst and the proper selection of cases. It was, for instance, necessary to use special tricks in order to avoid meeting of patients who might know each other socially.

Here I shall report on the group which I classified as character neuroses. With one exception they were not pure cases but had also various symptoms: obsessive thinking, compulsive behavior, attacks of anxiety occasionally, depersonalization, impotency and multiple tics. They have had between 300 and 500 sessions each with me alone with the exception of one who has had only 150 sessions. The group analysis followed largely the method described by Alexander Wolf, with certain modifications. Thus the patient was instructed that group sessions will be a minor adjuvant only to individual analysis not for the purpose of socialization or improvement of interpersonal relations but for the purpose mainly of gaining new material for individual analysis and new insights by observing others and the patient's own emotional reactions to persons, situations and subjects discussed. It was mentioned that a group of that sort, highly analyzed and permissive, is not representative of groups outside. As one

patient, extremely frustrated in his interpersonal relations, expressed it: "Why, this is no group at all; this is nothing!"

At the same time is was stressed that the analyst does not expect, however, the patients to follow strictly any rules at all and the analyst did not interfere with the further developments. Thus the usual cross-currents of changing emotional rapports and transferences (this distinction is important) could be always observed in this group like in other kinds of groups. The sociogram (Moreno) of such a group shows a kaleidoscopical picture of changing projections and transferences. It is just the somewhat indefinite character of the group, following the motto "every man for himself," that lends itself to such projections like an empty canvas. Some of these phenomena were analyzed by the patient himself or his partners on the spot, others became the subject of analysis in individual therapy. However, the subject of group analysis was not pressed in the individual sessions to the disadvantage of other material. Some patients rarely referred to it at all. However, even in these cases the influence of the group experiences was clearly discernible. It showed itself in shaken resistances, revised insights and infantile images, shifts of interest, new reality testing, etc. Sometimes the analyst referred to group experiences as a good illustration to what the patient was saying. Only time can tell whether a more aggressive and courageous use of this material might not yield even better results.

In our group therapy like in others we are dealing with something novel and long desired by the psychotherapist: here the physician does not use just the patients views of events which are so often nothing but a better kind of screen-memories. He steps down with the patient directly into life and becomes a witness to the events, a development mostly welcomed by the patient.

In our groups there is another witness: the recording machine. This is being used for therapeutic purposes in three ways: a patient at his own or the analysts suggestion would listen to a whole group sessions once more in order to relive it, to check on his impressions of others or his own actual behavior; the patient may catch up with a session he missed; the analyst can supervise his own behavior and analyze it, if necessary.

I have not decided yet whether to give in to the frequent desire of the patients for more group sessions. The results in this group were impressive: the one patient who has not been in a period of stagnation could quickly terminate the analysis; four others broke the deadlock and became very productive; the one patient who has not responded was a patient who for external reasons could come for analysis only once a week.

The individual analysis in these patients made extensive use of dream ma-

terial and also of day dreams. They frequently were dealing with the group especially in those patients who had problems with groups in life. A few examples may illustrate this.

In Anna's case three dreams show successive stages of her groping with her problems. Anna, a social worker, is considerably hampered by her complexes pertaining to speaking in groups of people. In the course of group therapy this turned out to be to a great extent a transference of many years of daily experiences at the dinner table highlighting her entire situation at home: her mother, a rejecting figure, was engaged all the time in a lively conversation with her brother about personal matters while Anna would purposely never open her mouth, convinced that no one could possibly be interested in what she had to say. In her first dream she was seated during a banquet with a group of elderly ladies while all her friends were at another table. When she tried to move over to their table she was stopped by a waiter who said that this table is reserved for important people only. In a later dream she is in a group of boys only in the analysts office. One boy cries and the analyst takes him on his lap and kisses him. Anna is surprised and envious; she feels left out. However, in the next sequence she is alone with the analyst, he takes her on his lap, kisses her and she likes it very much but in this moment her mother appears angry and with a black face. In a later dream she is again in the analysts office. The analyst takes another patient while she is still there. She is slightly annoyed. The analyst conducts an art class. There is a discussion on what is "subjective." She wants to be helpful and suggests that four oil paintings should be given to those who have none. The analyst says that Anna gets none because she already has a drawing. She thinks: "despite the fact that this is just I still feel cheated."

Sam is a patient who suffers from impotency and is struggling with tremendous sex taboos. He dreams of a party during which a woman is telling a joke and groping for a word. He promptly supplies the word "shitless!" Everybody laughs gaily but his brother and a few other people are slightly shocked. The next sequence of the dream was a flash-back to the twelfth year of age and yielded an important withheld sex memory.

Ted was an extremely rigid personality whose neurotic system since his third year of age centered around repressing love in order to remain independent. He recalls a dream about a human figure made up of a swarm of bees which is trying to pull him into her mouth in order to destroy him. This seems like a perfect image of transference of a parental figure to entire groups.

In my experience the following dynamic factors seemed to be outstanding and mostly responsible for the result achieved: 1) better realization of the patient's own resistance by direct observation (in part stimulated by the example

of the partners) or indirectly by diagnosing the resistance in others; 2) better insight into the process of transference and projection into the partners by watching their changing image; 3) understanding of the personal and specific structure of transference in the individual patient; thus in all five cases who "stagnated" it turned out that withholding of the love from parents as a solution of infantile conflicts accounted for their special difficulty in treatment thus creating not a negative transference but rather a "non-transference" form of transference. As one patient put it jokingly: "Doctor, I love you but I have no transference to you." Another patient said in referring to the group: "I have contempt for people who have transference; they are weak;" 4) listening to the discussion of the parental omnipotence in other patients contributed greatly to the working through of that factor to the advantage of independence and freedom from guilt; there was frequently a bewildered feeling as to the alleged omnipotence of the other patients' parents which was in the long run undermining the omnipotent image of one's own parents; 5) sooner or later the *subject of normalcy* came up and spotlighted the fact that the patient was subconsciously striving for a quite different and more infantile goal of therapy than the analyst did; this was clearly demonstrated when the one patient discharged after achieving freedom from symptoms and great emotional maturity was unanimously declared as the most neurotic of the entire group; 6) the analyst could observe and where necessary analyze where and why he had overlooked certain things. The latter factor may be the most important. A certain enthusiasm about this is recognizable in a number of writings on group psychotherapy whether directly expressed or not. In the case of long lasting psychoanalysis this has a special significance. Oberndorf suggested that in cases of excessively long analysis the analyst should consult with other analysts, be supervised in a way, or that he may need additional personal analysis. Group analysis may well turn out to be an easy substitute for all this. If it fulfills the speakers hopes it may even lead to a revision of standards as to when or why an analysis is excessively long.*

*Paper presented at the meeting of the American Psychiatric Association, Round Table on Group Psychotherapy and Psychodrama, Atlantic City, May, 1952.

SOME ESSENTIALS IN GROUP PSYCHOTHERAPY

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Here tonight, at this Round Table, the various speakers have described a variety of methods used in group psychotherapy. It would seem to me that there is probably some common denominator in all of these approaches which is provocative of "cure." In my group work I have found it helpful to attempt to identify certain conditions or essential happenings between the therapist (myself) and the group members in order for therapy to proceed.

The goals in group psychotherapy may not differ from the goals in psychiatric therapy generally. Change in the personality of the group members (and therapist) is what is hoped for so that the individuals may grow, become freer and less compulsive.

The FIRST ESSENTIAL is to use the patient's own metaphor. His thoughts, his feelings and his actions as expressed by his total behavior must become known to him. His own words, his slang and his vernacular and later the groups' words, slang and vernacular are to be used.

Each patient has his own inner and inter-personal psychology. This is in terms of is dreams, fantasies, actions, thoughts and feelings. Our only clue to finding out about the patient is by using his own metaphor which is representative of him and all of his experiences in life.

The therapist must be cautious about using his words, his ideas, his concepts and foisting them upon the patients. The use by the group of the therapists' concepts further abstracts the patients' experiences and denudes these experiences of still more emotional tone.

The patients must become aware of themselves by knowing their own metaphor and then accept themselves. A person can feel secure, can feel loved, can become and be happy without any intellectual understanding of the process. A child does not have to be told that he is loved nor does a tree have to know that it is growing.

The SECOND ESSENTIAL is the realization that the role of the therapist differs from the role of the patients in the group. This is particularly true early in therapy, less true later in therapy.

Originally patients help each other by example, advice, suggestion and direction. The therapist, however, must analyze what the patient does in acting upon the example and seeking the advice, suggestion and direction of others. Also he must analyze what those are doing who give the example, advice, suggestion and direction. For instance in a group of mothers, one mother asks the others what to do when her eight year old girl suddenly and flatly

refuses to go to school. One mother says "spank her and drag her." Another states, "It is best not to pay any attention to it." A third maintains it is best to let her stay home, comfort her and she will outgrow the difficulty. Still another says to immediately confer with the school teacher and finally one suggests to get in touch with the pediatrician.

The group therapist is aware of this question, the anxiety within the asking mother and the emotional response of the other mothers. He keeps the question open and asks for the expression of more and more feelings. He does not answer the question for he does not *know* the answer. The therapist wants to know how the questioning mother felt in this situation at home when her daughter refused to go to school and how does she feel in the group in asking for advice. Is she always seeking answers from others? Does she feel that her husband and other children are defiant? Is she herself defiant or compliant in the group? What does the staying home of the little girl remind her of in her own childhood? Eventually it must be discovered whether her question is motivated to get attention, to obtain sympathy, to point out how abused she is or perhaps how helpless she is, etc. Also her feelings when the therapist does not answer her question must emerge.

In short, patients first help each other on the conscious and manifest levels and later on, on the unconscious and latent levels. The therapist, however, always helps on the unconscious and latent levels.

The THIRD ESSENTIAL in group psychotherapy, I believe, is the understanding, knowledge and indeed conviction, first on the part of the therapist and later by all the members of the group that the group experience is, per se, the most important experience in their lives. It is not contrived and it is not substitutive for faulty family influences. It is not established to give the members greater social ease nor to obtain for them other gratifications denied in life. Human beings needing help because of deep inner conflicts are grouped together to achieve human help. Help is only forthcoming when they within the group participate in both conflict and cooperation. An unconventional atmosphere in which all fantasies, dreams, personal thoughts and feelings about each other and the therapist emerge must be encouraged.

It is in this setting, free from cultural artifacts, that the therapist fully accepts the humaness of his patients and of himself. It is, I believe, in this situation and under these conditions that individuals gradually become aware of themselves and change.*

*Paper presented at the meeting of the American Psychiatric Association, Round Table on Group Psychotherapy and Psychodrama, Atlantic City, May, 1952.

PSYCHODRAMA IN PRIVATE PRACTICE

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In 1946, during the Annual Convention of the American Psychiatric Association, the writer had occasion to visit the Moreno Institute in New York City. There, for the first time, as one of the spectators, he observed a "public session" in Psychodrama. He was profoundly impressed with this type of psychotherapy and decided, there and then, to apply certain of the principles of this methodology in his own private practice.

Upon his return to Detroit, the first new patient appeared to be an appropriate case. Although the writer's office was not equipped for psychodramatic therapy in the classical manner as devised by Dr. J. L. Moreno, he, nevertheless, proceeded to do the best he could despite these limitations.

Mr. X., a 44-year old married male, came to the writer with a chief complaint of "writer's cramp" involving the right hand, of 15 months duration. During this period, he had various forms of therapy, including medical, osteopathic, and psychoanalytic therapy. None of these proved effective. The patient was incapacitated from doing his regular work and this concerned him severely. His wife was forced to return to her previous occupation of school teaching, but her income was inadequate and they were compelled to reduce their standard of living.

For the past 20 years, shortly after he graduated law school and passed his bar examination, he obtained a position as Court Clerk, and subsequently, became court reporter because of his high proficiency in stenographic work.

He described his boss, the Judge, as a dynamic, cheerful, jovial "extrovert" who had the reputation of having a "learned judicial mind—when sober." He stated that the Judge was frequently inebriated while on the bench and would call a recess in order to receive from the patient the "legal facts involved in the case." The rulings and adjudications of the Judge were often the direct verbalizations of the patient's own legal opinions, a fact—which at first—caused the patient to feel secretly proud and important.

As the years went by, the patient stated, the Judge gradually assumed an attitude of displeasure and contempt toward the patient. Whereas previously, the Judge would invite the patient and his wife to the former's home and country club, this "companionship" came to an end. The patient could not understand why, nor did he verbalize his feelings to the Judge or anyone else.

He recalled nothing emotionally traumatic during the 24-48 hours preceding the onset of the "cramp." He recalled no dreams or symptoms of disturbed sleep. He had no physical complaints or illness for the past several years

except an occasional mild cold, which subsided without medicinal treatment.

Fifteen months prior to his first consultation with the writer, the patient awoke one morning and discovered the three fingers on his right hand, the middle, ring and little fingers, to be continuously flexed in various degree. The little finger was flexed and in contiguity with the palmar surface of the hand with sufficient firmness to produce a mild blanching of the depressed palmar area. The ring finger was flexed so that the middle phalanx formed a plateau between the two other phalanges. The ring finger was slightly flexed to form an irregular "C." The thumb and index fingers were completely free and uninvolved.

During the first hour, while the patient was reviewing these experiences, he appeared calm, passive, relaxed, and verbalized without any overt affect of resentment or hostility. This first interview took place in the usual manner, in the consultation room. The writer was seated at his desk which was in the center of the room, and the patient was seated in a chair, beside the examiner.

For the next half hour, the examiner then proceeded to relate to the patient his recent experience at the Moreno Institute of Psychodrama, and then was asked if he would like to test the possible effectiveness of "psychodrama" in his particular problem. He cheerfully and readily assented.

The therapist then seated himself on the sofa as far away from the desk chair as possible, and the patient was invited to sit in the examiner's chair. The consultation room was large, 16' x 20,' and furnished in a decor that lent itself appropriately to the plot of the respective roles to be acted out. The patient was instructed to imitate the Judge's behavior on the bench and in chambers, and the examiner, portrayed by the patient, then began to "take notes" in the traditional stenographic notebook, and with a postural attitude of meek humbleness.

The patient, humorously and facetiously, began to imitate the Judge. The patient's quiet, passive, genial attitude gradually but quite perceptibly began to change. He rose from the chair. He paced the floor. He became tense. His voice deepened, and he became overtly enraged and hostile. He shook his finger threateningly at the examiner, referring to him as "J.W.", which was the Judge's usual way of referring to the patient. The patient's face turned livid with rage as he literally ranted and raved at the examiner (in the role of the patient). The patient, in the role of Judge, accused the examiner of "knowing too much," and of "having enough on me to hang me." The tension increased, the patient became dyspneic, and his violent verbiage became incoherent.

Suddenly the therapist interrupted this tirade and commanded the patient

to change roles. The patient readily assented. Taking his own role, he proceeded to denounce the Judge (therapist) with a coherent, profane, verbal excoriation. By this time he was pacing rapidly around the room, perspiring, swearing, seemingly ignoring the examiner, and gesticulating with both hands. He then spontaneously clenched his right fist, the one involving the cramped fingers, and struck the top of the desk with enough force to crack the glass top. After about five minutes of such an action release, he began to cry, vociferously, for having been such a "damn coward for having taken his gaff for so many years." He then sat down in the chair he originally sat in, sobbing quietly. The examiner said nothing, but continued to be pre-occupied with note taking.

The patient then arose and noticed that his "paralyzed" fingers were free, mobile, and relaxed. He immediately exclaimed, with delight—"My God! I'm cured!" He rushed to the telephone and called his wife. Shortly afterward she came to the office, and they left, his right arm embracing her shoulders.

The patient was instructed to return the following day. On his second interview, the hand was found to be in perfect condition. It has remained so since 1946. In his last interview in May, 1951, the patient stated that his relationship with the Judge had "radically changed." The Judge was kind and respectful of the patient. In fact, upon recommendation of the Judge, the patient was admitted as a partner to a professional court-reporting firm, and is now enjoying a successful career as boss of the staff of junior court reporters.

During the interviews following the post-psychodramatic shock experience, the patient's relationship with the Judge was the *only* subject for analysis and re-education. There was no psychogenetic penetration of his life experience extraneous to the immediate patient-Judge relationship. The usual physical examination, Rorschach, T. A. T., autobiography, narcoanalysis, etc., were not done, the patient previously agreeing to this *deliberate*, unorthodox, calculated plan.

The writer contacted the patient in December, 1952, and was informed that the patient was still symptom free and was now a member of the same country club to which the Judge, in the early days, brought the patient as his "guest and court-reporter."

ROLE PLAYING AS A METHOD OF ACADEMIC EDUCATION

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Translation by GERHARD SCHAUER, M.D.

For quite a number of semesters I have been employing, in the frame work of a seminar held with the sociologic division of Cologne Research Institute, what we have been calling "role playing," as suggested by J. L. Moreno*. The more presumptious designation "Sociodrama" we have dropped. The stimulation to these experiments we owe to Moreno's valuable and comprehensive innovations, of which we have already repeatedly reported. He has, since, developed his psychodrama and sociodrama into the "Theater of Spontaneity," together with his associates.

With these daring and broad organizations our more modest and intimate seminar activities can not be placed on the same level. But also in goals and application they are different in some respects, since Moreno is a physician, a psychiatrist. Like Freud, Moreno's primary goal is to heal; his dramatizations are therapeutic sessions. May the differences between him and Freud be considerable, as he likes to emphasize, and the therapeutic tasks transferred by Moreno into the inter-personal field, the medical direction of purpose has remained the same. This, of course, is true more of his Psychodrama, while Sociodrama, understandably and increasingly, uses presentations of inter-personal relations in addition to its psychiatric purposes, and with this establishes the step from therapy to sociology. In Psychodrama the personal relationship between two or three persons is considered and dealt with, for the purpose of combating neuroses, resentments and prejudices. For instance the relationship between a mother and a daughter may be dealt with, where the daughter may resent that the mother is opposed to her relationship to a certain young man. Now this family relation between the two generations is enacted in dialogue form, so that the daughter plays the role of the mother and gives her reasoning, while the director enacts the role of the daughter. The purpose of this procedure is to induce the daughter to better become acquainted with the reasoning of the mother and to learn to understand her.

In sociodrama we deal mostly with ideas of reform, that is with a form of social therapy.

For us, who are exclusively sociologists, the contention of treatment of psychic damages or deficiencies is out of the question; all we wish to do in role playing is to illustrate, objectify and, possibly, also explain in post-enactment discussions, what takes place in social life. If in this process a catharsis occurs,

*J. L. Moreno, The Concept of Sociodrama, Sociometry, Vol. VI, 1943.
See also, Claude C. Bowman. Role-playing and the Development of Insight, Social Forces, Vol. 28, No. 2.

so much the better; however this is not part of our program.

The didactic and pedagogic purpose which is pursued in role playing, deserves attention in still other respects. I see in role playing a new academic instrument of education, which, in certain subjects, can be successfully set side by side with our more familiar lectures and seminars. I would like to distinguish three educational procedures: 1) the lecture, 2) the seminar, 3) role playing. It was great progress when, in addition to the old and honorable lectures during which only the instructor spoke and the students listened (or not), the "exercises" (seminars) were introduced, during which the audience was called upon to active participation and collaboration through expression of differences of opinion. Now there were questions, answers, cross discussions and concluding summaries with formulation of certain positive and negative results. These two educational methods will have to remain always the backbone of academic education; but in the sciences of man they need to be supplemented by role playing. Now the students do not only listen to the lecturer and participate in seminars, but they will also present by enactment. In the two other procedures the danger exists that, what is communicated remains empty words, that too little enters into the experience of the "auditor" (Horer) and is carried along purely by rote, as a burden to the mind, and is dropped when not needed anymore. This can not be else, because all these verbal presentations are organized around definitions. This is not meant to be criticism; I myself belong to those old-fashioned teachers who consider definitions as central in their lectures. But they are dangerous. They are often dealt with as plays of logic and as abstractions, which are remote from life as it is lived. I am never sure, in my attempts at a formulation, for instance, of competition or exploitation or imitation, whether the greater part of my students who copy down these magic words, so useful for examinations, really understands all that is meant to be said, and that is not meant to be said. But now let us have these students present competition or any other social process in enactment, where they are called upon to active experience! Now no memorizing or parroting will help anymore. The student must understand his subject matter and, to a certain extent, he must have experienced it.

True, this reproduction consists only of dialogues, discussions or general conversations (sometimes a confused noise making). Gestures and mimic expressions help along; only in specially talented students something akin to the professional actor's presentations is achieved. However it is not at all intended to make actors out of students of sociology. Nor do we wish to induce "pity and fear" in the spectator (at least not in every case), by a very moving play. (In some young people the temptation is greater to earn applause by being

comical).

But let us remember that sociology has as its task the exploration of the effect of man upon man (or of group upon group). This effect takes place in actions; these again assume mostly the form of verbal communication, and are therefore capable of presentation. The possibility of presenting its subject matter, sociology shares with some of the other branches of social science and of psychology. But this is true only with these disciplines as long as their subject matters are concerned with inter-personal relations, that is, as long as they deal with a sociological problem. It is true that even a phenomenon of depth psychology can be enacted, where the unconscious in its relation to other persons is presented; or in a seminar on criminal law, the course of a criminal action can be demonstrated. This means however always that social processes are shown, and, thus, a sociologic procedure is employed.

Our role playing is not playing theater where memorized roles are presented; nothing is prepared and no cues are given. Always we deal with improvisations, where only a theme is given beforehand, some of the problems related to this then may have been discussed. Only a few remarks between the actors are required before the play; these are concerned with the distribution of roles and the immediate course of the play. But surprises are almost inevitable, because of the unexpected turns of the play that may be brought about by an unexpected word of one of the participants.

An essential part of such seminar presentations is the general critical discussion which follows the play. Questions under discussion are: How much of the original problem was covered by the presentation? How could it have been done different? What clarification has been achieved? What has remained unclarified?

Certainly much is imperfect in role playing. Often it becomes apparent that the necessary life experience is missing in the young actor. A less important obstacle is timidity and aversion against self exposure. This may be due to ethnic differences. (Those students coming from the Rhineland where the Karneval is celebrated intensively, show more inclination and talent to come out of themselves than people from Westfalia or Pomerania). Female students are often at first more inhibited than their male colleagues. But we could observe also, like Moreno's group, that the initial reserve is overcome in the course of the play, and the enjoyment of communication radiates from one person to the other.

Still, much remains often quite superficial. Frequently human nature is not revealed as enough individualized; stereotypes are abundant—just like in everyday life, where the relation between man and man, as a rule, remains fixed by

conventional superficiality. Here, the seminar director must open perspectives that would otherwise remain closed, either by his personal participation in the play or by an intensification of the ensuing discussion. However I could observe again and again that many protagonists offered much more than was expected of them, and than they had been in a position to give in a strenuous examination.

It is not at all required to strive for perfect performances that can not be improved anymore. The aim is presence of mind and alertness in an emergency. But more important than these facilities is the incentive to get better acquainted with the complicated connections of inter-personal life and, so, to learn to enjoy intellectual work. Role playing never bores; rather does it have a modestly sensational element. The atmosphere of a stuffy class room is missing. It is activity, action, group life. There is no cathedra pulpit and no school bench.

It may be of interest to learn what subjects we have dealt with in recent years. Our enactments can be—in retrospect—divided into four groups: 1) *Attempts to reproduce a progressing development from scene to scene.* Here, the (unattainable) example is the stage drama in several acts. It is concerned with five, six or more scenes, in which more than three "actors" are involved, where main and auxiliary actors participate, but the group as a whole is not involved. 2) The presentation of only one or a few independent scenes with two or three persons. Here the dialogue, the conversation between two, is preponderant. 3) A special form that branches off from the second kind, is the presentation of opposed types in dialogue form (e.g. father and son, mother and daughter, businessman and artist, housewife and professional woman, etc.) 4) That, what we have called "Raetselspiel" (charade): Two or more persons enter a conversation and exchange their divergent opinions about a current question. The audience then has to identify occupation, class, party, etc. of the presented persons.

To the first category belong, among others, the following plays: a) Development and course of a social and governmental order of a group of shipwrecked persons on an island (in eleven scenes). b) Social rise of a young man from a degraded family to an honorable position in the community, with the help of humanitarian friends, and c) (in contrast) the social and moral downfall of a person of weak character under the influence of a degrading environment. d) Change of fortune in a landowner's family under the influence of political change (after a chapter of Stepun's autobiography). e) Rumor and gossip in a small town (slander of a disliked mayor). f) Fateful misunderstandings in an underground movement. g) Home and abroad (emigrant be-

fore leaving his homeland, on the ocean liner, after settlement). h) Life with a band of smugglers.

To the second category belong: a) Experiences during hoarding. b) Rivalry of leaders in the Wandervogel (Youth mouvement), (After Howard Becker's "Vom Barette schwankt die Feder"). c) Growing bureaucracy. d) Competion among actors. e) Preparation of a strike. f) Detection of a woman spy. g) Conversations on trains.

As examples for the enactment of opposed types can be cited: a) Discussion of the choice of occupation of a young man, between father and teacher, father and mother. b) Laymen discuss atom bomb and war danger, etc.

It was always of importance to give an idea of the richness of interpersonal relations; but not less important, to order the drama theoretically into sociologic categories during the discussion following the enactment; also, to comprehend the polarity which operates between behavior and situation, and to identify the forces of motivation operating in the observed and experienced behavior. Our work program included the distinction by contrasting social and personal "I," categorical and sympathetic relationships, sociable and solitary character types, genuine and impersonal relationships, group formation and group dissolution.

ON THE IRRELEVANCE OF GROUP PSYCHOTHERAPY IN MASS CONFLICT*

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I would like to take this opportunity to deplore the increasing application of psychiatric concepts to larger national and international relations. In some respects psychiatrists extend their interests to these immense social problems with the best intentions. We see all about us confused and troubled people and try to apply the psychodynamic formulations of the consulting room to the whole complex world. Our good intentions cannot however conceal the irrelevance of our proposals. In other respects our suggestions betray a grandiosity that impresses the listener less with the validity of our vast therapeutic overtures than with the fact that we are ourselves diseased.

It was bad enough in recent years to hear our urgent recommendations that national and international conflicts could be avoided, if only political leaders, hell-bent for neurotic, personal aggrandizement, would submit to psychoanalytic treatment. But now, *group therapists* are out to save the world. We have either regressed to the point where we are reliving our infantile omnipotence or we have been deluded by the illusory insistence of our patients that we are, in fact, 'gods.' If it required any further demonstration of the failure in many instances of psychoanalysis to resolve social conflict, we need only examine our relationship to one another. I know of no group that is as torn with rivalry and dissension as psychiatric and psychoanalytic factions. We, who cannot get together, would promote group relations! We, who prescribe treatment for political leaders, have each our almighty devices for solving the world's ills. We are then not always the therapists. We too are tainted by the sick social process. We forget the dictum: "physician, heal thyself." Until we can demonstrate a capacity for better group relations within our own house, our counsels to larger segments of the body politic seem out of place.

But my objection to our treating the masses and its leaders is more fundamentally based on other grounds. I believe we are unscientifically extending the province of psychiatry to the categories of economics. The laws that govern organic chemistry do not necessarily apply to inorganic chemistry. And the formulations of organic interaction do not of necessity cover the principles that determine the chemistry of colloids. This is not to say that each science is unrelated to the next. They are. But a loose application of the laws governing one body of knowledge tends to obscure rather than clarify important details. In the same way the categories that explain the behavior of rats may

*Read at the Round Table Meeting on Group Psychotherapy and Psychodrama, May 10, 1951, at the 107th Annual Meeting of the American Psychiatric Association, Cincinnati, Ohio.

throw some *general* light on human psychodynamics. But *we* have a feature distinct from any lower animal—consciousness—which makes us so qualitatively unique in the animal kingdom, that an entirely different set of guiding laws determine our behavior. Therefore, an easy movement from the conduct of rats, or monkeys, to that of man is more often confusing than clarifying. In the same way a facile interpretation of the motivation of political leaders and the masses is downright silly when projected from the group psychotherapeutic treatment room.

This does not mean that I do not think Truman and MacArthur, the Pentagon generals and the President's Cabinet, should not be individually or group analyzed. They and we might all profit thereby. But such recommendations are impractical, impossible and will go unheeded anyway. They expose our own irrational aspirations. No doubt neurotic leaders and led would profit from psychotherapy. I am an individual and group analyst because I am scientifically convinced of the therapeutically socializing value of analysis. Let it be understood also that I know that psychotherapy would enable them to face and deal with realities that are obscured by destructive compulsion. I have no objection to everyone's getting psychotherapeutic help who needs it. But there are more urgent material and human needs than psychoanalysis, that are better met by non-psychotherapeutic methods. The laws that govern the denial and gratification of these needs are economic, not psychological. And the resolution of these problems will not be accomplished by applying our prescriptions. Our "recommendations" are erudite but irrelevant, emotional but misplaced, well-intentioned but unscientific. We are beating our breasts in vain. The material and emotional needs of humanity will be met on a national and world scale by non-psychiatric approaches. They will be and are being met by masses of people and political leaders who are increasingly aware of their real needs.

Let us not then in our enthusiasm for psychotherapy irrationally expand our effective roles. We now hold we can do more than treat the mere individual alone. We can treat groups of people. But taking on the whole world is maniacal and messianic, if not paranoid. I would like to suggest that in the category of economics, the economists and the laws of economics will dicate ways and means, rather than our proposals.

Finally, we experts in group relations, who would like to make the nation and society a harmonious and complementary whole, have assembled in congenial conclave. Let us see if any two of us can agree.

THE CONFLICT IN TELEVISION: PSYCHODRAMA, THE HOPE FOR THE LIVING ACTOR

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From the point of view of the legitimate stage, television seems to be the ultimate assault of the machine upon the stage of the living actor. Whether we view the new form in a practical or a theoretical light, the process which commenced with the invention of the motion picture appears to be complete; the actor is torn away from his audience and is a picture image upon a tube.

Yet this loss is only a repetition of the loss the actor experienced with the motion picture, and is only one factor in the total situation. For in one kind of television performance, the so-called "live" show, the actor has regained certain advantages. In the "live" show he usually has an immediate face-to-face audience, which in the larger studios may be of the same size as that in a legitimate theater. At the same time his immediate audience has been enormously extended through the machine, and he invades private homes by the million. There can be no direct interaction between the actor and this larger audience, so that the immediacy is not complete. But the *apparent* immediacy is strong. The viewer is able to share the point of view of the studio audience, and the performer is able to interact with the studio audience as if it were the total. Although he cannot *see* his total audience, he knows that they are there in the moment of his production, and this knowledge stimulates both actor and viewer.

However, these strong factors do not operate in the other kind of television . . . . the kinescope show. For this is nothing but a repetition of the movie, with a further loss to the spectator. In the movie theater, the audience still exists as a large collective body, and has its audience reactions which contribute to the whole experience. But with present television movies,* the audience has gone home, broken up into twos and threes; perhaps there is not even an audience, but a single auditor. From the receiving end of the line, one cannot imagine an experience more utterly diluted in its theatricality.

The struggle to bring about television movie *theaters* is consequently not only an economic struggle on the part of the present movie-house operators and their allies—it is also a theatrical struggle on behalf of that collective audience which does not wish to be dispersed, but wants to share the experience collectively. But this is a difficult and complex question. For the present, television is beamed primarily toward the small receiving set.

*There is of course a valid technical distinction between kinescope (the film transcription of a studio performance or a public event) and the television movie (a film produced on a set or a location). But the end product is fundamentally the same thing: an entertainment commodity on film, in both cases subject to editing, cutting, recomposition, and all such forms of extra-temporal manipulation over which the actor cannot exercise control.

For the moment, then, our concern must be with the actor, and not the audience. Even with "live" television, an auditor can isolate himself and refuse to share the experience with his fellows, or perhaps his fellows will refuse to share it with him. But the knowledge of some kind of collective presence, even one composed of isolated individuals, helps to activate the performer.

Those who regard the legitimate stage as the primary form of theatrical entertainment know the strength of this stimulation, whether they get it from a seat in the orchestra or a position on stage. It is the real magic of the theater . . . the feeling that it happens NOW, to US. It is a state toward which the actor constantly strives: to be as immediate, as much in the part in the moment, as it is possible for him to be. It is the force that occasionally turns the planned performance into the impromptu performance. It is the feeling which inspires the actor to new line-reading, business, and gesture, in the midst of the performance that has been totally rehearsed. Such moments make the actor a creator, rather than a mere interpreter, and the feeling for creation is the strongest feeling of any artist.

There is a name for this force which comes into play when the actor feels caught up by the moment. It is *spontaneity.*

It is impossible to discuss the full usage of spontaneity in brief. But the actor must have it to some degree, or he is no actor. With him, since he is what he is, spontaneity comes into its fullest play *only* in the presence of an audience. He may feel its force partially in some of his moments of preparation, but he is not a writer of novels, nor a scientist in a laboratory, who can gain his inspiration while isolated. The personality of the talented actor requires the audience for its fullest expression.

The motion picture in effect attempted to isolate him in a laboratory. But the motion picture, which in its production lacks audience, lacks sequence, and lacks the feeling of totality while it is being produced, operates to crush and kill the spontaneity of the actor. Moreover, he has lost control of the situation: everyone tells him what to do, even while he is doing it. The live actor is at least in control of the situation in the moment of production. The whereabouts of the director and the script-writer are of no importance at that time.

The live actor has rightly sensed the fact that television has given him his chance for a comeback. It is a real opportunity, in which the stake is great. Nothing less than the life of the living theater is at stake. The actor will fight for his life while there is breath in his body; not to do so would be suicide. The mechanical colossus of television, commanding vast resources in money and skill, is already blotting out huge segments of the other entertainment forms.

The radio and the motion picture are daily losing both actors and audience to television. As the industry expands it requires space, and as it centers in New York it takes over the capitol-buildings of the legitimate stage itself. The New York theaters are turning into television studios, and the old actors are in them in new roles.

All the old actors are returning to this new television theater. Vaudeville was supposed to be dead beyond recall, and suddenly it comes to life. Television is the happy hunting ground of every variety of theatrical virtuoso: the spontaneous comic, the mimic, the gagster, the songbird, the acrobat, the juggler, and dozens more. Old forms of radio and the theater are found; the quiz show, the variety show, the musical show. One thing is striking about all this new production: *the more spontaneous and impromptu the performance, the better it is liked by the audience.*

If this is the most powerful and popular kind of television performance, the question naturally arising is: How can we make the "live" show *wholly* spontaneous? At present we have but a few performers on the genius level, who apparently are able to be spontaneous at will for long periods of time. Examples are the great comedians and masters of ceremony. In order to move toward the spontaneous performance, we require techniques and methods which will proceed from the talent-level of the average performer, designed to arouse in him the fullest degree of spontaneity.

In the realm of the other theatrical arts, spontaneity already operates to a much greater degree than it does in the realm of the actor. We are all familiar with the spontaneous musician, and to a somewhat lesser degree with the spontaneous dancer. But the actor, who deals in the spoken word arising out of bodily action, is still by and large tied to a script which must be carefully rehearsed. Occasionally his spirit of the impromptu breaks through this tight pattern, and he improvises. But it is still improvisation within the script itself, a set pattern which controls and confines him.

On the other hand, the hot jazz musician requires but a slight stimulus, and he is off into the heights of on-the-spot creation. The stimulus may be only a rhythmic beat supplied by the drummer, or five or six notes supplied by the pianist. Sometimes the performance evolves from the pattern of a written song, but when it reaches its fullest expression the song itself, as a written, pre-determined thing, is left far behind. Similarly, the dancer may respond either to music or his own inner rhythms with certain dance configurations which are wholly new, even though they be composed of his skill in given "steps." At his height, he also *makes up* the steps.

How can the talented actor do this? Do his techniques exist, and is such

a dramatic art of the immediate moment possible? First of all, such an art has already been achieved. It originated over forty years ago with J. L. Moreno, founder and producer of Das Stegreiftheater (The Theater of Spontaneity) in Vienna. As an art form it was then somewhat in advance of its time. But the basic ideas originating in that theater have been carried over into such realms as psychology and sociology, where they have been refined by Dr. Moreno and others into simple and governable techniques. The theater, which is supposed to mirror life, can extend this accumulated theatrical and psycho-sociological knowledge into a new dimension.

What is the stimulus, or *starter,* for the actor spontaneous? He may have many stimuli, since he deals with the realm of interaction between man and his total environment. But the concrete realization of his imagery is first of all in terms of some kind of *situation,* whether the characters involved number one or one hundred. With the written play or sketch this situation is supplied by the playwright, who is a kind of actor-before-the-fact of actual production. The playwright also supplies dialogue and action, and either he or the director may supply movement: gesture, business . . . when and where to stand and sit . . . very little is left to the actor. Possibly even character interpretation is dictated to him.

As a first step, let us bring the playwright into the moment of production, as an actor. Let him suggest the characters and situation, perhaps play the leading character himself, and allow the whole cast to take it from there. But suppose the actors are not able to do so? They must have devices, specific operations, and these must to some extent be controlled, shaped and directed. The director comes back in a new role, as another actor. His function is not to force an interpretation on the actor, but to interact with him to obtain a release of the creative impulse. There can be many variations of function: playwright and director can of course be one person.

How does the director stimulate and channel the creative impulse? First, he commences from the suggestion of a situation, which can come from any source, perhaps the news of the day, and assigns roles to the dramatis personae. The action and dialogue commences, with the director standing ready to seize cues arising from the actors as to the developing course of action, to cut a scene if it lags, and to send in "rescue" players who are kept on the sidelines. There, from the vantage point of the momentary observer, they are in position to warm up to the situation being enacted. The director, like the athletic coach, does not put his whole squad on the field at once.*

* (For a more complete treatment of the functions of the director and the more technical aspects of spontaneous television production, see J. L. Moreno, Psychodrama, New York).

This is dialogue, the assumption of roles by the actors. But greater complexity is possible, and the techniques are ready to provoke and exploit that complexity. Some of these are the techniques of the *double*, the *mirror*, and the *role reversal*.

We are familiar with theatrical soliloquy, where the actor speaks his thoughts to the audience. The *double* technique is one of enlarged and extended soliloquy, in which two persons stand for one, holding a dialogue. Sometimes they agree, and sometimes disagree, as Hamlet argued with himself, fighting back and forth. But two people may be more dramatic than one. They interact with and stimulate each other, building a spontaneous interchange.

The *mirror* is another extension of the self. It is direct doubling in action, facial expression, and sound, such as laughter, sobbing, and inarticulate expression. It soon produces a tremendous dramatic effect, both upon the actors so engaged, and the spectator beholding the action.

The *role reversal* is dialogue with the parts interchanged. It is usually introduced when one character cannot adequately respond to the antagonist in the role being played. It facilitates the continuity of the drama by allowing the individual who is possessed of the greatest spontaneity at the moment to enact roles other than his own. It consequently increases the facility of those of less spontaneity, in that they can lay hold of the objective characterization they have just seen enacted by the opponent, and play it back to him. This avoids the necessity of a break for instruction to the actor on the nature of his role . . . the action continues uninterruptedly.

These are a few of the basic techniques of the spontaneous director. What of the role of the audience? Suppose that the situation which the playwright presents is of little interest to them? Then, it may be best to extract the departure point from the audience, to find the situations which are of greatest significance for the specific spectators at hand. This involves the audience, and gives them a chance to participate. Current programs reflect the tremendous desire of the spectator to participate.

Spontaneous acting performance, in combination with impromptu music and impromptu dance, suggests many possible forms with constantly expanding artistic horizons. But in order for it to operate with full strength, the situation must be kept as live as possible.

However, there are those who suggest the filming of even such limited impromptu performance as we now have, to be released over the air at any time. Some of this is being done already, but if all performances are thus released, television as a form will ultimately suffer, just as the radio has suffered from transcription. Deterioration is bound to result from the separation of the mo-

ment of production and the moment of reception. The separation will act as an enormous damper on the interest of the audience and the spontaneity of the performer.

Let us not be persuaded that the kinescope reproduction of a "live" show is the same thing as the show itself! It is not, any more than the kinescope of last week's football game is the same thing as a game viewed today. The immediacy, the urgency, the moment, have departed from such products. Neither the public nor the actor will be deceived. The public knows the difference between yesterday and today, and the actor is aware of the size of his new audience. He has tasted blood, and his throat is full of new power. He will not settle for anything less than the whole, and he wants it in the moment he is producing. He needs that feeling of urgency, the feeling that he must act before the moment escapes. If the audience is to be attracted, they must have the same feeling . . . that they may miss the moment. But a film? "What is urgent about a film? It can be taken or left alone. After all, they may run it again next week, or next year! What's the rush? What does it matter?" That is the audience speaking.

Now let the actor speak. What does he want? "I just want to be alive." A simple request, but a profound one. Playgoers will remember the heroine in Kaufman and Ferber's *Stage Door,* and her denunciation of the motion picture from the actor's point of view. It went something like this: "Oh, no, that's not acting . . . all life shut out, all human response shut out . . . they put it in a can, like Campbell's soup, and if you *die* the next day it doesn't matter. You don't even have to be *alive* to be in pictures!"

Let the actor live! Some time ago he was forced to sell his birthright for a mess of pottage. He had no choice but to accept money . . . a high economic status . . . in exchange for his artistic freedom, for the lowest *aesthetic* status he has ever known. Now he has partially revived, through television. Give him his chance to live again.

I speak here for the actor. The word I speak is a two-edged sword, a word of warning to the machine-idolater, and a word of hope to my fellow actors: It is only television itself that will suffer from the "canning" of a live performance, from taking the road of least resistance and turning the living creativity of the actor into a mere physical product, a commodity. For even if you persuade the actor, or force him to accept the idea that the filming of a live show is the same thing as the show itself, *he still wins!* The living actor will ultimately use and triumph over the dead machine. His new audience has also tasted blood. The huge American audience, separated for at least three decades from the actor by the motion picture, is experiencing his genius anew through

television. This audience is not yet wide-awake, but it is stirring. It prefers the show with an audience reaction to the show which is completely dead and momentless. It begins to feel itself at home again in the old role of the living audience.

In spite of itself, the machine must give the actor his studio audience. In the presence of that audience, armed with the knowledge of his art, in command of the situation, he will pulsate with creativity. However his larger audience be removed from that moment, they will feel his powerful attraction; they will be drawn to him as by a magnet.

Just as radio and television through their broadcasting of athletic events have *increased* rather than decreased the attendance at those games, so even the recorded live show will ultimately draw the mass audience to the living theater. They will thirst for the full experience. They will demand the real McCoy.

When they arrive they must find the same thing they saw on television: *spontaneity in production.* That is another question, a problem for the legitimate theater to solve. The theater has a house which must be put in order.

Psychodrama, which has developed the foregoing spontaneity techniques, is ready with its concrete forms and proposals to facilitate a new organization and direction of the theater. As it expands through the medium of television, in contact with the new mass audience, spontaneity theater will continue to develop its manifold techniques and forms. The stage, which has already benefited enormously from the work of Das Stegreiftheater and all that has come from it, will be still further enhanced. Television is the opportunity of the moment. Unlike the motion picture, it may allow the living actor to embrace it without crushing him in the process.

The machine theater, which took away the independent status of the actor with the motion picture, gives it back to him with television. Blessed be the name of the machine. The theater *is* immortal, so help us God!

SOME COMMENTS TO THE TRICHOTOMY, TELE-TRANSFERENCE-EMPATHY

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Empathy, as defined by Lipps*, is a "one-way" feeling into the private world of another ego and as such a psychological phenomenon; it satisfies the needs of the psychologist. But it does not take care of the "two-way" and multiple feeling into each other's private worlds of several individuals and the socioemotional structures resulting from them. This is, however, a process of greatest importance to sociologists and sociometrists. Parallel with this Freud** developed the concept of transference, which signifies the unconscious projection of fancied experiences upon the person of the physician. Whereas empathy tries to feel into something real, transference tries to feel into something unreal. Transference tries to satisfy the needs of the psychiatrist. It is an individual-centered, centrifugal phenomenon like empathy although with a psychopathological connotation.

This is the situation with which I was confronted when I tried to find a theoretical framework for my sociometric and psychodramatic discoveries. Neither transference nor empathy can explain in a satisfactory way the emergent cohesion of a social configuration or the "double" experience in a psychodramatic situation. First, because these represent two or multiple ways of interaction, second because they are seen as a social whole, not from a plane superior to them, from the point of view of one particular person A, B, or C, although they are included in it. It is a sociological phenomenon. I hypothecated therefore, that empathy and transference are "episodes" within a more elementary and more inclusive process, *tele*. This concept was constructed to satisfy the needs of the psychologist, the psychiatrist, the sociologist; I defined it as "An objective social process functioning with transference as a psychopathological outgrowth and empathy as esthetic outgrowth" and explained further "Developments in the tele process are Einfuehlung, empathy of an actor into his part—empathy is positive but the process of *reciprocation* does not enter into its meaning,"—and transference "The factor responsible for dissociation and disintegration in social groups." I defined tele as the factor responsible for the increased rate of interaction between members of a group, "for the increased mutuality of choices surpassing chance possibility."

If the psychologist insists that the factor responsible for all forms of "inter-personal sensitivity" is empathy or an empathic process, or if psychoanalysts dilute the concept of transference, as many psychoanalytically oriented group psychotherapists are doing, they are stretching the meaning of these con-

*Theodore Lipps, "Das Wissen von Fremden Ichen," Psychologische Untersuchungen, I, pp. 694, 1907.

**Sigmund Freud, "Vorlesungen zur Einfuehrung in die Psychoanalyse," Vienna, 1926.

cepts beyond recognition; they lose their original and generally accepted meaning. A good scientific term has its own profile. By such playing with words we lose two good concepts and ruin a third. Therefore, I offered a solution which preserved both concepts, transference and empathy in their original profiles and relate them logically to a larger concept, the *tele hypothesis.*

The part which empathy plays in the tele process in the course of sociometric testing can easily be explained; the testee will need some degree of Einfuehlung to judge who among the members of a group like him, dislike him or are indifferent towards him. This ability becomes particularly important in a modification of the sociometric test which I have called "sociometric self-rating." "He (the testee), should pretend that he is taking part in a sociometric test and choose or reject (the members of the group) according to preference and rank. He should make a guess what every one of these people feel towards him and what reasons they might have. The validity and reliability of data from sociometric self-rating can be determined by giving a group of individuals an open sociometric test, immediately after they have rated themselves."* In this sense the sociometric self-rating test is an empathy test.

It is more difficult to unravel the function of empathy in role playing and psychodramatic situations. I have pointed out the need for a wider concept when I first began to systematize the experimental approach to group formation in statu nascendi. "Es gibt Spieler, die durch eine geheime Korrespondenz miteinander verbunden sind. Sie haben eine Art Feingefuehl fuer die *gegenseitigen* inneren Vorgaenge, eine Gebaerde genuegt und oft brauchen sie einander nicht anzusehen. Sie sind fuer einander hellseherisch. Sie haben eine Verstaendigungsseele, eine mediale Verstaendigung."** "There are role players who are linked together by a secret bond. They have a sort of sensitivity for each other's *reciprocal* inner processes, a gesture suffices and frequently they do not have to look at one another. They are clairvoyant for one another. They have a special sense for communication, a medial understanding."**

It was Wallin*** who suggested that "the method of empathy seems to be one of the basic principles in the technique of psychodramatics," and later Cottrell**** recommended repeatedly a deeper study of the empathy problem. Just as the transference theory has proved insufficient to explain the phenomena of reality testing and social cohesion on the group level, the empathy theory is

*"Sociometry in Action," **Sociometry**, Vol. V, 1952, p. 301-302.
**"Das Stegreiftheater," 1923, p. 57; transl. "The Theatre of Spontaneity," Beacon House, 1945.
***See Wallin, in "The Prediction of Personal Adjustment," Paul Horst and Associates Social Science Research Council, 1941, p. 223-224.
****Leonard Cottrell, Jr., "Some Neglected Problems in Social Psychology," American Sociological Review, Dec., 1950.

incapable of explaining the phenomena of multiple reciprocity of feelings. It was the empirical test which aided me in the clarification of this riddle.

The "double situation" in psychodrama is a clinical technique in which the client is interacting with his double, portrayed by an alter (auxiliary) ego; it can also be used as an experimental design, it provides an observer with an excellent opportunity for the study of the interweaving of empathy and transference in the tele process. Certain facts stand out and have been identified by many observers.

A) There is "the feeling in" of the alter (auxiliary) ego into the patient. The alter ego (therapist or counselor) is the active, empathizing agent; the patient (client or subject) is the object. This process is empathy. It corresponds to the "guessing" of choice going out from A to B in the sociometric realm.

B) There is the "return feeling in" of the patient or client into the alter ego-therapist. It is part and parcel of every double situation.

(From a transcript)

Double: I'm unhappy, I should not have such terrible thoughts.

Patient: Yes, I have thoughts of ending my life; I cannot stop them.

Double: I couldn't stop them, but I will.

Patient: I will. I must forget him.

Such a return feeling can be called "retropathy." It corresponds, in the sociometric area, to the *response* from B to A in return for a choice or rejection.

C) But there is not always agreement between ego and patient. The empathic statements, true or untrue, of the alter ego, are often violently resented by the patient.

(From a transcript)

Double: I love that man.

Patient: Oh no, I don't love him. I hate him!

The challenging of the client is often a part of the technique to bring a feeling to crystalization. After a pause the client extends:

Patient: I loved him once, but now I hate him.

Because of this internal struggle it is useful to differentiate between "*positive*" and "*negative*" empathy just as we differentiate between positive and negative tele.

D) One of the most significant phases in the double drama is when the double and the client reach an almost complete unity of communication; in the acting out of feelings and thoughts, gestures, movements of the patient and alter ego complement each other as if they would originate in one and the same person. It is more than Einfuehlung from A to B or B into A; they have the

same sorrow and the same pain, or the same ecstasy or the same love. The distinction between double and client is gone; they share in a single "Erlebnis." This phenomenon may be called "omnipathy," a term coined by Max Scheler.*

In social situations the empathy from A to B and the retropathy from B to A happen simultaneously; the same movement from A to B has then a *double* meaning, it may be seen as empathy by A but as retropathy by B, it is a "circular" empathy.

E) The acting out of an experience *real* to the patient, especially to the psychotic, is for the alter (auxiliary) ego a play, a skill, an ability. The feeling of grief because of having lost her lover in an aircrash, or being fired from a job and without means of support, or hearing voices informing him of his wife's disloyalty and ordering him to act, etc. is often an internal and external reality to the patient. But it is unreal to the alter ego. This inequality of status produces profound conflicts; the behavior of the alter ego may appear artificial and contrived and upset the patient. The solution to this is frequently to have another patient as a double, one with similar psychotic experiences, if possible, a psychotic leader in the sociogram of the ward. The patient may trust and admire him, whereas he may distrust and resent a professional ego. Another solution to this conflict is openly to have the alter ego admit to the patient: Yes, it's so, I am acting the part, but it gives me an opportunity to understand you better. Or, finally, and often most effective, if the professional alter ego is able to transform himself, a skill, an intervention, becomes genuine love.

F) The patient feels himself into delusionary and hallucinated events and persons. This phenomenon has been called "autotele." The alter ego has to follow the patient in this difficult task.

G) The trichotomy tele-transference-empathy opens up great potentialities for development. "Emotional expansiveness is subjectible to training."**

"As a compass of interhuman relations it is primitive, but I believe that our intuition in this direction is trainable."***

H) Quantitative studies of the tele-transference-empathy complex have been on the way since 1937 but it is particularly in the monographs and papers of Zerka Toeman that the advances have been recorded.****

*Wesen und Formen der Sympathie, 1922.

**"Who Shall Survive?", p. 136.

***See "Sociometry in Action," op. cit., p. 302. See Tele charts in Sociometric Statistics of Social Configurations," **Sociometry**, Vol. I, p. 365.

****See "The Double Situation in Psychodrama," especially the chapter on the problem of validation, **Sociatry**, Vol. I, 1947, p. 446; "Clinical Psychodrama," **Sociometry**, Vol. 9, 1946; and Psychodrama Monograph No. 12, 1944, "Role Analysis and Audience Structure."

SOCIOMETRIC NETWORK ON AN ACUTE PSYCHIATRIC WARD*

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This study is an analysis of the spontaneous group structure of the female wards of the Boston Psychopathic Hospital as revealed by (a) patterns of positive choice (Moreno method) pervading the ward, and (b) observational data concerning interaction of all persons on the ward. The social organization of the ward at the time of this study seemed to be integrated around one patient whom we shall call Ruth Center. We observed the structure of the ward at its high period of organization, and after the discharge of Ruth to a convalescent ward, at its period of disintegration. We also studied social patterns on the convalescent ward shortly after Ruth was admitted there. Since this is one of the first studies of its kind, and since the tools employed were revealing of emotional patterns generally neglected by clinical perception, patterns which may have a direct bearing upon therapy, the observations are presented in some detail.

Methods of Study of Ward

I—*Sociometric Choice*

This method was first utilized by Moreno (1) for finding "tele" relationships. Tele was defined as a force of either attraction or repulsion between individuals. The importance of "tele" relationships lies in the fact that communication and authority rest in these informal channels, rather than in the more formal hierarchic structure of organizations. These patterns have been shown to exist in girls delinquent homes, (Jennings, 1937 (2)), American villages, (Lundberg, 1937 (3)), and air force units, (Jenkins, 1948 (4)). Jennings (1950) (5) has the most complete bibliography of usages that have been made of this technique. Sociometric analysis has only recently been expanded to include the study of personality patterns of the individuals making up the sociometric configuration.

In the sociometric interview, each patient was asked;**

(1) Have you heard about the patient picnics held here at the hospital?

(2) What do you think of these picnics?

(3) Which persons would you like to go with on these picnics? (If no answer was forthcoming to this question, it was sup-

*This research has been made possible under the auspices of a grant-in-aid by the American Nursing Association.

**There was no implication given that answers to the questions would direct any alteration of ward activities. This is generally the case in the use of the sociometric interview, as in Jennings (2), change of the girls' living quarters because of the interview results.

planted by the question, "Which persons would you spend most time with on this picnic?")

II—*Time Sampling of Ward Social Behavior (The Spot-Check)*

The "spot-check" consisted of periodic observations of social activity of all the patients on the ward. The method is a modification of the "spot-check" of Hyde and Kandler (7). The periods selected for observation, (thirteen observations each day) were those considered most valuable in following changes in ward activities. Activities of each patient were scored into the following categories:

(a) interaction or non-interaction
(b) affective content of interaction (positive, negative, or neutral affect)
(c) productivity on the ward, (ward work, recreational activity, or lack of production).

The only data from the "spot-check" used in this particular study was that of interaction or non-interaction. Interaction was defined as any behavior on the part of one individual which changed behavior of another individual.*

The following functions were then derived; (1) *ward interaction index*, defined as the ratio between the number of interactions and the number of observed patients; (2) *an individual interaction index*, defined as the ratio between the number of interactions of a given individual and the number of observations of this individual. Correlations between the interaction fluctuations of different patients on the ward, as well as between the ward and patients individually were also obtained.

Our data were then analyzed with respect to:

(1) the relationship of the leader, (defined as that person who received the greatest number of positive sociometric choices) to the acute ward, including:

(a) the relationship between the leader and her clique, defined as a group receiving a number of in-group sociometric choices greater than those directed to the out-group,**

(b) the relationship between the leader and the ward isolates, defined as those members of the ward who neither received nor gave choices,***

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*Murray (6) uses as a unit of interaction, " . . . the movement and words of the actor . . . and the reaction of the alter . . . " The movements and words of the actor as a single unit on our scoring; the reaction of the alter is a second unit.

**The formula for clique was as follows:

$$\frac{\text{number of choices to In Group (total N choices made)}}{\text{number of choices to Out Group (number persons} - 1)}$$

***Though there were more than four isolates on the ward, we felt it logical to use only those who had an opportunity for social contact, thus excluding the physically ill and the new admissions not yet oriented to the ward society.

(c) the relationship between the clique and the total ward, as well as between the isolates and the total ward,

(2) the effect upon the acute ward of the removal of the leader and her clique, and

(3) the effect of the leader upon the convalescent ward to where she was transferred.

SUBJECTS

The population on the acute and convalescent female wards of the Boston Psychopathic Hospital consisted of patients diagnosed schizophrenic, affective psychosis, psychoneurosis and psychopathic personality. Schizophrenic and affective disorders predominated. At the time of the study, there were 31 patients on the acute ward and 25 patients on the convalescent ward. There were no patients over 60 or under 16 years of age. Admissions and discharges averaged 2 to 3 patients per day. The average stay of patients in the hospital was approximately 80 days.

All the patients were under active treatment—either somatic therapy, psychotherapy or social therapy. The social therapy included games, dances, movies, television, amateur programs, beach parties and patient government. The question posed in the sociometric investigations concerning the identity of the patients preferred as picnic companions was a realistic one, for the study was carried on during the summer months when picnicking was an important social and recreational event.

It is beyond our scope to describe the clinical details of the patients under observation. Since the investigation was focused primarily around Ruth Center, who was the dominant figure on the ward, a brief clinical note of this patient is included.

Clinical Data Concerning Ruth Center

Ruth Center, a slender, attractive, married, white, 32-year-old female was admitted after a suicidal attempt. She was depressed upon entry, but regained composure shortly after admission. After clinical observation, she was diagnosed as psychopathic personality.

Ruth was the third of four siblings in a father-dominated family. Her father was financially secure, but lost everything in the market crash when Ruth was 13 years old. He was always penurious; he haggled with his wife over grocery expenses, and through harsh treatment of his children, produced in them considerable animosity, fear and resentment.

The loss of the family fortune was followed by a humiliating descent of the family on the social scale. The father lost his grip as family head, and the

children were forced to seek their own means of security.

Ruth's attempt to deal with the realities brought on by the family's social decline resulted in a series of psychopathic activities. At 17, she had a summer affair with the father of the girl whom she was tutoring, and from that time on, she adopted the pattern of seducing all her employers. She claimed no sexual gratification, stating that she merely wished to "satisfy" her companions. At 28, she married one of her employers, "Mr. Center," head of a music company, who had divorced his first wife in order to marry the patient. Before his marriage to Ruth, Mr. Center was primarily a social drinker; after marriage, he became an alcoholic, lost his job and he was eventually supported by Ruth's earnings. In keeping company with her husband in the bars and taverns which he frequented, Ruth herself became an excessive drinker. She developed new affairs with employers resulting in two abortions. Prior to her admission to Boston Psychopathic Hospital, Ruth twice attempted suicide, each attempt resulting in brief hospitalization.

These attempts occurred while under the influence of alcohol and appeared to be impulsive, ill-judged reactions to acute frustration.

Although superficially an attractive person, Ruth had no close friends at any time in her life and belonged to no organizations. In the hospital she responded readily, but cooly, to approaches of others. However, she rarely initiated interaction.

Results

(1) *Ruth Center's role on the ward.*

At the time of the observations, there were 31 patients on the acute ward. Ruth dominated the ward insofar as she was the central figure in the choice patterns as determined by the Moreno technique. Figure I shows the "direct connections" of Ruth with other ward members. We note that Ruth chose four patients, and was in turn chosen by eight patients, one of whom was a reciprocal choice.* In other words, there were 11 individuals to whom Ruth was closely connected. This represents 11 out of 30 patients (not counting Ruth herself) or 37% of the ward population directly related to Ruth. We shall see later that four of these individuals were members of Ruth's clique, two of whom chose Ruth, one chosen by Ruth and one a reciprocal choice.** During four months of observations made on this ward, great variations in cohesiveness were noted. The ward was most highly organized, however, at the time when Ruth was dominant (See indices of organization in Table VI).

*Any of four choices was included in this analysis and no evaluation of order of choice was made.

**It was of great interest that Ruth only reciprocated one choice. Two of her choices were of ward members who were near isolates. We were unable to obtain any direct evidence of Ruth's knowledge of her role as leader.

Figure II shows the "two-step connections" of Ruth Center. Five of the "one-step" or "direct connections" were in immediate relation to other individuals. The added relationships of the five "direct connections" involved a total of seven other patients in the ward. Figure II shows that each of three "direct connections" chose one other patient and two of these were chosen by two other patients. Adding together the one and two-step connections of Ruth on the acute ward, we note a total of 18 patients related either to Ruth or her close affiliates. This represents 60% of the ward population in close affective proximity to Ruth. If we consider three-stop connections, three more individuals would be involved (This is not shown by Fig. II). A total of 21 out of 30 or 70% would then be related to Ruth, leaving only nine patients out of Ruth's orbit. It is of interest that of these nine patients, five were either highly withdrawn as a result of schizophrenic maladjustment, or were at times in seclusion because of grossly anti-social behavior. Two others had been admitted on the interview day, and two were physically ill.

Potentially, Ruth could have extraordinary control over the ward social activities and atmosphere. (We believe that this dominance was not fully appreciated by the clinical psychiatrists). The relationship between Ruth Center's interaction rate and that of the ward, which will be discussed below, gives a clue as to the manner in which her potential dominance might have been exerted had the occasion arisen.

(2) *Relationship between number of choices made by patients and the number who chose Ruth.*

The patients were asked to name those whom they would choose as desired companions. They were limited to a maximum of four choices, but not all patients made four choices. Some made no choices, some made one, two or three choices. Table I shows the distribution of choices. It will be noted that eight patients made no choices. These were essentially the isolates or highly withdrawn people peripheral to ward activities. One patient made one choice, one patient two choices, eight patients three choices, and seven patients four choices. Of the eight patients who made the three choices, two chose Ruth, and of the seven patients making four choices, six chose Ruth. The choice of Ruth was far greater than would be expected by a chance distribution of choices of the ward population. It appeared to us that those patients who were in better contact, gave more choices and were also drawn into Ruth's orbit.

(3) *Relationship between the interaction rate of Ruth and her clique members and between Ruth and non-clique isolates.*

Table II shows a correlation between the fluctuations of interaction rates of Ruth Center and the four members of her clique. Interaction rates were

determined by the "spot-check procedure." (See section on methods). The number of observations and the days of observations are given in the table. The interaction rates of the clique members were close to that of Ruth. Correlations of .50, .78 and .60 were obtained for different clique members with Ruth. These are highly significant relationships.

Table III shows the correlation of the interaction rates of Ruth and four non-clique isolates. The isolates were randomly selected from those who had no relationship to Ruth, according to sociograms. We note that the correlation coefficients were .18, -.18, .39 and -.43, respectively. A slightly positive correlation (+.39) was obtained in the case of Mary and a somewhat negative correlation (-.43) in the case of Della. It would appear from these data that Della was more negatively disposed to the activities of Ruth and her cohorts than Mary. Clinically, Della was very negativistic, while Mary had only transient periods of interest in interaction with others.

A completely different social mood characterized Ruth and her clique as compared to non-clique members. The correlation between interaction rate of Ruth and her clique members was high despite considerable fluctuations in their absolute level of interaction. On the other hand, the fluctuation rates of non-clique members indicated that they were much more independent of each other.

(4) *Relationship between interaction rate of Ruth, her clique and the ward.*

Table IV gives an analysis of the relationship between each of the clique members and the ward interaction rate. The table indicates that for Ruth Center, who was observed a total of 167 times over 12 days, the correlation was .83. For Doris, Ona and Vera, her clique mates, the correlations with ward interaction were .69, .85 and .63, respectively. Data for clique member May were inadequate for statistical manipulation. Altogether, the correlation technique indicates a very high degree of interdependence between clique member interaction rate and general ward interaction rate.*

The hypothesis that reciprocal sociometric choices might be more highly correlated in their interaction rates than non-reciprocal choices was not borne out. In the case of the Vera-Ruth reciprocal relationship, the correlation was .50 compared to .78 for the Doris-Ruth interrelationship and .60 for the Ona-Ruth interrelationship—the latter two pairs being non-reciprocal.

(5) *Relationship between interaction rate of non-clique members and ward.*

Comparison of interaction of non-clique "isolates" and total ward interaction is shown in Table V. We note no consistent pattern of fluctuation. In

*The absolute interaction rates for the clique members were as follows: Ruth, .38, Doris, .30, Vera, .42, Ona, .37, May, .33.

the case of Mary, there was a slight positive relationship (+.26); in the case of Della, a definite negative relationship (-.48); Veda and Joan showed no essential correlation with total ward interaction.*

It would appear therefore that clique members were in harmony with ward overall interaction, whereas non-clique "isolates" were indeed deserving of that designation because of relative lack of relationship to ward interaction.

Figure III shows graphically the differences in day to day fluctuations of Ruth, the clique leader, and Veda, a typical isolate, in relation to total ward interaction rate. The graphic presentation points up the close relationship between Ruth and the total ward interaction rate, and the lack of relationship between Veda and the total ward interaction rate.

B. *Change in the pattern of ward activity following transfer of Ruth and two members of her clique from the ward.*

As has been noted, the organization of the ward during Ruth's stay was characterized by: (1) a centripetal pattern of attraction with Ruth as a center; (2) close correspondence between interaction rates of various clique members; and (3) close correspondence between clique member interaction rates and ward interaction rates. In order to throw light upon the effect of Ruth and the clique upon the ward, social interviews were made on the acute ward after Ruth and her colleagues were transferred to a convalescent ward. The observations were made six days after Ruth's transfer.

(Table VI gives data pertaining to the social and psychological climate in the acute ward both during and after the time that Ruth and her colleagues reigned as chosen persons). The number of "isolates" remained the same. Instead of 27 choices directed towards the leaders—defined as the five most chosen—only 16 choices were directed towards the leaders. The social cohesiveness of the ward was greatly reduced. When Ruth and her clique were on the ward, none of the ward members made choices to individuals outside the ward society. After Ruth and her satellites were transferred, there were eight choices made outside the ward society. When Ruth and her clique were regnant, there were no choices made by patients or personnel. After Ruth and her clique left the ward, six choices of personnel were made by patients.

The removal of the clique from the ward meant a dramatic change of ward organization and cohesion involving a less centralized organization, more centrifugal interest—that is, more choices away from patients and away from the ward.

*The absolute interaction rates for the isolates were as follows: Veda .10, Joan .09, Della .14, Mary .06.

C. *Ruth Center's role on the convalescent ward*

We were interested, not only in determining how the acute ward, which Ruth had just left, changed after transfer of this dominant personality, but also in studying the convalescent ward which Ruth now made her home, to see the influence of her personality on this new society. This particular investigation of the convalescent ward was carried out four days after Ruth entered that ward. In the new situation, Ruth tended to set up patterns similar to those which she had set up in the old situation, showing a consistency in her effect upon mentally ill patients, whether in the acute or convalescent stage. It should be noted that Ona remained on the acute ward and that Vera was discharged outright, so that at the time of observation on the convalescent ward, only May and Doris of Ruth's intimate circle remained. Our observations indicated that Ruth, after only four days on the convalescent ward, became the central figure again. She was most chosen, receiving six choices. She in turn chose four persons, two of whom were her original clique members. Two persons were reciprocal choices with Ruth. Figure 4 shows this relationship.

Considering both direct connections and two-stop connections on the convalescent ward, we note that the society was far more complicated than it was on the acute ward. There were relatively fewer "isolates" and several persons had already established themselves as key persons, rivalling Ruth's total grasp at this stage.

In only four days, however, the progress which Ruth had made was remarkable. Unfortunately, it was not possible to follow Ruth's progress on the convalescent ward for a longer period, for she was promptly transferred to an open ward and then discharged to the community.

Discussion

When the mentally ill patient, already in retreat from society, is thrust upon a psychopathic ward, he faces a social challenge somewhat akin to that of the community in which he has just failed to adjust. In a bewildering new physical setting, he may grope for a sense of order and stability and seek emotional security sometimes by tentative contacts with patients or personnel and *sometimes*—all too often—by withdrawal. The situation is confused by the constant shift of personalities, by the unusual functions of a treatment-oriented society, as well as by disrupting psychological tensions within the patient himself.

One important dimension of ward society is illuminated by patterns of affective relationships which spring up as a natural consequence of people living together. In this spontaneous and informal network the new patient receives a place. Problems of adaptation differ very greatly depending upon

whether the patient is in a central, a peripheral, or an isolated position. The same individual, admitted to a ward at a different time may meet a different social organization; during his period of residence on the ward, considerable social shiftings may occur because of new admissions and discharges, because of changes in social valance. The ward society is therefore a complex, intricate and dynamic structure with subtle and far reaching effects on the patients' mental life.

Although the physician is interested in total treatment of his patient, he currently emphasizes intra-personal dynamics to the relative neglect of interpersonal dynamics. Spontaneous groupings of the type revealed by sociometry can easily escape clinical notice. The groupings are not necessarily identical with the more formal groupings of patients in activities such as recreation and self-government. From individual psychotherapy alone the psychiatrist may be totally unaware of the social network on the ward, or the degree to which the network competes with him for strong relationship with the patient. The social group may strengthen or weaken his hand. Much of what transpires may be shared among patients and kept secret from the doctor; the necessary catharsis for psychotherapy often transpires in the group itself. Perhaps the mystery of spontaneous improvement or relapse of patients who rarely see the physician is to be found in these neglected relationships. It becomes necessary, therefore, to explore the needs fulfilled by these inter-relationships in order to ascertain the extent to which they help or interfere with the general medical program.

If the doctor's perception of these networks is inadequate is this also true for other personnel? The question is a fair one because ward care personnel—the nurses and attendants—are in intimate contact with patients during the largest part of each day, while the doctor's relationship is limited to remote administrative planning or to a few hours of direct psycho-therapeutic contact. In attempting to implement the doctors' orders, ward personnel repeatedly come up against the social organization—which they must handle. There is evidence to indicate that personnel are often acutely aware of these phenomena and their potentialities. When permitted to communicate freely with physicians they demonstrate a surprising amount of insight into ward social life.

The general problem of leader and clique dynamics is critical to our understanding of the contribution of ward organization to recovery or disease. We may hypothecate that the clique is a helpful influence when it furthers the hospital goal of better treatment for all. Under these circumstances, leaders and clique members might aid by allaying anxieties of new patients, by orient-

ing them to ward expectations, by calming excited individuals, smoothing the course of specific somatic therapies, reinforcing identification with the treatment team and contributing in an active and responsible way towards socialization. Obviously, the total effect of alignment with the purposes and goals of the hospital hierarchy depends upon the soundness of the treatment program already inaugurated. Since it is impossible for the hospital hierarchy to devine all the needs of the patients, a good clique, in addition to its loyalty to the hierarchy, helps through its additional insights into patients' moods. Ruth Center, for example, reached out for contact with isolates, lending a ready and non-critical ear to the complaints, and attempted to bring these patients into the group.

A "poor" clique, on the other hand, develops an in-group feeling with strong negative attitudes towards both personnel and other patients. Some such groups, led by aggressive paranoids express antagonism to the point of physical violence or may even direct aggression against themselves. Two instances have come under direct scrutiny where cliques in strong rebellion against authority have attempted group suicide. Leadership under aggressive psychopaths must be handled carefully, for the psychopath is relatively well-integrated, makes quick superficial relationships, and thus may form a dangerous anti-social focus. A type of benign psychopath, however, such as Ruth Center, may have a favorable effect. Here the prime interest seemed to be in narcissistic gratification. Her easy charm attracted other patients and no strong hostility was directed either against personnel or patients. Obviously, clinical diagnostic categories are not in themselves sufficient for prediction of social trends. Leadership as a social phenomenon must be studied on its own merits—if we are to control it.

Cliques form in hospitals as a manifestation of a gregarious tendency which has always been a means of promoting security. The ward is better even inadequately organized than completely disorganized and chaotic. The informal social network tends to structure the ward society and in this sense alone gives some element of order; however, the existence of organization has inherently threatening possibilities for patients. Some understanding of this is obtained when we study the changes following transfer of Ruth and some clique members to another ward. A less cohesive society took the place of the old, tightly-knit group, new patients moved into the limelight, and several patients who did not find the new situation entirely pleasing, shifted their interest to personnel or to individuals outside the ward. With new roles came new problems. Personnel were now in a position to accept bonds from patients

TABLE I

ATTRACTION TOWARD RUTH

Acute Ward

No. of Patients making Choices	No. of Choices Made	No. of Patients Choosing Ruth
7	4	6#
8	3	2*
1	2	0
1	1	0
8	0	0
Total 25**	-	8

* Significant at .05 level

\# Significant at .01 level

** Five patients were not psychologically integrated enough to give answers. There were thus really 31 patients on the ward.

TABLE II

CORRELATION BETWEEN FLUCTUATIONS OF INTERACTION RATE OF RUTH CENTER AND HER CLIQUE MEMBERS

Clique Members	No. of Observations	No. Days Observed	RHO
Doris	130	9	.78
Ona	95	7	.60
Vera	49	5	.50
May	-	3	*

* Inadequate Data

TABLE III
CORRELATION BETWEEN FLUCTUATIONS OF INTERACTION RATE OF RUTH CENTER AND NON-CLIQUE ISOLATES

Non-Clique Isolates	No. of Observations	No. Days Observed	RHO
Vida	167	12	.18
Joan	48	5	-.18
Mary	167	12	.39
Delia	95	8	-.43

TABLE IV
CORRELATION BETWEEN FLUCTUATIONS INTERACTION RATE OF CLIQUE MEMBERS AND TOTAL WARD

Patients In Clique	No. of Observations	No. Days Observed	RHO
Ruth	167	12	.83
Doris	121	10	.93
Ona	76	7	.85
Vera	58	6	.63
May	-	4	*

* Inadequate Data

TABLE V
CORRELATION BETWEEN FLUCTUATIONS INTERACTION PART OF NON-CLIQUE MEMBERS AND TOTAL WARD

Non-Clique Isolate	No. of Observations	No. Days Observed	RHO
Vida	176	13	.04
Joan	57	6	.13
Mary	176	13	.26
Della	76	9	-.48

TABLE VI

COMPARISON OF ACUTE WARD BEFORE AND AFTER TRANSFER OF RUTH AND CLIQUE MEMBERS

	Pre	Post
Number of Isolates	7	7
Numbers of Choices of Leaders	27	16*
Number of Outgroup Choices	0	8
Number of Choices of Personnel	0	6

* Significant at .01 Level ('T' Test for Small Samples)

TABLE VII

ATTRACTION TOWARD RUTH

Convalescent Ward
Convalescent

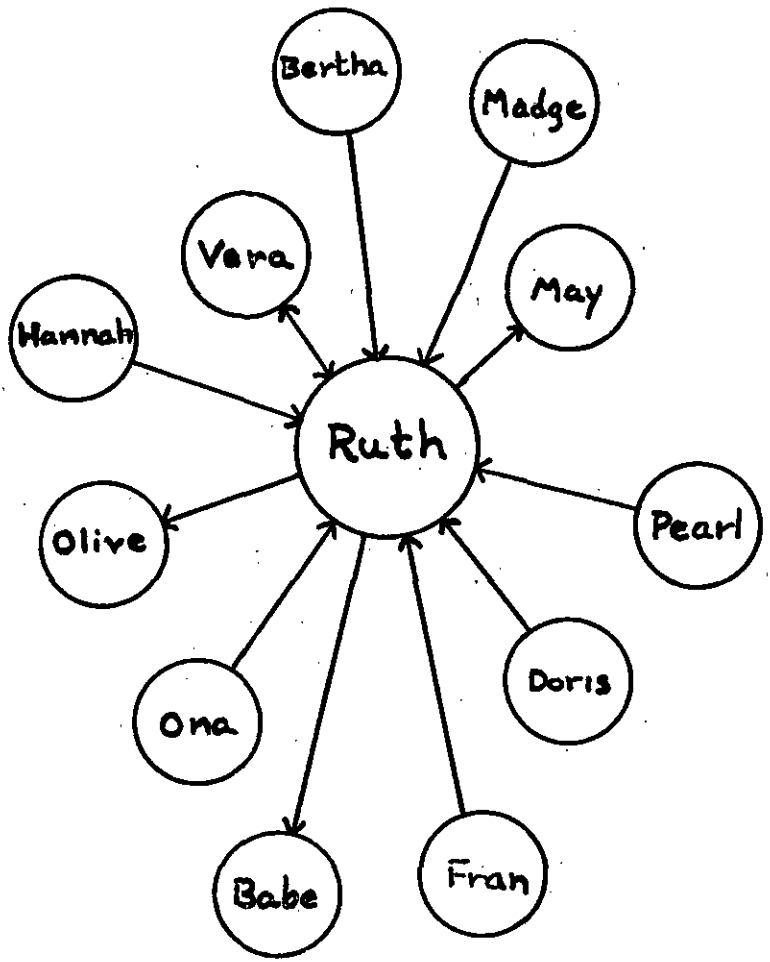
No. of Patients Making Choices	No. of Choices Made	No. of Patients Choosing Ruth
6	4	5*
6	3	1
7	2	-
1	1	-
5	0	-
Total 25	-	6

* Significant at .01 Level

FIGURE I

"DIRECT CONNECTIONS"

Acute Ward

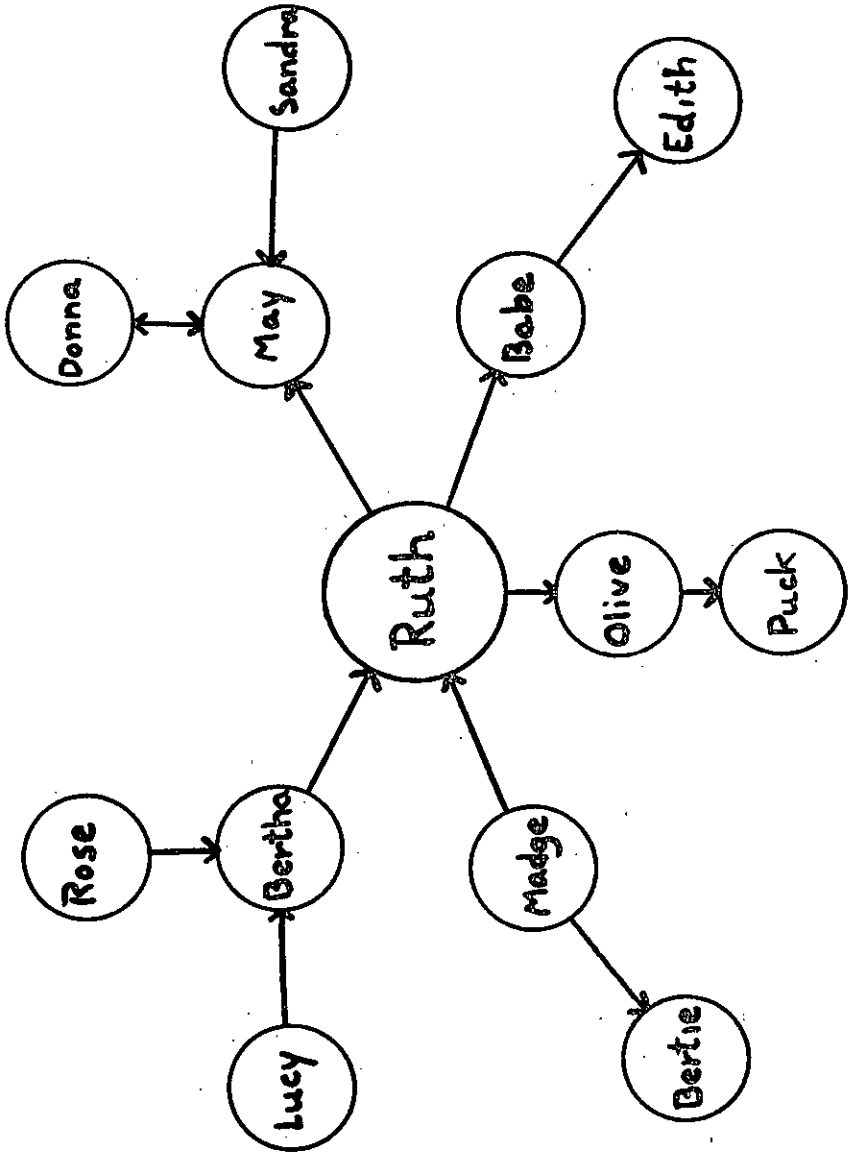


Ruth Chose Four Persons.
Ruth was Chosen by Eight Persons.
One Person was a Reciprocal Choice with Ruth.

FIGURE II

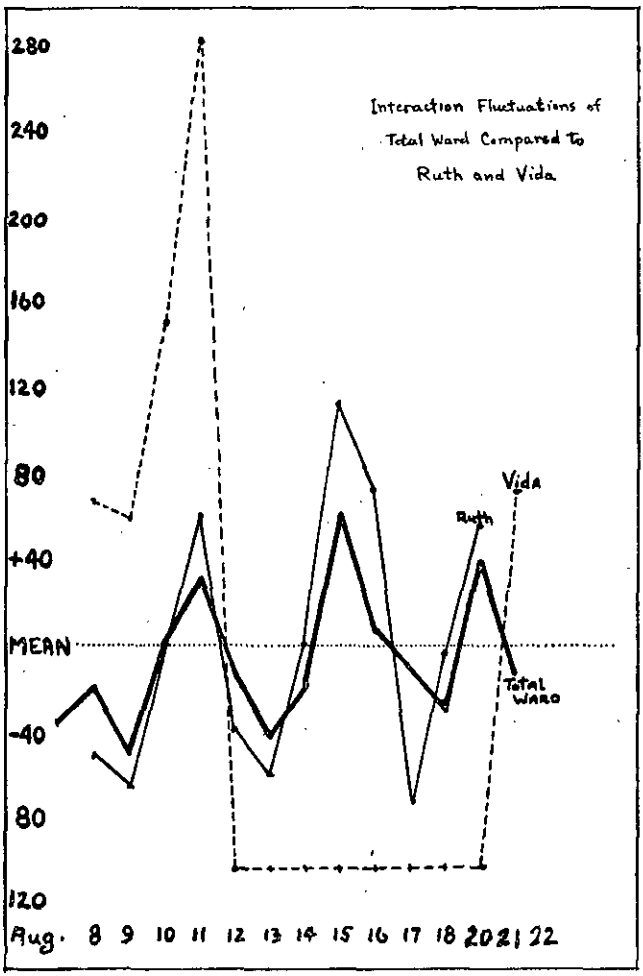
"TWO STEP CONNECTIONS"

Acute Ward



Five are Direct Connections.
Seven are Two-Step Connections.

FIGURE III
INTERACTION FLUCTUATIONS OF TOTAL WARD COMPARED TO RUTH AND VIDA

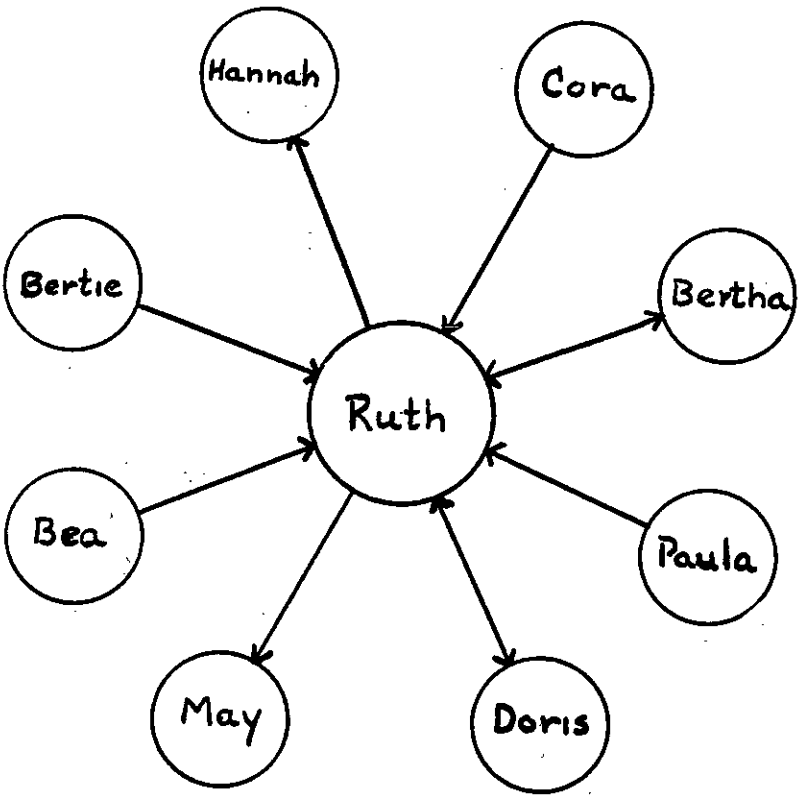


Note: Comparison Done by Rank Order Correlation (RHO) Using the Mean of the Observations for Each Day.

FIGURE IV

DIRECT CONNECTIONS

Convalescent Ward

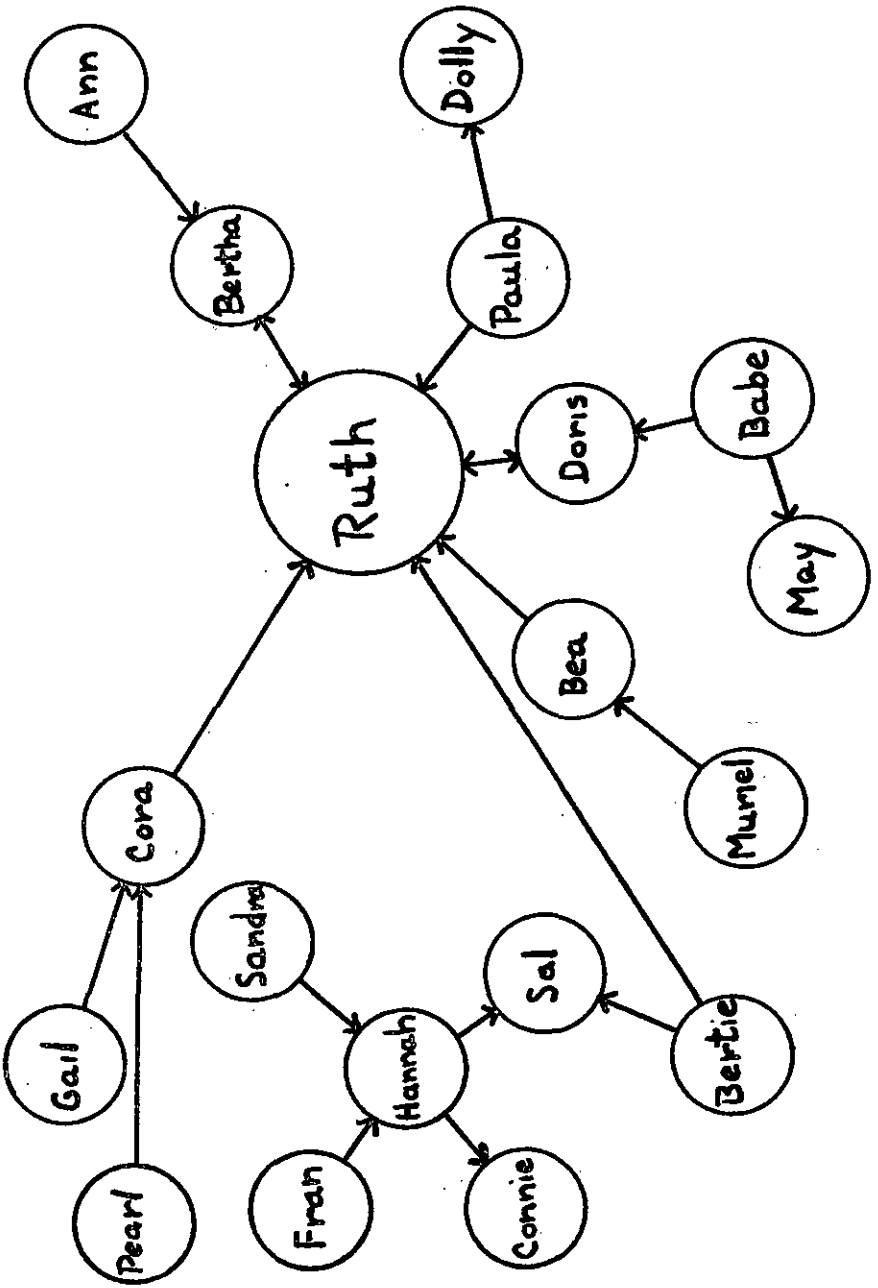


Ruth Chose Four Persons.

Ruth was Chosen by Six Persons.

Two Persons were Reciprocal with Ruth.

FIGURE V — TWO-STEP CONNECTIONS — Convalescent Ward



Eight are Direction Connections

Ten are Two-Step Connections

who expressly desired their companionship. Perhaps new gratifications were in store for those patients who moved to the center of the organization; new threats may have emerged for the leader and her clique as they moved into another ward where their pre-eminence was not yet established and where a central position could be secured only by upsetting prevailing leadership.

The significance of a breakup of ward organization was brought home to us poignantly on one occasion when one member of a three-person clique who had been receiving deep insulin treatment was suddenly transferred from a convalescent ward to an acute ward because of a propensity towards insulin reactions. The other two members of the group promptly began to show aggravation of psychotic symptoms which resulted in *their* transfer to the acute ward. If personnel had been alerted to the significance of the clique relationship, one of them might have substituted herself for the insulin patient in an attempt to keep the clique intact and thereby prevent the deterioration of the other members.

Perhaps the greatest skill of ward personnel would be in recognizing their best role, either of detachment or of involvement in the ward social net. The problem of bringing the isolated patient into the group, of setting up and maintaining favorable groupings appears to be of utmost significance to patient welfare. Unfortunately, this area of social therapeutics is at present almost completely uncharted.

Summary

The social organization of the acute ward for psychotic females of the Boston Psychopathic Hospital was investigated by sociometric interview and by time sampling studies of the interaction rates of all ward members. The following were observed:

1—The ward social life was highly organized about one central figure. This patient was a young, attractive female with a diagnosis of psychopathic personality, interested in other patients, and ready to listen to their complaints uncritically. She and four other patients constituted a clique toward whom the great majority of "choices for companionship" of the other ward members was directed.

2—The interaction rates of the central figure and her clique fluctuated directly and this in turn correlated highly with the interaction rate of the ward as a whole. Non-clique isolates showed much lower interaction rates than clique members, which correlated negatively or not at all with total ward interaction rate.

3—After the discharge of Ruth and two clique members from the acute ward, a profound change occurred in the ward social organization. Although

the number of isolates remained constant, the central figures were much less dominant in terms of "choices for companionship," and a significant number of choices were directed either towards personnel or outside the ward population.

4—Upon transfer to the female convalescent ward, within four days, the central figure again became a dominant member thus showing the repetitive pattern of social leadership.

5—Although the social climate may be of great importance to the mental health of the patient, it is suggested that too often its significance is overlooked by clinical psychiatrists who focus chiefly upon individual and group therapy.

6—We have formulated some possible dimensions of "good" and "poor" social leaders and cliques.

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ESTABLISHING A PSYCHODRAMA PROGRAM

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Since many new psychodrama units are being established it would appear useful to give a general outline for their organization. This information is taken from successful programs now in operation.

The minimum personnel requirements for setting up a program are a Psychodramatist and a Psychodrama Assistant. The Psychodramatist should have a thorough background in personality and Psychotherapeutic theory with at least one year training at an accredited center for Psychodrama.

The Psychodrama assistant need not be trained in Psychodrama but should be familiar with personality theory and have a flexibility which would not be inconsistent with participation in Psychodrama.

JOB DESCRIPTION FOR PSYCHODRAMATIST

Under general supervision of the appropriate medical office of the Institution (usually the Superintendent, Assistant Superintendent or Chief of Psychotherapy Branch), the Psychodramatist supervises and directs the psychodramatic therapy program for the Hospital and participates in the Hospital's educational and research programs.

Psychodrama provides action group therapy for patients who are medically approved and selected on a basis of the patient's need and sociometric structure within the groups. This type of therapy is designed to help each patient gain insight, new relationships with people, and a more adequate view of himself and others.

The Psychodramatist supervises the direction of, and directs sessions on the therapy levels indicated for the best interests of the group. He is responsible for the administrative organization of the program and its integration with total Hospital procedure. Patients are divided into four major groups for treatment: (1) acute, (2) continued therapy, (3) rehabilitation, (4) special group. Acute groups are composed of patients from the receiving services whose illnesses are not long standing. Continued therapy groups are drawn from patients who have been hospitalized for two or more years and rehabilitation groups contain patients who are about ready to leave the Hospital. Special groups consist of alcoholic groups, T. B. groups, etc., and research groups.

The Psychodramatist directs or supervises other staff members in the direction of sessions wherein groups are assisted in moving toward a selection of scenes in which the patients are both actors and audience. A director, by asking questions, reflecting feelings, varying his relationships, encouraging, interpreting and otherwise stimulating the group, achieves participation in a general

discussion until the interest of the group is focused on one particular problem. He then selects or the group selects the Therapeutic Persona of the drama, i.e. the patient in whom the problem area is most clearly crystalized. Other patients are chosen for auxiliary roles on a basis of therapeutic role assignment and the various phases of the problem are portrayed spontaneously by these members of the group. The Psychodramatist administers therapy on an individual basis to patients who need help in their adjustment to the group so that they can participate in and be benefited by group therapy sessions.

The Psychodramatist develops information for psychodrama by visiting patients on the wards to maintain close contact with developments in their cases, discussing patients with the medical officers, studying briefs of patients' case histories, and working with relatives who may attend and participate in the group sessions.

He supervises and trains assistants and supervises and trains other employees and volunteers in the techniques of psychodrama, directing sessions, playing auxiliary roles, briefing patients' histories and other pertinent records, in the critical observation and evaluation of patients' participation in and reactions to group therapy, and in the preparation and maintenance of records and reports. He trains patient-assistants in auxiliary techniques.

Rehabilitation groups are usually directed by Social Service or by Vocational Rehabilitation. The Psychodramatist supervises the conduct of Psychodrama sessions for the rehabilitation groups which are designed to help the patient meet family and community problems and attitudes when he is on visit or discharged from the Hospital. These meetings represent a group approach to social case work and emphasize current interpersonal relations in the family, obtaining employment, and adjustment to social and community situations and activities.

The Psychodramatist participates in the training program of the Hospital by conducting training sessions and seminars and giving lectures and demonstrations on the theory and techniques of psychodrama and its application both in teaching and therapy. Regular sessions are included in the organized training for psychiatric residents, psychology residents, Chaplain interns, Occupational Therapy interns, student nurses, etc. Special sessions are conducted for various groups who are interested in learning something of the theory and techniques of Psychodrama for use in training and/or therapy. The latter groups include members of the Hospital's staff; outside groups; visitors such as students from universities; Red Cross training personnel; church groups; social workers; educators; administrative personnel; etc.

Participates in the Hospital research program by collecting, summarizing

and interpreting data in the areas of group and action dynamics and applications of specific Psychodramatic techniques.

Serves as consultant to interested groups within the hospital and to outside organizations on the use of Psychodrama in various settings and its application to training, education, and industry, and on related matters such as the organization of Psychodrama programs and planning physical facilities for Psychodrama. Coordinates Psychodrama activities with other types of therapy; recommends changes in administrative practices and procedures and hospital policy regarding the use of Psychodrama; supervises the maintenance of space and equipment assigned to the department; interviews prospective employees and recommends appointment; supervises the preparation of correspondence and reports, maintains adequate precautionary measures for the safety of the patients; and performs related duties.

JOB DESCRIPTION OF ASSISTANT TO THE PSYCHODRAMATIST

Under the general supervision of the Psychodramatist, the Assistant serves as an auxiliary ego in Psychodrama sessions, acts as director of certain sessions, participates in the educational activities of the department and is responsible for the routine administrative-clerical work.

Specifically—Participates in psychodrama sessions by serving as an auxiliary ego in various scenes which are spontaneous and unrehearsed and which dramatize a variety of situations following group discussions. Participants in this type of group therapy include both men and women patients and the sessions are conducted on the therapy levels indicated for the best interests of each group. The Assistant must become familiar with and apply all auxiliary techniques used in Psychodrama such as doubling, role reversals, and mirror techniques.

Regularly directs psychodrama sessions where the problems to be dealt with are kept on a more superficial level, directs sessions for the rehabilitation group in the absence of the person who usually conducts these sessions. For training purposes, takes notes on group sessions and directorial techniques, discusses these sessions with the Psychodramatist. Assumes the role of director for brief periods in any group or in certain sessions, applying the directorial techniques previously discussed.

Participates in the educational program of the Section by assuming various roles in training sessions which are either spontaneous or planned and are used to demonstrate and train various groups through psychodramatic techniques. As required conducts visitors through the Psychodrama Theatre and explains the scope of the hospital program and the highlights of Psychodrama as used in a mental hospital.

In accordance with prescribed procedure, takes detailed notes and prepares a summary of each session including participants, degree of participation, roles taken, action covered, and any other pertinent information. Transfers pertinent information to file cards of individual patient. Supervises from one to three patients who assist with the work of the Section by performing auxiliary roles, typing reports of sessions from recording machines, filing, maintenance of roles, etc. Assists Psychodramatist in the maintenance of space and equipment, prepares correspondence and reports, observes necessary precautionary measure for the safety of the patients, and escorts patients to and from the Psychodrama Theatre when necessary.

In some situations it may be advisable to employ male and female personnel to escort patients to and from the theatre. In other situations it may be more feasible for the wards to take this responsibility. In the event that such personnel are hired, the job title is Psychodramatic Technician. These personnel should be trained in auxiliary and directorial techniques and assist with the general program. At times they may direct very superficial sessions on the wards dealing with interpersonal problems of ward relationships.

JOB DESCRIPTION—PSYCHODRAMA TECHNICIAN

Under general direction of the Psychodramatist and the direct supervision of the Psychodrama Assistants, the Psychodrama Technician must be trained in auxiliary and some directional techniques. The technician participates, at the request of the director or patient, in spontaneous and unrehearsed scenes which are set up and enacted on stage by the group, dramatizing various situations related to the group discussion. Roles assumed are—parent, sibling, friend or whatever is called for in a particular production. The technician is called upon to participate in auxiliary techniques such as doubling, role-reversals, etc. At times may serve as director of a session.

The technician assists with the general program of the psychodrama department, in note-taking during the sessions, in keeping the session records and in helping with up-keep of departmental records such as individual patient records monthly reports, etc.

The technician escorts patients to and from the Theatre and observes necessary precautionary measures for the safety of the patients. He often can act as a liaison between wards and the psychodrama department, and may be trained to direct sessions on the ward, pertaining to problems which patients encounter in their ward adjustment.

The next problem is the selection of space for the Psychodrama Theatre and the construction of the stage.

Theatre Selection and Stage Construction

The Psychodrama Theatre should be centrally located for the patients it is to serve. A room 48' x 48', with a ceiling, at least 13' high, will be adequate for most needs. If there is a lower ceiling it will necessitate reducing the rises of the various levels of the stage. This results in a second level which cannot be used comfortably for interviews. A low ceiling also prevents the use of small tables or chairs as a substitute balcony when moving into power roles.

The room's construction should be such that it can be blacked out. Otherwise, the stage lighting may not be effectively used. Rest room and drinking fountain facilities should be easily accessible.

The stage should be sturdily constructed. (For plan see Figure1 and 2) In order to prevent a drum effect when people walk upon it, sub-flooring should go all the way across on each level. (See figure 2) This is especially necessary when sessions are being recorded as the sound of heels will overpower voices.

The screens shown in Figures 1 and 2 may be made of plywood or ceiling, and should be stained to match the natural finish of the hardwood flooring used.

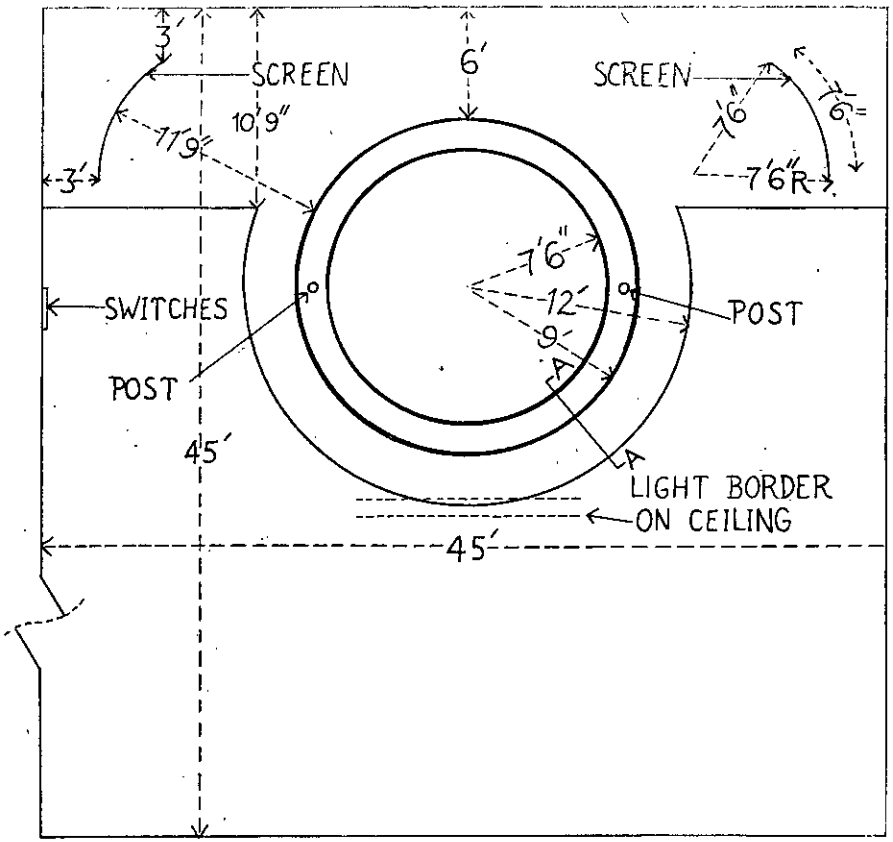
Stage Lighting

Lighting should be wired so that separate switches control stage and house lights. Stage lights should be on a four-color circuit with dimmer controls. There should be a master switch controlling all stage lights as well as switches for the individual color circuits. Baby spots, or light borders, may be used.

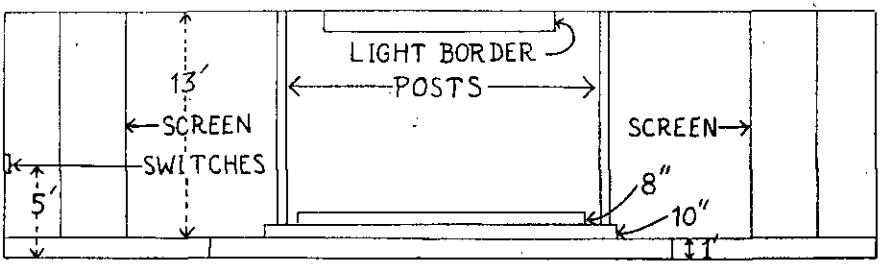
Light borders are preferable in that they give more diffuse light for the entire stage area. You may use a single border, or two borders, one over the front of the stage, and one in the center, rear. Borders should be tilted so that the shadow line falls in front of the audience's chairs. Suitable borders may be ordered, ready wired, from most large theatrical supply houses. Usually, a 75-100 watt border light, constructed of 2-gauge sheet metal, and wired with number 12 asbestos wire, will be satisfactory. Recepticles should be one piece porcelain, or aluminum type with medium screw base sockets, spaced on 8" centers. Roundels in white, amber, red, blue, and green should be purchased with appropriate retaining rings. The amber roundels are used in the white circuit (See Figure 3) 100 watt bulbs will give a satisfactory intensity of light as wired in the diagram.

For dimmer controls we find "Superior Variable Voltage Control" most satisfactory. These dimmers work by throwing the voltage back in the line, and do not heat up or hum. They do not squeak nor require graphite applications. These are available through most large radio supply houses. The size needed for these lights has an output of 135 volts and 7.5 amps., and 1.0 KVA.

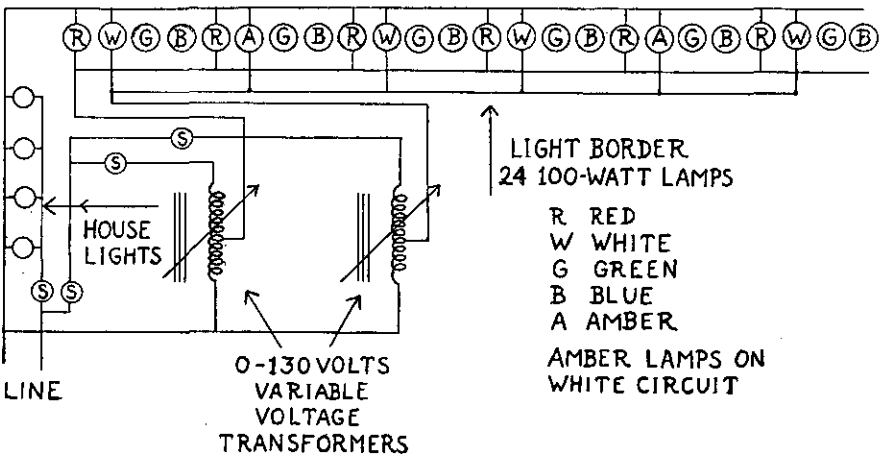
A double outlet should be available near the light controls so that recording or other equipment may be used.



SCALE 1/4" = 1'-0" PLAN FIGURE 1



ELEVATION FIGURE 2



WIRING DIAGRAM FIGURE 3

Stage Furniture and Seating

Stage furniture should be of neutral design and as light as is consistent with practicability and sturdiness. Inexpensive rush furniture is quite satisfactory. There should be two arm chairs, two small end tables, and a larger table of standard height (approximately 28"x28") a chaise lounge and four straight chairs.

The types of chairs used in the Theatre for the audience is dependent upon the kinds of groups with which you expect to work. In Mental Hospitals, if you carry a full program you will find a number of untidy patients who can be worked with quite satisfactorily. The chairs, therefore, should be easy to clean. We have found that metal folding chairs without upholstering are most

satisfactory. These are easily moved to satisfy requirements of all members of the group.

The Groups and Types of Patients

The diagnosis of the patient is of no consequence—neurotic, psychotic, paranoic depressed—it does not matter. It is all-important that there is a group of favorable sociometric structure into which the patient may fit. If this exists, the patient will respond favorably.

Groups should be made up as far as possible, so that they contain a range of sickness. This is in order that the group can supply auxiliary egos within itself and not rely upon trained personnel to any great extent. The group should be heterosexual—about one-half men and one half women. Twenty is a good number for this type group if it meets three times a week.

At times it may be necessary, for administrative reasons, to form a continued therapy, or chronic group. These patients often are out of contact and will necessitate the use of trained auxiliaries in the sessions. The size of such a group may go to the extremes. It may be comparatively small (10 or less) allowing intensive work with all members but giving many sessions of a low productive level.

At the other extreme, groups as large as forty-five may meet with success. This necessitates less intensive work on the part of the therapist, but results in a greater intensity of intra-group relations and a higher productive level. Such a group should meet at least twice weekly.

A full program should include a rehabilitation group as it is primarily a teaching situation, dealing with limited problem areas. Large numbers of patients may be worked with at the same time.

Records

Every Psychodrama Theatre should have recording equipment. Tape recorders seem to be superior to other recording media. Tape does not readily tangle or break and gives up to one full hour per reel. Tapes may be used over and over again. In the event that you wish to transfer material from a tape, it may be re-recorded onto Dictaphone or other stenographic instruments.

Tape is not practical if you wish to file permanent recordings of all sessions. The expense is too great. The usefullness of such a filing system has yet to be proved. It is our policy to transcribe sessions of special interest and to hold tapes of other sessions for approximately two weeks. These are used in making briefs of the sessions and for teaching. The briefs are subsequently filed.

The number of microphones needed will be determined by the accoustical equipment in the theatre. In most theatres four microphones are necessary—two over the audience; one on adjustable cord over the center of the stage

where interviews take place; and one over the rear-center of the action level, also adjustable, so that it may be placed to catch low tones in intense sessions. The use of four microphones necessitates the use of a microphone-mixer with four channels.

Before purchasing, recording equipment should be tested in an actual session to assure its adequacy.

Notes should be made on sessions, independent of recordings in order that non-verbal material will not be missed. These may be filed without transcribing.

A running record of each patient's participation on stage and interaction with other group members should be kept and progress notes entered in the history from time to time.

SUMMARY

This paper presents job descriptions of personnel for establishing a Psychodrama program and details of construction for a Psychodrama Theatre. The author will be glad to supply any further information desired.

PSYCHODRAMA GROUP THERAPY

It's Effects Upon the Role Behaviour of Schizophrenic Patients*

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Chapter I

Statement of the Problem and Theory

This study is an investigation of certain effects of Psychodrama, a dramatic action method, on the role-taking ability** of selected schizophrenic patients. It derives from a theoretical position in which it is postulated that the ability to take roles is essential for effective communication and the development of the "social self," which in turn, plays an important part in personality formation and adjustment. It is further postulated that schizophrenia can be considered a developmental disorder in which individuals have an inadequately developed "social self" and their maladjustment is reflected, among other characteristics, in their inability to take roles and share their thinking and feeling with other people. Finally, it is postulated that the schizophrenics' mode of communication tends to be simple, "concrete" and "private." In view of these postulates, it was felt that a therapeutic technique, such as psychodrama group therapy, which permits communication through non-verbal, as well as verbal channels and which emphasizes role-taking and role-playing in interaction, might be effective in reaching the schizophrenic on his level and providing him with an opportunity for social and emotional growth.

The psychodramatic technique grew out of Dr. J. L. Moreno's initial experiments in the Theater of Spontaneity in Vienna. It was following his observation of the unique opportunity afforded for spontaneous self-expression and self discipline in role playing and social interaction, that Moreno developed psychotherapeutic action techniques within the framework of extemporaneous drama. He says: "Historically, psychodrama represents the chief turning point away from the treatment of the individual in isolation . . . from the treatment of the individual by verbal methods to the treatment by action methods . . . It is an effective combination of individual with group catharsis, of participation with action catharsis." (13, p. 10).

Moreno's theory of child development provides the theoretical basis of psychodrama, especially the two primary concepts of: 1) role-playing precedes the emergence of the self and is vital for self-development, and 2) spontaneity is

*From Veteran's Administration Regional Office, Seattle, Washington. This paper is based on part of a dissertation submitted to the faculty of the Department of Human Development, University of Chicago, in candidacy for the degree of Doctor of Philosophy.
**Role-taking ability is here defined as the subject's ability to put himself actually or imaginatively in the place of another person and to communicate with others on the basis of shared frames of reference.

the creative motivator, necessary for the infant's growth and is required for effective living and adjustment in later years. Moreno looks at infantile role-learning as a co-action process; a two-way emotional relationship which forms the basis for all future development. This role development takes place first in interaction with the mother or mother substitute. The mother-child relationship is built, from the very beginning around mutual roles. The mother performs a double function: first that of constantly anticipating the needs of the child by being alert to his role requirements, such as eating, eliminating, and sleeping; and second, that of portraying, in the so-called auxiliary function of the giver those roles required by the child in his first orientation to the outside world. The child himself functions in this co-action process as the role receiver. It is this intercommunication in action between infant and mother which leads to the first independent role taking of the infant. (13, p.63). Through the first interaction with the mother the infant develops a set of "psychosomatic" roles of eater, eliminator and sleeper. When the infant begins to distinguish reality from fantasy two new sets of roles emerge: social roles and "psychodramatic" roles, which are personification of imagined things, both real and unreal. As the roles crystallize he gains consciousness of the self as differentiated from others, and also of the self as a part of a larger interaction system.

Moreno's theory of roles and other social psychological formulations of roles and role behavior provide the basis of the definitions of the following terms used in this study: Role behavior refers to motivated behavior of specific individuals as they take their different roles; it is a form of communication based upon shared frames of reference, and determined by other personal and group influences. It is unique to each individual, but at the same time easily recognized and shared by many others. Role, on the other hand, is a sociological concept and describes the function and not the specific behavior. Role-taking refers to the attitude and the behavior of putting oneself actually or imaginatively in the place of another person. Role-playing is usually used more specifically to describe behavior, the portrayal of a role in action. In this study which deals with both, fundamental attitudes and behavior, no systematic attempt was made to distinguish role-taking and role-playing. Such a separation was felt to be artificial and misleading in the therapeutic setting of this experiment. Moreno has supported this view by saying: "It has been found in hundreds of try-outs that the process of role-taking is not only cognitive and that, on the other hand, the process of role-playing is not only behavior or mere acting, but that cognition, perception, behavior and action are finely interwoven and cannot be neatly separated." (58A)

Spontaneity, the other basic concept in Moreno's theory, is defined as the readiness of an individual to respond as required. It is a condition and a conditioning of the subject—a preparation for free action. Moreno assumes that spontaneity is available to the individual in varying degrees of readiness, from zero to maximum and operates like a psychological catalyzer. Favorable conditions for the emergence of spontaneity are a universe in which some novelty is possible and where there is a high degree of unpredictability of coming events. Since the infant's universe is new and unpredictable, the emergency and development of spontaneity is greatly stimulated and functions as the creative motivator for action. "Spontaneity and creativity are regarded as primary and positive phenomena and not as derivatives of libido . . . From the way in which men of genius warm up with their whole organism in status nascendi to creative deeds and works, we can get the clues of how every infant, in miniature, warms up and maintains itself from the moment of birth." (13, p.49) The first manifestation of spontaneity is the "warming-up" of the infant to his new surroundings. "Warming up" denotes the process by which the individual brings his body and mind into motion by use of physical and mental starters. Moreno claims that the "warming up" process may be seen "in every expression of the living organism as it strives toward an act." (13, p.56). This "warming up" is functionally related to action. To act is to be "warmed up" to a spontaneity state in which the whole organism is energized for flexible adjustment to a novel situation.

The essence of the psychodramatic method lies in spontaneous role playing and enacting of the individual's life situation. The most concise definition of psychodrama can perhaps be found in the word itself. Psyche, a word adopted from the Greek, originally meant the personification of the life principle, and in present psychological usage has come to mean the self, the mind, the soul. Drama is used in its original Greek meaning of action. A literal translation of "psychodrama," then, is "the self in action." Emphasis is placed on the recapitulation of the unsolved problems within a freer, broader, more flexible social setting. The drama in this instance, therefore, may be defined as an extension of life and action, rather than its imitation.

Psychodrama uses external forms of the theater (such as the stage, the director, actors playing roles, and an audience) as the setting for the spontaneous enactment and catharsis of individual problems in a therapeutic group situation. The "stage" is used more as a "social platform" (13, p.24) than a stage in the theatrical sense. It may be merely a free area in a room, and the stage setting

is always furnished by the players' own imagination. The content of the dramatic action is the individual's own life and/or his own fantasies. Each subject is in turn the main actor, presenting his own problems in his own roles.

The co-actors, called "auxiliary egos," take the roles required by the subject in order to help him enact his scene, and to duplicate the emotional atmosphere of the environment in which the role is played. This "auxiliary ego" function is performed by trained therapeutic actors where necessary, and otherwise by patient-group members.

While the audience in conventional drama remains the passive observer, the audience in psychodrama functions more as a Greek chorus, or sympathetic reflector of the actor's feelings. The feeling of participation is heightened by the fact that the members of the audience will in turn become active participants of the drama. Catharsis, as conceived by Aristotle and as it has been applied in conventional drama since his time, emphasizes the effect on the spectator, the audience. Psychodrama, however, places the primary emphasis upon the catharsis which takes place in the actor-patient as he "lives out" his conflicts, and is only secondarily concerned with the emotion shared by the patient-audience as it co-experiences his feelings and problems.

The director, in contrast to the "auxiliary egos," is mostly outside the situation on the "stage;" he functions both as director and therapist, initiating and stimulating the dramatic action. He leads the therapeutic discussion which follows each scene and maintains a close rapport with the patient-audience.

Psychodrama, as a group treatment technique for psychotic patients was first used in this country by Moreno in the early 1930's in his mental hospital at Beacon, N.Y. and from the beginning the method was found to be particularly suitable to the treatment of schizophrenic patients (59, 60, 61). During the last ten years, partly through the impetus of the war and its urgent demand for effective group treatment methods, psychodramatic techniques have become widely used in mental hospitals and out-patient clinics throughout the country (31, 38, 39, 40, 48, 26, 53, 56, 75). To this date, however, little systematic investigation of the effects of psychodramatic treatment has been undertaken. This study is an exploratory attempt in this direction.

Hypotheses

The theoretical considerations presented above and the assumptions drawn from them lead to the following hypotheses:

1. Participation in 25*** psychodramatic group therapy sessions will result in quantitative and qualitative changes in "role taking ability"**** as measured on an action test, a role test.
2. Participation in 25 psychodramatic group therapy sessions will result in quantitative and qualitative changes in various dimensions of "role taking ability" on a non-action test designed to measure role behavior and social interaction, the Maps test.
3. Participation in 25 psychodramatic group therapy sessions will not result in quantitative changes on a test designed to measure "basic personality structure," the Rorschach.

and to this restatement of the purpose of this investigation: It is an attempt to measure the effects of a psychodramatic group action method on the role-playing ability of selected individuals (specifically, schizophrenic patients). Further, this investigation should furnish clues about role behavior as it may relate to total personality adjustment, and give some evidence of the effectiveness of a group action method in the treatment of schizophrenics.

CHAPTER II

Experimental Design

For the purpose of determining whether or not the role-behavior of schizophrenics would be effected by psychodramatic group therapy and what changes in role-behavior would occur as a result of this treatment, three groups of schizophrenic patients were selected; two groups of experimental subjects and one group of control subjects. Three testing instruments were selected and administered as pre- and post-tests to measure by comparison changes in significant areas of role-behavior.

Therapeutic Procedure

The psychodramatic therapy procedure used and evaluated in this study can be outlined as follows:

In an effort to provide a relaxed and informal atmosphere, the treatment sessions were held in a fairly large, dimly lit, comfortably furnished recreation room. A large open space approximately half the size of the room was left for the "stage" or action area. This was furnished only with a table and a few chairs, as the rest of the setting was dependent upon the patient's imagination. In the remaining half of the room a semi-curcular arrangement of chairs fac-

***This number of treatment sessions was set on the basis of the writer's own experience as an optimum beginning period for the observation of significant changes, and not as completed treatment.

****Role behavior has been described in the theoretical section as a form of communication based upon shared frames of reference. In other words, it is behavior shared and recognized by other people in the social situation. Role behavior in this study specifically refers to the subject's "role taking" behavior as it is directly (on the role test), or indirectly (on the Maps test and Rorschach test) revealed through his performance in different test situations. The dimensions of role (taking) behavior measured will be discussed under instruments.

ing the stage served as "audience" seating and as a discussion area. As the sessions progressed, however, the distinction between "action" and "audience" areas became less apparent.

The first half hour of the initial sessions was devoted to a brief introduction of the persons present and a summary of the type of action and discussion in which it was hoped that they would participate. This was followed by a brief discussion in search of common experiences which would be suitable for initial dramatizations, and which would establish a group feeling. The situations immediately prior to, and responsible for, hospitalization were quickly agreed upon as the most meaningful common experience.

In the remainder of the sessions the patients were encouraged to bring out specific personal problems and were asked to act out the problem situations with the help of trained auxiliary egos. The sessions usually began with an informal discussion in which patients would indicate how they felt, what they had been thinking about, and what problems they might want to bring up. At the point where the discussion led to the description of situations which could be carried out in action, the patient who brought up the specific situation was asked to "show" what happened rather than describe it. He then moved to the action part of the room and such auxiliary egos were selected from among the other patients and the trained therapeutic actors as were needed to help the patient enact the situation. In the beginning this choice was most frequently made by the therapist, but as the sessions progressed it evolved more and more upon the patient actor.

Each role taking situation was followed either by related action situations suggested to the patient-actor by the original dramatization, or by a discussion. Eventually, however, discussion concluded each role enactment or group of related role enactments.

The discussions first explored the emotions of the patient-actor during the dramatization and then his feelings in the original situation. The discussion then became general, and from this general response was drawn another patient's situation; thus the action-discussion sequence was repeated. As the sessions progressed, the amount of discussion necessary to elicit new role situations from the group tended to decrease, and the spontaneous initiation of roles increased. The last few meetings were utilized in drawing together the material which has been brought out both by and within the group, and in an effort to relate this material to the patients' present and future reality. It was explained that the termination of the sessions did not necessarily imply completion of treatment, and that it was hoped that the individuals would continue to explore the areas opened during the meetings.

Experimental Procedure

This study was carried out in the veterans' section of a state mental hospital from which thirty schizophrenic veterans were selected as subjects. These patients were chosen on the basis of certain criteria to be discussed later, and were then divided by another set of criteria into three balanced groups of ten patients each. Of the three groups, two were the treatment (experimental) groups and were conducted in the same manner by the same therapist. The third group did not receive any therapy outside of the regular hospital routine and functioned as the control group. The tests were administered in the three weeks between the grouping and the beginning of therapy, and again promptly after completion of the treatment period.

Both treatment groups met on the same day four times a week, and each session lasted approximately one and one-half hours each. There was a ten-day break in treatment after the twelfth session due to the absence of the majority of the patients during the Christmas and New Year's holidays. Each experimental group had a total of twenty-five treatment sessions over a period of approximately two months.

SELECTION OF SUBJECTS

The subjects used in this study were drawn from a male veteran population of approximately 1000 schizophrenic patients. They were chosen from several psychotic wards of a large state mental hospital according to the following criteria:

A. Mental condition

1. Psychiatric diagnosis of schizophrenia with some of the following specific characteristics:

a. Loss or extended absence of one or both parents in infancy, reweakened foundation for emotional and social interaction.
b. Asocial childhood background, that is, limited participation in play and other social activities with poor and/or limited social experiences.
c. Difficulty in communicating with people.
d. Withdrawal from environment, as expressed in little or no interest in surroundings and/or construction of a private world.
e. Difficulty in establishing and/or maintaining a satisfactory heterosexual relationship.
f. Difficulty in getting and/or holding a job.

(In the first chapter it was postulated that schizophrenia may looked upon as a developmental disorder, characterized by an inadequately developed social self and/or a breakdown in the socialization process. This was the point of view of schizophrenia taken in this study, and therefore the above factors which may cause or reflect inadequate social development were included among our selection criteria.)

2. No discernible organic involvement bearing on mental condition as evidenced by case history and hospital examination. (This was done to avoid additional variables due to organic disorders).
3. Intelligence level average or above average as judged by education, practical experience and/or tests. (Intelligence below average might have introduced new variables).
4. An adequate degree of reality contact to permit participation in group therapy sessions from the beginning, as judged by interview with patient.

B. Age: 20-35 years old.
(This age group was considered desirable for two reasons: a) it was felt that the psychotic withdrawal mechanisms would be less firmly entrenched in a younger patient group and that these patients would therefore be more amenable to a social and emotional "learning" experience; b) it was felt that patients in this limited age group would be able to share more common experiences).

C. Number of previous hospitalizations. No more than three and total duration of hospitalization three years or less. (This relatively brief hospitalization period was considered desirable for the same reasons as those given for the age range).

D. No other treatment immediately before or during experiment.
1. No shock treatments closer than three weeks previous to testing and six weeks previous to therapy.
2. No type of organic or planned psychological therapy during entire experiment.

With the foregoing criteria in mind the actual selection of patients proceeded as follows:

Psychiatrists were asked to select a number of patients whom they thought would meet these criteria. Case histories on the patients suggested were consulted and those considered potential subjects were selected for interviews with the group therapist or assistant group therapist. It was found in the interview that many patients were unsuitable because of qualitative elements, such as inadequate reality contact and disinterest in any type of group activity or therapy, which did not appear in the case history or the psychiatrist's evaluation. Administrative difficulties, such as early discharge eliminated another considerable portion. Therefore, out of 100 patients interviewed only forty patients finally met all criteria. Because of marked changes in patients' condition and unexpected administrative changes, such as electric shock treatment or discharge, only twenty-nine* of these forty patients remained at the beginning of the therapeutic period.

*All twenty-nine patients were transferred to the same hospital ward at the beginning of the treatment period. Thus all twenty-nine patients lived as nearly as possible under the same hospital condition with the exception of the experimental variable, the psychodramatic group treatment sessions, for the two experimental groups.

During the treatment period of approximately two months the original group of twenty-nine patients was reduced to twenty patients. In the afternoon group, four patients were lost; one by transfer, one by discharge against medical advice between the first and second session, one by re-evaluation of diagnosis during the holidays, and one after completion of the sessions but before post-testing. In the morning group, one patient was put on electric shock and therefore dropped from the group. Four patients were lost from the control group during this same period. (It is interesting to note that only one of nineteen experimental patients, as against four out of ten control group patients left against medical advice. This suggests that the experimental group patients were apparently more motivated to stay until termination of treatment. At the end of the experiment there were at least six patients remaining in each group, which was the medium expected when the study was begun.

Assignment to Groups

The relatively large number and complex nature of selection criteria made grouping by such techniques as matched pairs or matching of (entire) groups impracticable from the outset. Several selection criteria, such as number and duration of hospitalizations, psychiatric classification of type of schizophrenia, number of Negro patients and previous shock treatment were considered important external variables to be distributed proportionately among the three groups. The degree of illness was thought to be the most important variable. Since it was not feasible to use internal criteria derived from diagnostic test results and other clinical data, to determine "degree of illness," it was felt that an external measure of duration of illness, i.e., the number of times hospitalized and the total duration of hospitalization in months) would at least in part approximate the actual degree of illness. Patients were assigned so that the mean duration of illness for each of the three groups was approximately equal. Then an attempt was made to "balance" the three groups as evenly as possible according to the other variables; distribution of psychiatric classification, number of Negro patients and distribution of shock and non-shock patients. Table I contains a summary of the final grouping. For specific details of each group see Table 6 in Appendix A. The two treatment groups were conducted in order to test the unexplored assumption that the results obtained in one group could be duplicated in another similar group.

Instruments

The three instruments used in the evaluation of this study were the Rorschach, the Make A Picture Story Test, and a role test. All patients were given the same orientation on all three pre-tests; namely, that these procedures were

TABLE I

DISTRIBUTION OF PATIENTS ACCORDING TO GROUPING CRITERIA

	Selection Criteria																			
	No. of Hospitalizations					Duration of Hospitalizations In Months					Diagnosis					Shock Treatment		Race		
	1	2	3	M	Md	1-10	11-20	21-30	M	Md	Schiz., Paranoid	Schiz., Undet.	Schiz., Catatonic	Schiz., Incipient	Schiz., Reaction	Est. Insulin	None	W	N	
No. Patients Group Aa . .	7	2	0	1.2	1.1	7	0	2	8.7	6.8	4	3	0	1	1	5	4	7	2	
No. Patients Group Bb . .	7	2	1	1.4	1.2	6	2	2	9.3	8.8	3	5	1	1	0	7	3	7	3	
No. Patients Group Cc . .	7	2	1	1.4	1.2	6	4	0	8.5	8.8	4	5	1	0	0	6	4	7	3	

aGroup A—Morning Experimental Group

bGroup B—Afternoon Experimental Group

cGroup C—Control Group

to help the therapists (with whom patients had gotten acquainted in interviews) to form treatment groups at some indefinite time in the near future. This was done to maintain a constant set for all patients.

The Rorschach Test

The Rorschach test was used in this study to investigate the hypothesis that a limited number (twenty-five) of treatment sessions would not result in quantitative changes on an instrument designed to measure "basic personality structure," even though both quantitative and qualitative changes in role behavior would appear on such instruments as the MAPS test and the role test. This test, which was the first given at both pre- and post-testing was administered by the same examiner to all patients.

Clinical application and research findings have supported the assumption that the Rorschach reveals the "depth" structure and underlying mechanisms of personality (50, 73) and there is evidence for clinical validation (82, 68, 66, 50, 73, 28, 29, 71) and reliability of this test (50, 52, 81, 77, 78, 4, 73, 6). Furthermore, the nature of the test material contains no conventional social stimulus, which would call for a more or less conventional, social response. This permits the most "private," personalized type of projection and distinguishes the Rorschach from the other two projective instruments, (the MAPS and the role test) used in this study.

The test consists of a series of ten standard inkblots, five of which are partly or fully colored, and five of which are non-colored, that is, they consist of grey, white and black combinations. These cards are presented in a standard order and the subject is asked to respond in describing what the blots might be. Since the blots have no form beyond that accidentally introduced by the subject, it leaves the widest possible scope for highly personalized associations of the subject. The only limitations placed on these responses are imposed by the personality of the examiner and the personality of the subject.

The MAPS Test

The MAPS test was used to investigate the hypothesis that participation in psychodramatic group therapy sessions will result in quantitative and qualitative changes in various dimensions of "role taking ability" on a non-action test designed to measure role-behavior and sensitivity to social interaction. This test was given second in the testing series in both instances. Due to time limitations, however, three different examiners had to be used on the pre-test. Post-tests were administered by the only pre-test examiner still available, and one new examiner. Difficulties caused by this variation in examiners is discussed in Chapter III, Section A.

The MAPS Test is more structured than the Rorschach, in the sense that it consists of a series of more or less specific "backgrounds" and "figures." These background pictures for the most part depict a social or natural setting, such as a living-room, a street scene and a forest. The "figures" represent a variety of people, men, women and children, some of whom may be typed in that they are almost always seen as doctor, priest, or mother, whereas others are not identified, as a member of any particular social group. All these people are expressing different emotional attitudes, such as pleasure, dejection and fear.

The test consists of twenty-two achromatic background pictures and sixty-seven figures. The subject distributes all figures on a table before him; then, as he is presented with each background card, he is asked to choose one or more of these figures, place them on the background and tell a story about the picture and the people in it.

The number and choice of background cards used is flexible and may be determined by the purpose and the nature of the problem investigated. Shneidman, in his original research, has selected an average of nine backgrounds. For the purpose of this study the same number of backgrounds was used. These were eight cards essential for the objective scoring of the test, and one free choice card which the patient could select from the remaining fourteen pictures. Standard administration and scoring procedures were followed as outlined in Shneidman's manual (19).

The test appears to be particularly appropriate for use in this study since (a) it was constructed to investigate " . . . formal characteristics of the psychosocial aspects of fantasy production in schizophrenia." (19, p. 149.) (b) it was standardized on a population sample of schizophrenic and normal patients, (c) it furnishes objective, statistically significant scoring signs for the analysis of choice, placement and inter-relationships of the test "figures" as recorded by the examiner, on the basis of which Shneidman, the MAPS test author, was able to distinguish schizophrenic from "normal" responses. It must be kept in mind, however, that only 100 cases (fifty schizophrenic patients, of whom seventy-two per cent were diagnosed as paranoid schizophrenics and fifty "normal" subjects) were used as the total population sample, on which the test is based and hence the reliability and validity of the results (19, pp. 194-204), especially in view of the complex area of investigation, must be considered highly questionable.

Regardless of these statistical factors, however, the test material provides a more or less defined social setting within which the patient's social and emotional orientation and interaction with people may be explored. It was thus felt that the instrument would yield one type of objective measure of the schizo-

phrenic's projected role-behavior in a variety of social situations.

The Role Test

The role test was used to investigate the hypothesis that participation in psychodramatic group therapy sessions will result in changes in role taking ability on an "action" test. This test was given third in the testing sequence, and was administered by the same examiner both times. The same three judges rated patients' role-behavior during pre- and post-testing.

The role test which was constructed specifically for this study consists of three social roles (mailman, father and friend), which the patient is asked to portray in action and words, and three interaction situations (situation with a woman, situation with hospital attendant and future situation), which the patient is asked to enact with another person. The test was developed to furnish a concrete behavioral measure of the patient's role-behavior in different situations.

Moreno and some of his students (57, 76, 58, 37) have constructed various types of role and interaction tests, all unstandardized as yet, which furnished the basic test pattern for the development of the role test in this study. In the selection of roles and situations, it was considered important to meet two conditions:

1. The roles and situations selected should fall within a framework of "meaningful" experiences for the schizophrenic patients, and

2. The roles and situations selected should cover a varied and broad enough range, so that some generalizations about a patient's role-behavior could be made from this sample. Thus the test battery was developed in the following manner:

Development of Role test battery—Schizophrenic patients from non-veteran wards of the hospital were first asked to discuss very generally things they liked to do and roles they would like to play, next they were asked to talk about some of the roles they have played and which of these roles they thought they would like to resume when they left the hospital; finally they were asked to suggest roles which they felt were important to most people and discuss why they were important. The comments and suggestions of patients, plus a few additional social roles which were taken from other role tests furnished the first list of roles and situations. From this list our later selection was made.

Next, non-veteran schizophrenic patient groups were formed, composed of four or five patients each, and their individual reactions to the role list was obtained. Then each patient was again asked which of these roles he had played and which he would like to play. From these roles he was then asked to portray in action and words one or more to the rest of the group. In this fashion

such roles as father, friend, mailman and storekeeper were found with which all patients were acquainted and which they all could enact in a more or less adequate manner.

This same procedure was followed for the selection of social situations which required interaction with one or more people. The final list of roles and situations consisted of three role portrayals and three interaction situations. The role portrayals chosen were those of mailman, father, and friend. The patients had decided these were all meaningful roles to them, and it was felt that at the same time these would include a sample of role-behavior in the intimate family group, in the peer group and in the wider community group. The social situations selected were that of a situation with an attendant, a situation with a woman, and a future situation.

These situations, like the roles, had proved to fall within the range of meaningful experiences for the patients and to lead from a concrete hospital setting, which patients had to meet in their daily hospital life, to a situation which could be real or imaginary (situation with woman), to a completely unstructured future setting which permitted the patient to project and enact unrestricted fantasy if he wished to do so. Thus, it was felt the three roles and three situations met the conditions of meaningful experiences to the patient, and represented a fairly varied and broad range for portrayal of role-behavior.

Having established the battery of roles and situations to be used in the test, general directions for test administration were worked out. The non-veteran patient's suggestions for the most easily understood wording were used in the test instructions (see instructions, Appendix B).

Development of the Role Test Scale—

I. Categories of Role-Behavior

The next step was to select a list of the most important and meaningful categories of personality traits and interaction qualities which would be apparent on such a test. These were defined and described as accurately as possible and submitted to judges for critical examination. After repeated discussions with the judges, and after observation of the behavior of the non-veteran group in the chosen role situations, some categories which seemed to overlap and others which could not be readily observed were eliminated. By unanimous agreement the following eight categories were chosen which seemed to describe the most significant and at the same time the most readily observable aspects of role-behavior.

A. *Interaction with and emotional responsiveness to others*: This refers to the amount and quality of communication, emotional, verbal, and physical with another real or imagined person.

B. *Realism*: This refers to the individual's clear perception of the actual emotional and intellectual qualities of the world around him, as evidenced by his sharing or paralleling the perceptions of most other people. Specifically, in relation to role-behavior, it refers to the appropriateness of emotional responses and "realistic" intellectual role portrayal.

C. *Emotional intensity*: This refers to the amount and quality of emotional energy expressed by the individual in response to feelings from within him or in response to other people.

D. *"Affiliative" interation*: This refers to feelings, words and actions indicating empathy and positive emotional interaction with another person. Specifically, it refers to friendly, sociable, outgoing and sympathetic behavior, as opposed to withdrawing, isolated, shy and hesitant behavior.

E. *Ability to adapt spontaneously*: This refers to the ability to meet new situations in a flexible manner, that is, to seek new solutions and to change attitudes and behavior patterns for more appropriate ones, as required. It is also a freedom from constricting anxiety which enables the individual to express himself "on the spur of the moment." It should not be confused with impulsive, explosive emotional release.

F. *Personal security and comfort displayed in role*: This refers to the relative familiarity and ease, as opposed to strangeness and tension, which a subject displays in a role. Personal security is considered to be indicated by his enjoyment of the role and external manifestations of self-confidence.

G. *Ability to take and act out a role*: This specifically refers to the subject's ability to put himself in the place of another person (to look at a situation from more than one perspective), and to show in action what this other person might do or say. Here we are concerned primarily with the more conventional characteristics associated with a role or a situation.

H. *Ability to apprehend and describe a role*: This refers to the subject's verbalization of what he thinks a mailman, etc., might do or say, as opposed to role enactment.

These eight categories as applied to the six test situations furnished the content of the role scale. Since this and the last step in the role scale constructions deals primarily with activities to be carried out by judges, a few words about selections of judges are appropriate here.

II. Selection of judges

In the selection of judges four factors were considered important: that they were qualified clinicians; that they showed some interest in the project, (either positive or negative); that their attitude toward the experiment was variable (both positive and negative); and that they were available for pre- and post-testing. The three judges selected were all psychological trainees with a minimum of two years graduate study and two years clinical experiences. All judges were interested in the study, although their attitudes toward the role test and the psychodramatic treatment technique were quite different. Judge B was encouraging and enthusiastic ,Judge V reserved judgment, Judge H was

openly skeptical. Only one of the judges (B) had some experience in observing patients in role playing situations before the beginning of the experiment.

III. Definition of Scale Points and Training of Judges

In order to establish a common frame of reference for the judges by which they could rate patient performance on the different scale categories, definitions for low, middle, and high points on the scale had to be developed. This was done in the following way:

Fifteen people, eight "normal," non-hospitalized subjects and seven hospitalized schizophrenic patients were asked to take the role test used in this study. Detailed observation was made of the performance of all subjects in the three roles of mailman, father and friend, and these activities were tabulated.

For seven of the eight scale categories (excluding G), observation notes on the role-behavior of the fifteen subjects tested, plus previous observations of other patients' role-behavior, were scaled as the basis for definitions of low, middle, and high (see Appendix).

For category G, separate actions were summarized into groups of activities, several groups for each role. These groups of activities were called role aspects. Those role aspects which had been portrayed by ten or more subjects of our sample were felt to be primary role aspects. These were considered the most common, and therefore the most conventional characteristics of the three roles. They were:

Mailman

Primary role aspects:
Picking up mail from Post Office.
Carrying mail from house to house.
Interaction with people in connection with mail delivery.
Other role aspects:
Talking and activity with people, children, dogs, etc., along route.
Talking to fellow employees.
Pick up mail with truck from letter drop box.
Other special mailman functions (special delivery, parcel post, COD, etc., insured parcels).
Riding to and from job.
Rest periods on job (lunch, etc.).

Father

Primary role aspects:
As authority figure in family circle.
As disciplinary figure with child.
As comforter, physical aid, and protector to children.
Discussing problems of family with wife.
Other role aspects:

As teacher with child.
As playmate with child.
With baby.
Resting at home with paper, slippers, coffee, etc.
Going to work.

Friend

Primary role aspects:
Peer who shares play or recreation (games, meals, entertain, etc.).
Friend as helper in activities (such as doing work while sick, helping out on job, favors, etc.).
Friend as confidante (discussing more intimate problems).
Other role aspects:
Friend as co-worker.
Friend as acquaintance.
Friend as host or guest.

Thus the role aspects mentioned, plus the subject's specific activities and his elaboration of detail in his role portrayal, furnished the basis for defining low, middle, and high points on the scale for category G. This, however, is applicable only to the three roles of mailman, father, and friend. The three interaction situations called for less conventional and more individualized role-behavior, and hence low, middle and high performance for these situations had to be defined in more general terms (see Appendix B for form and instructions).

After all definitions had been established they were again submitted to the judges for final discussion. Then two trial ratings were made, followed by discussion, of patients not involved in the experiment, and these proved sufficient for the judges to arrive at a common understanding of terms. This scale, then, was used by ten judges as a method of recording the patient's performance on the role test.

The three tests: the Rorschach, the MAPS test, and the Role test, which were discussed in this section (under instruments), furnished the measuring instruments for collecting the raw data of this study.

CHAPTER III
QUANTITATIVE FINDINGS

Limitations in Applying the Design to the Field Situation

The Rating Scales: Role Scale, MAPS Scales, Rorschach Scales

In order to investigate role-taking ability, rating scales with categories describing those aspects of role-behavior felt to be most important, were developed for each measuring instrument (Role test, MAPS test, Rorschach test).

On the Role test such a scale was constructed both as a method for recording the patients' role performance and for the purpose of rendering the

data amenable to quantitative handling. The Role test was designed to get a direct measure of role taking activity. On the other hand, from the MAPS test and the Rorschach, role taking had to be inferred. Therefore, on these two projective tests, only those role scale categories were chosen which could be adapted to ratings of role-behavior.

The MAPS test data were found to lend themselves readily to ratings of patients' projected Interaction and Realism, as defined on the Role test scale. The examples of Interaction and Realism were taken from the MAPS test stories; these examples were categorized in terms of high and low degrees of those two qualities to provide the judges with a guide for rating the stories (see rating scales and instructions to judges in Appendix C.).

The Rorschach data were treated in terms of Spontaneity, as well as the Realism and Interaction aspects of role-behavior. These dimensions, in addition to being considered particularly important in role-behavior, had also been found relatively easy to rate by judges in two previous unpublished studies (46, 74).* These qualities were defined the same as on the Role and MAPS scales and examples for each dimension were given which were appropriate to the test data. However, due to the wide usage and standardization of the Rorschach, specific examples of low, middle, and high points on this scale were not needed. In fact, rigid definitions of scale points in this instance were considered a handicap to an experienced judge's evaluation and ratings. (See rating scale and instructions to judges in Appendix D).

Scores on all scales were obtained by asking clinically qualified judges to rate the patients' role-behavior according to the specific categories and scale points. On the Role test the ratings were made directly, by observation, and therefore quite extensive preparation and training of judges were necessary (see Chapter II, section on Role test). On the MAPS test and the Rorschach, however, ratings were made indirectly from test data, a more frequently used clinical procedure for which the judges were already better prepared from the beginning. On the MAPS test the task of judging was further simplified by using the same three judges who rated the Role test, thus assuring familiarity with the categories to be measured. Hence, a brief discussion concerning clarity of instructions and only a few trial ratings were felt to be sufficient prepar-

*N. Haimowitz (46) and S. Siegel (74) independently developed a manual for evaluating certain aspects of personality from the Rorschach test for their dissertations. Both included the characteristics of Realism, Interaction and Spontaneity (using somewhat different terms) in their manual and listed a number of quantitative and qualitative Rorschach factors for each characteristic as a guide for the judges' ratings. The majority of these same Rorschach factors were listed as guides for rating the three characteristics in the present study. Haimowitz found a mean correlation (between three raters) of .600 on reality orientation, .512 on attitude toward others, and .707 on spontaneous quality of functioning. Siegel found a median correlation (between six raters) of .807 on reality orientation, .742 on interpersonal functioning, and .549 on rigidity vs. flexibility.

ation. These judges were not used on the Rorschach scale, however, since particular skill in Rorschach interpretation was considered of primary importance.* Ratings of Rorschach data and Rorschach interpretations were made in terms of "Realism," "Spontaneity" and "Interaction" without reference to role-behavior as such. The possible relation of these Rorschach categories to role-behavior could only be inferred and this will be discussed as a separate question in Chapter IV.

In order to establish statistical confidence in judging the various scales, inter-judge reliability was determined for each scale. After obtaining this measure of reliability the actual test results were subjected to quantitative analysis, primarily by the *t* test of differences in group means.

Difficulties in Statistical Analysis of Data

It soon became apparent that the statistical results were obscured by the difficulties inherent in a clinical study of this type, dealing with a relatively unexplored area of investigation and in which many unpredictable elements come up in the course of the experiment. One such difficulty involved the necessarily small population sample. Ten patients per group was considered to be the maximum size suitable for the specific treatment procedure employed, and six patients per group the minimum for effective group treatment and statistical interpretation. Counting on some reduction in group size regardless of many precautions, the experiment was begun with the maximum number of ten patients per group. This allowance for attrition was originally considered to be a liberal margin. The two experimental groups remained within the expected group size of six to eight patients. The control group, however, due to unpredictable circumstances (see Chapter II) and marginal cooperation, was reduced to six patients on Rorschach post-testing, five on the MAPS, and four on the Role test. This created difficulty in statistical analysis on all tests, particularly due to the reduction in the scoring range at post-testing. Thus, while the variability within the control group did not differ significantly from the variability within the experimental group at pre-testing, a significant difference was apparent at post-testing. (This was further complicated by an increased variability in the experimental group, which is discussed in more detail under presentation of statistical results). This difference in variability within groups invalidated the ordinary use of, and reduced the probability of significant re-

*Two Rorschach judges had more than five years experience in giving and interpreting the test and are considered experts with this instrument by other qualified clinicians.

sults on the *t* test, since this test is based on the assumption of homogeneity of variances.*

On the Role test, which was taken by the smallest number of control group patients, an additional difficulty was introduced. The original criterion for participation in the Role test and for rating of the test performances was for the patient to leave his seat and make some attempt at action, however minimal this might be. This criterion did not raise any problems on pre-testing since only one out of thirty patients tested refused to leave his seat. (This patient did not receive any rating). This participation criterion proved too late to be inadequate. At post-testing two of the six patients left in the control group refused to cooperate in action and only described what they would do, remaining in their seats. These patients could not be rated and thus a comparison of their pre- and post-test scores was impossible.

One of the patients in the experimental group was greatly depressed at the time of post-testing, and although his inner pre-occupation prevented him from doing more than just standing up and mumbling, he did make the effort to get out of his chair and attempt some action. Under the participation criterion, therefore, he was rated, but received only the minimal score.

A more appropriate criterion might have allowed scoring of the verbalization by the control group subjects without participation, which would have offset the extremely negative rating in the experimental group and increased the variability within the control group. Another possibility would have been the omission of the totally inadequate participation, as well as the verbalization without action. In the analysis of the date it was shown that due to the small size of the sample, elimination of this one case actually raised the *t* test results from a statistically non-significant level to significance at the five per cent level.

The necessity for having the MAPS test administered by several different examiners introduced a third difficulty in carrying out the original design. It was known that the relationship existing between examiner and subject would influence the objective date obtained, and on the Rorschach and the Role test it was possible to arrange for one examiner to do all the pre- and post-testing. On the MAPS test, however, three different examiners had to be used initially. It was felt, however, that their use for both pre- and post-testing would allow uniform results. But again unpredictable circumstances intervened, eliminating two of the three pre-testers, and the pressure of time made it necessary to add

*An approximate method for applying a t test under such conditions of different variances with different group sizes has been developed by Cochran and Cox (36) and reported by Snedecor (20). This method was used whenever necessary in the analysis of the data in this study.

one new examiner on post-tests.* However, careful inspection of the data derived from the rating of Realism and Interaction on this test revealed that examiner differences obscured not only ratings on the basis of story content, but also interfered with the standard objective scoring of the test.* Even though the reliability of the latter was questionable from the beginning, comparison of these test scores with rating scores would have furnished information concerning this reliability. One small section of the MAPS test data was finally discovered on which statistical analysis of examiner differences did not yield significant results. This was the patient's choice of story figures on the basis of the figure's outgoing or withdrawing characteristics. This was the only part of the MAPS test data which could be subjected to further statistical treatment.

In view of these three major difficulties encountered in carrying out the original experimental design no conclusive statistical results could be obtained and the findings revealed only possible trends.

Presentation of Statistical Results

The Role Test

Hypothesis 1: Participation in twenty-five psychodramatic group therapy sessions will result in quantitative (and qualitative) changes in "role taking ability" as measured on an action test, a role test.

Statistical confidence in judging role-behavior had to be established before analysis could be undertaken. The inter-judge reliability ratings on overall scores of pre-tests of three judges were 87 (Judges B, V), 90 (Judges B, H) and 95 (Judges V, H), giving an average inter-judge correlation of 91. On post-tests they were 94 (Judges B, V), 78 (Judges B, H), and 98 (Judges V, H), with an average inter-judge correlation of 90. This very high agreement between the three judges' ratings on both pre- and post-tests may be attributed to two factors: 1) the raters' participation in the definition of scale categories and their training in the use of the scale; and 2) the great variability of performance in the patient group, ranging from minimal role taking ability to considerably higher role taking ability. Since the scores used were the average of three judges' ratings, the reliability based on these mean scores would be still higher than any of the separate reliabilities. These results indicate that the three judges were rating the same thing and permit us to consider the combined Role test scores sufficiently reliable for use in t test analysis.

*Objective demonstration of examiner differences influencing projective test results has been furnished by the Army Air Force Research (45) which found significant differences between examiners in terms of productivity elicited on the Rorschach. These findings have been supported by a recent study by Baughman (27) whose results indicate that some examiners are interchangeable, while others are not interchangeable.

*This new examiner had both more clinical experience and better acquaintance with the MAPS test than the other examiners.

The next step to investigate the relationship between scale categories. The scores of each patient for the Role scale categories were obtained by asking the judges to rate each test situation (such as mailman and father) on all eight categories and to make a global rating of each category at the end.* Although definitions and directions were clear there is no positive assurance that the judges actually rated separate categories. A consistently high relationship between ratings of all categories for each patient, using Pearson r was found, which points to the possibility that judges gave more global than separate ratings. Another factor which may account for the high relationship between categories has to be considered in this connection. In the test construction it was not known to what extent the eight categories were independent and to what extent they were related to each other. It was only postulated that they were all important aspects of role-behavior and were all involved in role taking ability. The lowest correlations in rating of categories A toF (Interaction, Realism, emotional intensity, affiliative spontaneity and personal security) with category G (the ability to take and act out a role) were ninety-two on pre-tests and ninety-seven on post-tests. These extremely high correlations may mean either that the judges did not differentiate the categories or that these categories actually are correlated very highly in the behavior of the role player. The question raised is unanswerable on the basis of these data. It may be reasonable to assume that the judges attempted to follow direction and that a high relationship exists between categories as interpreted by the judges. Therefore, primarily overall scores were used as the final measure.

If the first hypothesis is to be supported by the data, we must expect a significant difference between the means of experimental and control groups on Role test scores. The first, most striking finding was the difference in variance of the distributions of experimental and control groups' difference scores (difference score equals post-test minus pre-test scores). One factor, the unavoidable reduction in the control group size, has been previously discussed (in Chaper I). The great variability which arose within the experimental groups during the course of treatment was another factor in creating this difference. Since twenty-five treatment sessions with schizophrenic patients could be considered only a beginning phase in the treatment process for most patients, it was felt that both positive and negative changes would be apparent at the arbitrarily chosen time of post-testing and this would seem to be supported by the great range shown by experimental group patients. In other words, these difference scores reflect the variety of different patients' mid-treatment reactions

*Judges did not know which were experimental group patients and which were control group patients.

—from intensified disturbance with evidence of disintegrated functioning, to reduced disturbance and evidence of better adjustment.

On pre-tests the F ratio, using variance of combined experimental groups and control group was 1.88. This is statistically insignificant with degrees of freedom of 13 and 3. (F=8.74 would be significant at the 5 percent level). Similarly, *F* ratios between each experimental group and the control group, and between the two experimental groups were insignificant.*

On post-tests, however, the F ratios between control group with each experimental group was significant at the 5 percent level, but the *F* ratio between the two experimental groups was not significant.* The following table shows variances and *F* ratios, based on pre- to post-test difference scores of combined experimental groups and control group on several Role Test categories.

TABLE 2
VARIANCES AND *F* RATIOS OF COMBINED EXPERIMENTAL GROUPS AND CONTROL GROUP ON SEVERAL ROLE TEST CATEGORIES

Categories	Variance Within Groups		*F* Value a
	Experimental Group	Control Group	
Overall b scores	52.20	3.41	13.41
Realism Scores	46.78	2.44	19.17
Interaction Scores	68.19	8.22	8.29
Spontaneity Scores	38.92	2.54	2.54

a*F* Value at five percent level of significance (for "df" 13 and 3) =8.74.

b overall Score=Sum of mean scores of all Role Test categories.

From the above table we again see that experimental group variances differ significantly from control group variances on several categories, with the exception of Spontaneity.

All findings on variances point to a consistent trend of great variability within the experimental groups after termination of treatment, as compared to low variability within the control group (during the same time period).

In order to determine whether the means of experimental and control groups differed significantly *t* test comparisons were made. First, a comparison

*between: experimental group A and control group was 1.57; experimental group B and control group was 2.98; experimental group A and experimental group B was 1.90.
*F between: experimental group A and control group was 15.87; experimental group B and control group was 13.49; experimental groups A and B was 1.17. This significant difference in F ratios of each experimental group with the control group, as compared to no difference between the two experimental groups, furnishes some evidence of the reliability of the treatment technique.

of initial role taking ability had to be made to determine whether the groups were comparable in the beginning of the experiment. This comparison of mean pre-test scores on experimental and control groups on the sum of Role test categories yielded no significant differences. Therefore, the two groups could be considered comparable in respect to their means.

A *t* test comparison based on pre- to post-test differences scores between experimental and control groups, *not considering the direction of change* (i.e., plus or minus changes) was then made. The results are shown in Table 3.

TABLE 3

MEAN DIFFERENCE OF TOTAL EXPERIMENTAL GROUP a AND CONTROL GROUP b ON SUM OF ROLE TEST CATEGORIES

Means		Difference	*t* Value	Level of
Experimental Group	Control Group	in Means		Significance
6.95	1.77	5.18	2.15	5%

a Experimental Group N=14

b Control Group N=4

From Table 3 we can see then that the mean change in the experimental group differs significantly, at the five percent level of probability, from the mean change in the control group. This indicates that greater changes in role taking ability were recorded for the patients participating in psychodramatic therapy sessions than for the control group patients. However, this does not tell us anything about the direction of this change.

On *t* test comparisons where the direction of change was included, the variances between experimental and control groups differed significantly, as previously mentioned. Therefore, Cochran and Cox's (36) approximate *t* test method was applied. Table 4 shows the results:

TABLE 4

MEAN DIFFERENCES OF TOTAL EXPERIMENTAL GROUP AND CONTROL GROUP ON SUM OF ROLE TEST CATEGORIES AND SEPARATE CATEGORIES: REALISM, INTERACTION AND SPONTANEITY ON THE ROLE TEST SCALE

	Categories			
	Categories Sum of	Realism	Interaction	Spontaneity
Difference in Means	2.79	4.04	2.96	2.64
t Value	1.25	2.04	1.12	0.79
Level of Significance	20-30	Approx. 5%	20.30	40-50

According to this test only differences in the Realism category came close to statistical evidence.*

These results obtained on Role test ratings, though inconclusive by rigid statistical standards, all show a trend in support of the hypothesis that participation in psychodramatic therapy will result in changes in role taking ability most clearly in the area of Realism, less so in Interaction, and least in Spontaneity, and that these changes tend to be in the direction of increasing ability to take roles.

The MAPS Test

Hypothesis 2: Participation in twenty-five psychodramatic group therapy sessions will result in quantitative (and qualitative) changes in various dimensions of "role taking ability" as measured on a non-action test, the MAPS test.

The difficulties in the analysis of this test material, created by examiner differences, have been previously discussed. Only in the patients' choice of story figures on the basis of "outgoing" or "withdrawing" characteristics did examiner differences permit further analysis. By analysis of variance it was shown that this difference was not statistically significant on either pre- or post-tests.

In order to categorize the story figures as "outgoing" or "withdrawing" six judges were asked to rate fifty-four figures on these characteristics. The "outgoing" quality of a figure was defined similarly as the "affiliative" quality of Interaction on the Role test. It referred to a positive emotional attitude in Interaction with other people, which in this case had to be inferred from the identity given the figure. Specifically, it referred to attitudes of "moving away from people."

The rating scale ranged from -3 to +3, excluding the zero point. The plus side of the scale represented degrees of "outgoing" characteristics, the minus side degrees of "withdrawing" characteristics. The zero point was excluded

*It was previously mentioned, in connection with the difficulties encountered in the statistical analysis, that elimination of the one extremely low case in the experimental group (who was included on the basis of inadequate participation criteria) raised the differences to give statistical significance between the five per cent and ten per cent level of probability. Since the heterogeneity of variances and the small number of control group subjects reduced the probability of obtaining significant t test results and since absolute difference between groups, on the other hand, appeared to be marked, the two groups were also subjected to separate tests of the null hypothesis. The following questions were asked: If we assume that the population mean difference in the experimental group is zero, does the observed difference obtained in the experimental group vary significantly from chance? And again, if we assume that the population mean difference in the control group is zero, does the observed control group difference vary significantly from chance? In answer to the first question it was found that the mean of the experimental group was significantly different from zero at the five per cent level for "overall" scores, between two per cent and five per cent level on "realism" scores, at the five per cent level for "interaction" scores and at the ten per cent level for "spontaneity" scores. The corresponding mean differences of the control group, however, were in no instance found to be significantly different from zero. The level of probability for the different categories ranged from forty per cent to eighty per cent. These results tell us that some change in the positive direction has taken place in the experimental group, while an independent test of the control group did not indicate any change.

for purposes of forcing the judges to rate the figure either as "outgoing" or as "withdrawing."

The figures were divided into male and female groups, including children, and each of these groups of figures was then divided into outgoing and withdrawing sub-groups. Out of thirty-two male figures, eight figures with the highest scores were chosen for the outgoing group and similarly eight figures with the lowest scores were chosen for the withdrawing group. The same procedure was applied to the group of twenty-two female figures, furnishing six figures with the highest scores for the outgoing group, and six figures with the lowest scores for the withdrawing group. This resulted in a total of fourteen figures with high scores for the outgoing group and fourteen figures with low scores for the withdrawing group.

Each patient's pre- and post-test scores are the difference between the number of positive (outgoing choices) and negative (withdrawing choices) scores. The final scores are the numerical difference. The sign given this final score indicates whether the change from pre- to post-test was in the direction of an increase or a decrease in the choice of outgoing figures. (e.g., pre-test score -2, post-test score +5, final score +7).

A *t* test was applied to these final scores of experimental and control group patients in order to determine whether the two groups differed significantly in their choice of outgoing figures. The respective means of the experimental and control groups were 3.5 and 0.4, which difference was found to be significant at the ten percent level (t value of 1.76).

Another approach was used to make a comparison on the basis of number of patients choosing each of the fourteen outgoing and similarly number of patients choosing each of fourteen withdrawing figures. Hence, the scores used in these distributions are the number of patients, rather than the number of outgoing and withdrawing figures. The pre- and post-test frequencies for both outgoing and withdrawing distributions were tabulated for the experimental and control group. Difference scores between pre- and post-test for each of fourteen figures in the outgoing group, and fourteen figures in the withdrawing group were calculated. *t* tests were applied between the experimental and control group for both the mean number of patients choosing outgoing figures and the mean number of patients choosing withdrawing figures. The *t* value for the distributions of difference scores on outgoing figures was 1.83, which is significant at the ten percent level. For withdrawing figures the distributions of difference scores gave a *t* value of 1.77, which is significant at the ten percent level.

The results obtained on this section of the MAPS test data indicate that patients who participated in psychodramatic therapy sessions chose definitely more out-going story figures and definitely fewer withdrawing story figures than the control group patients. It was postulated that the out-going-withdrawing quality, as it was here defined, is involved in role taking ability. On this test only inferences about role taking ability can be made. Thus, by inference it may be assumed that these findings furnish some evidence in support of the second hypothesis.

The Rorschach Test

Hypothesis 3: Participation in twenty-five psychodramatic group therapy sessions will not result in quantitative changes on a test designed to measure "basic personality structure," the Rorschach test.

Again statistical confidence in judging Rorschach categories had to be established before analysis could be undertaken. The inter-judge reliability ratings (of two judges) on Realism, Interaction, Spontaneity, and the combined ratings (arithmetic mean) of these three categories ranged from 69 to 83, giving an average inter-judge correlation of .77. The reliability for the average of the judges' ratings would be again higher than any of the separate reliabilities. These results again permit us to place some confidence in the technique and to consider these ratings sufficiently objective for use in *t* test analysis.

The scores for the Rorschach scale were obtained by asking the judges to rate each test on Realism, Spontaneity, and Interaction, as defined in instructions to judges (see Appendix E). The tests were identified only by number (1-38); patients' names and testing dates were removed prior to ratings. Half of the tests, on which the judges' ratings differed by more than one point, were submitted to a third judge for rating. On these tests the average score of three judges was used as the final score for the patient. Again, as on the Role test, there is no positive assurance that the judges rated separate categories. It is again assumed that the judges attempted to follow directions and inspection of ratings seem to indicate that this was the case.

If the third hypothesis is to be supported by the data, we must expect no significant difference between the means of experimental and control groups on Rorschach test scores. The results of *t* test analysis, however, do not support this hypothesis, but rather show very similar trends to those found on the Role test.

Agai n the problem of heterogeneity of variance of the distributions of experimental and control groups' difference scores was encountered. The *f*

ratios between experimental and control group difference scores on Interaction and combined Realism, Interaction and Spontaneity were significant beyond the one percent level for the former and significant at the five percent level for the latter. On Realism and Spontaneity the variance within both groups was large and no significant differences were found.

A *t* test comparison between experimental and control groups on the basis of pre- to post-test difference scores gave the following results:

TABLE 5

MEAN DIFFERENCES OF TOTAL EXPERIMENTAL GROUP AND CONTROL GROUP OF REALISM, INTERACTION, SPONTANEITY AND ALL THREE CATEGORIES COMBINED ON THE RORSCHACH TEST SCALE

	Categories			
	Realism	Interaction	Spontaneity	Combined
Difference in Means	13.56	2.27	2.62	5.75
t Value	2.36	0.91a	0.54	2.12a
5% Level of Significance	2.11	—	—	2.25
10% Level of Significance	—	1.76	1.74	1.83

a *t* by approximate method.

From Table 5 we can see that the mean change on combined Realism-Interaction-Spontaneity ratings and Realism ratings in the experimental group differed significantly from the mean change in the control group. On Interaction, according to Table 5, no difference was found, but a *t* test comparison disregarding direction of change (i.e., plus and minus signs) gave a significant differene at the two percent level. Only on Spontaneity was no difference found, with or without direction of change. Contrary to expectations, these results point to a trend in some quantitative changes on this test designed to measure "basic personality structure."

CHAPTER IV

QUALITATIVE FINDINGS AND DISCUSSION

In the quantitative analysis we were concerned with the existence and amount of change apparent in the comparison of pre- and post-tests. Now qualitatively, let us consider the *nature* of these changes as seen in group trends (on each test and over the entire test sequence) and in the individual. This consideration should serve two purposes: a) to provide observations and content material as illustrations for quantitative findings; b) to discuss new trends

which did not appear in the statistical analysis.

Because this qualitative discussion is necessarily based on inferences and the writer's subjective impressions and interpretations, several qualified clinicians were asked to examine each patient's test records. They made independent qualitative evaluations of the data and in an effort to reduce bias, only those findings which agreed with the evaluations of other clinicians were included in this discussion. The fact remains, of course, that the experimenter and her judges were looking for positive changes and therefore the conclusions brought out in the following pages should not be considered as definitive evidence. Instead, this discussion is concerned with trends which explain and amplify the statistical findings; and with the discovery of leads toward the clarification of role (taking) behavior and the evaluation of a role taking therapeutic approach.

Evaluation of Group Trends

In the statistical analysis we were concerned with group trends. Our major findings for the treatment group as a whole were consistent "positive" trends of change in role taking behavior and in some areas of basic personality structure. What did these changes mean and how were they expressed in different test situations?

In the development of the role scale eight categories of personality traits and interaction qualities had been selected which were considered important aspects of role-behavior. However, statistical analysis revealed that the judges did not differentiate these categories in their ratings. For this reason, quantitative findings on the role test were primarily based on combined scores of all categories. Similarly, on the Rorschach scale, it was not known to what degree the judges rated the categories separately. We have some tentative evidence, however, that Realism can be rated reliably on the Rorschach, although Interaction and Spontaneity ratings are less reliable (see Chapter III). Thus quantitative findings showed mostly overall trends of changes, with the possible exception of reality orientation as evidenced by the Rorschach. Qualitatively we are looking for more specific changes, both in areas of personality and behavior included in the scales, and in other areas not included in the scales.

Qualitative evaluation was made in terms of specific qualities of personality and behavior, as these were derived from an examination of the test records. Primarily, these qualities which appeared to characterize each patient's test performance, and those qualities in which changes from pre- to post-test performance were consistently apparent, were noted. From these lists qualities common to the group could be detected for one or more tests. The qualities

so derived can be briefly described as 1) Interaction, 2) Realism, and 3) Expression and Control of Emotions.

1. *Interaction and "Identification"*

The importance of social communication in personality development and adjustment was discussed in the first chapter. At that time it was postulated that maladjustment in schizophrenia (as defined in this study) is reflected in the individual's inability to take a variety of roles and to communicate effectively. For this reason, change in the quality of social interaction was considered particularly pertinent to this study and the relevant results of our examination of test records are presented in some detail in the following pages.

Changes could be observed in four areas on the role test: a) the patients' social techniques of communicating with people; b) the patients' ability to enter into social relationships and to develop them; c) the patients' choice of social relationships; and d) the patients' ability to share feelings in interpersonal situations. These four areas of interaction are related to Category A (Interaction with and emotional responsiveness to others) and Category C (Ability to take and act out a role) on the role test scale and are, at least in part, included in the judges' quantitative ratings of these two categories.

a. The Patients' Social Techniques of Communicating with People

For the purpose of this discussion we will consider the social techniques of communicating with people to be the more external and formal aspects of interaction, rather than an expression of the total personality.

An illustration of change in this area is the pre- and post-test record of one experimental group patient (JuM) in the role of friend on the role test.*

Pre-test: Friend

(Patient walks towards the center of the action area and stands in the same place as he did in the previous role enactment). "Hi Bill, haven't seen you for a long time. (He remains standing in the same position, somewhat slumped, with his head down; fairly blank facial expression; no body movement). Do you go to school now or are you married? I have the same position, I am still working at the post-office. (He talks to himself, rather than to the other person). I'd tell him my plans, ask him what his plans are, and maybe make a date to see him again. That's about all."

Post-test: Friend

(Pause—patient shows some resistance at first, then asks to have somebody act as friend with him).

Pt: How about going down bowling. Maybe I can beat you.

F: Let's go get some hamburgers first.

Pt: All right. (They walk along and patient stops on the way). Do you want to go to that restaurant?

*This and the following Role test descriptions are observation notes which were taken during the test. They are not complete records, but only excerpts taken from the test.

F: Looks okay . . . two hamburgers.

Pt: And coffee. (talk some about bowling).

F: How are things on your job?

Pt: Making pretty good money now. It's nice work—has some drawbacks, but I don't mind too much.

F: Figure you can save some up and then get out?

Pt: Yes, save up to go to school. How is your job? Make much there?

F: Lousy.

Pt: (Sympathetically) At least you are working days. That's one advantage . . . I have to work nights.

F: . . . these hamburgers are not bad.

Pt: We might as well get going . . .

In comparing these two records* some definite changes in Interaction may be observed. On the post-test the patient showed more out-going action in his relationship to the other person. He was able to participate in a common activity, rather than merely describing it and he seemed more interested in talking to the other person.

Another illustration of change in social techniques is the pre- and post-test record of patient JaW, an experimental group patient, in the situation with a woman on the Role test.

Pre-test: with woman

(Patient tells the girl what role she is to play) You are a typist in an office and you are typing away. I am coming in, punch the time clock. (He tries to move away from her, does not respond to her at all. Every time she says something he gives her something to do, completely rejects her). Now go on, you are just typing, same all day, don't say anything, just type. (Quite tense in situation, very hostile).

Post-test: with woman

G: Hello.

Pt: How are you?

G: What are you doing these days?

Pt: I'm kept busy. (Hand to face, sitting at table; keeps same position. Fairly long pauses. Embarassed about her question regarding his free time).

G: Why don't you come up to the house some time?

Pt: Haven't got much time left after work.

G: My little sister has been wanting to see you.

Pt: How old is she? (only looks at girl occasionally) Any good dances around here lately?

G: I don't really know. No one takes me out.

Pt: What's the matter? (laughs embarrassedly)

G: I guess I'm just a drag.

*It may be argued that the changes observed on the post-test were brought about by the patient's substitution of a real person for an imaginary person. However, examination of pre- and post-test records of all patients showed that each patient interacted in a consistent manner with both imaginary and real people. It was therefore felt that interaction with real and imaginary people could be used interchangeably.

Pt: I never heard of that before. (Conversation continues until examiner cuts off scene).

On both pre- and post-test this patient felt hostile towards the girl in the situation and behaved in a rejecting manner. However, on the post-test he was less abrupt in his approach, showed more skill in handling the situation and was able to stay in the situation rather than having to withdraw from it.

Similarly, for twelve out of fourteen experimental group patients, protocols of Role tests at the end of the treatment series, as compared with pre-therapy protocols, showed more action and interaction with other people, more awareness of conventional mannerisms of social communication and more ease and self-assurance in social situations. For the two remaining patients more withdrawn behavior and a general decrease in action and interaction was observed. This may indicate more preoccupation with their emotional problems at this time. In the control group, four out of six patients showed somewhat more action and interaction on post-tests, but with the exception of one patient this tended to be more "acting-out" behavior, rather than socially conforming behavior. In other words, control group patients who demonstrated increased interaction did not seem to improve in social techniques, but showed greater freedom in acting out highly personalized roles and situations.

Role test findings for the experimental group patients appeared to be confirmed by general observations of the treatment sessions. During the course of treatment each group member acted in a variety of "psychodramatic" roles and situations. As the treatment progressed the majority were more ready to assume the roles required in the enactment of their own or other patients' situations; there was physical movement in action situations and somewhat more awareness of the conventional forms of interaction behavior; they also seemed better able to initiate and carry on a conversation with another person in psychodramatic situations, and with group members during discussion periods.

b. The Patients' Ability to Enter into Social Relationships and to Develop Them

A typical example of change in this area is the pre- and post-record of experimental group patient DaW in the role of father on the Role test.

Pre-test: Father

(Gets up, verbalizes on getting up, tired. Washes up, shaves, washes hands, buttons shirt, puts on pants, socks, shoes. Goes downstairs, sits down at table. No conversation. Verbalizes on kissing wife. Sits down on train). Good morning, Mrs. So-and-so. (Goes to office, sits at desk, eats lunch, back to work, checks time, starts getting things together, punches time-clock, back on train, going home). Can't explain much more.

Post-test: Father

I am coming home in the evening at 5 or 6 o'clock. (To wife)—How are you? What are we having for dinner tonight? Fish—fine—my favorite dish. How are the children doing in school? Fine.

I'll have to put some overtime in on Saturday. We can't go on that trip we planned. But we will go soon. Where are the children?

Here they are!

Hello, Bob. How are you?

(Family sits down to dinner—eats dinner).

(To Junior)—What did you do at school today, Bob? You, John? That's good—that's good. I remember when I went to school. Twelve years ago. Had to do a lot of work. (More conversation).

After dinner: I think I'll go read now.

This patient's approach to the post-test interaction situation seems more direct and definite. He no longer defensively describes the situation and remains external to it. Instead, he enters into the situation and talks directly to the wife and children. His attitude appears to be more out-going and he shows more interest in developing personal relationships. Seven out of fourteen experimental group patients approached the various post-test interaction situations more definitely and directly; their attitudes tended to be more out-going, their activities more specific and their language contained fewer qualifying statements, such as "perhaps," "probably," and "maybe." These characteristics were all interpreted to be associated with the patients' ability to initiate and develop a social relationship. In the control group only one patient showed a more direct and definite approach to a social relationship.

c. The Patients' Choice of Social Relationships

Differences from pre- to post-Role tests among experimental group patients in this area may be illustrated by another patient's (PiF) performance in a future situation.

Pre-test

(I am running an automobile.) Hello, Joe, want to ride in my car? (Joe on street). We'd stop off to eat and discuss family, how he gets along with his wife and I with my wife. I drive off and take him home. It's hard for me to think ahead in the future.

Post-Test

Patient chooses situation with girl friend—they have just become engaged. "What shall we do?" (She) "Let's celebrate." (Pt.) "Okay, we'll go out and celebrate the engagement. Go to a movie. (It's a good feeling to trust a person, that she won't break the engagement. It's a good movie—a Western). It's over. Let's go and have supper—Here's a modern restaurant—it's air-conditioned. Shall we go in?" They enter. "What would you like?" (She) "You order." (Pt.) "Let's have some ham. Do you want a big meal? Or Sandwiches?" (She) "No, sandwiches." (Pt.) "I'll order beer. Waiter, give me five ham sandwiches and four bottles of beer. How long should we be en-

gaged? About a year? I'm not certain about my job. I hate to take the chance it might not work out. Not too long? Okay, six months, then, we'll see how things turn out."

Here we can see movement from a more distant, casual relationship toward a more intimate relationship. The patient was able to allow himself to be more emotionally involved and to establish a relationship in which an exchange of feelings could take place.

Another type of change in this area may be illustrated by ViD's choice of a relationship with a woman:

Pre-test: Woman

(I am visiting Betty, the oldest of three sisters who lived upstairs in our house. She is the one I did the most talking to). "Good afternoon—I would say I've been away, sick, in the hospital, but I am better now. (Keeps standing in the same spot, head stooped, talks in a very low voice). I haven't seen her for two years. It is difficult to carry on a conversation. I see you are a good girl now. Do you go out much?" (Then he talked about a movie he had seen).

Post-test: Woman

(Situation: at dance, has a drink in one hand. The first time he has seen her—getting acquainted with her). "I'd walk by. I dropped the cup. Did I get some on your gown? I'd be embarrassed. Mind if I sit here? Maybe I can finish the coke without spilling it. Are you here alone? Mind if I talk to you a while? (Holds cup.) I don't come often. I don't know the fancy numbers. (Voice trails off.) I can't see what they get out of jitterbugging. We could try. May I have the next dance? (They dance to whistling).

Oops, my shoes." (Make believe music. Continue conversation and getting acquainted; situation cut off by examiner).

Here we note a change from a relationship which may be described as more formal and familiar, to a less familiar, more "socially-difficult" relationship. Again, instead of remaining external to the situation, the patient appears to be less defensive and enters into the situation both with action and conversation. Similarly, in the "situation with a woman" seven out of fourteen experimental group patients who selected a relative, a secretary, or an older woman on pre-tests, portrayed situations with a wife, date situations, and more casual meetings with potential girl-friends on post-tests. None of the control group patients demonstrated changes in their choice of personal relationships.

d. The Patients' Ability to Share Feelings in Interpersonal Situations

The tendency for experimental group patients to show more interest and ability in sharing their feelings was brought out by patient JeL in the post-role test situation with a woman.

(Patient structured the situation as a discussion about the psychodrama meetings, with a woman in the role of group therapist). ". . . fellows came and

first they didn't talk much . . . fellows seemed agonized—troubled . . . Then they talked about themselves and showed what happened to them. My memory has been revived. I remember lots of things now. Did good to remember them . . . I have hope for the future."

Several other patients demonstrated increased sharing of feelings as follows: On pre-tests they depicted situations with a friend as casual meetings, where they stopped on the street, asked a few questions and left. On post-tests, however, the same patients spent some time with their friends, ate, drank, or went out together with them and instead of merely asking questions they exchanged experiences. Other patients began to use such phrases in their interaction situations as "I had the same experience . . . I felt the same way . . . "

Ten out of fourteen experimental group patients seemed to portray their roles in a less mechanical manner. They seemed to move emotionally closer to people and to establish more of a give-and-take relationship. These characteristics were associated in the evaluation with the ability to share feelings. None of the control group patients seemed to show emotional involvement or sharing of feelings in interaction situations.

Some movement in this area could be observed more directly during the psychodrama meetings. As the treatment sessions progressed, patient-initiated discussions increasingly centered around feelings, rather than content; the majority of patients showed more interest in other patients' problems and activities and entered more readily into group discussions.

From the above discussion it can be seen that the treatment group as a whole seemed to show fairly uniform trends of change in the four interaction areas which were felt to be most pertinent on the role test, in spite of the great variability of individual reactions to interaction situations. Examination of the test results seemed to indicate that the changes involved more than mechanical role taking skills. The patients' attitudes toward themselves and other people appeared to be different; they tended to show a somewhat greater feeling of self-esteem and more interest in other people. This, in turn, enabled them to approach people and situations more definitely and directly; to enter more readily into social relationships and to develop them; to move from more distant to closer relationships; to move from familiar to "new" and more difficult social situations; and to attempt to share their feelings with other people.

In connection with the discussion of experimental group changes, it would seem appropriate to include an example of the lack of change in these four areas which characterized control group pre- and post-role tests.

Following is a description of a control group patient's (CaW) performance in the situation with a friend.

Pre-test:

"Hello, Bill. What do you know? We'd talk about sports—I play ball, swim, shoot pool. We could play golf." (He sets the ball up on the tee, swings an imaginary golf club, and watches the ball's flight). "Now it's your turn." (Watches friend's play).

Post-test:

"Hello, what are you doing? I've been away quite a while—haven't seen you. How are you getting along? I don't have much to talk about—we might play cards. (Shuffles cards, deals, makes a few motions of play). Examiner: "Anything else?" "Oh, some kind of sport—go out for a swim."

Here we see little change in social techniques of communication; the patient remains external to the relationship and there is no emotional involvement or interchange.

Examination of the MAPS test stories tended to support these qualitative findings on the role test. Although examiner difference invalidated quantitative analysis based on story content, this material could be used to investigate qualitative trends in this area. On this test interaction with people and sharing of feelings was inferred from the content of the stories. The records were analyzed according to durable, intense, intimate and definite aspects of interaction as described aspects of interaction as described on the MAPS test rating scale (see Appendix C).

The following story (by PiF) illustrates the changes in interaction quality found among experimental group patients:

Pre-test: Livingroom

"I got two people standing in the day room—mean livingroom. This is a man and a woman. The man is helping the woman clean house. They're married people. They're trying to clean house as quick as possible so they can go for drive in country (Else?) Go out to dinner, then to show. Then come back and sit in day room—livingroom, talking of what a wonderful time they had."

Post-test: Livingroom (moves figures about some and tells story).

"Here's doctor, his wife and two children. Doctor gets up and wife makes breakfast for him. After breakfast he gets in car to go to work and she is getting two boys ready for school, making sure shoes are shined, teeth brushed, clothes clean and she asks them to be as good as possible in school and they promise they'll try."

"Then doctor comes home—no, he eats out because he's so busy and he tells his wife and she says all right. Kids come home from school and eat and mother asks how was school and they say all right and then kids go back to school for a few hours."

"Doctor comes home and kids come home and they eat dinner and doctor is telling how much money he made that day and they talk about having new curtains and a new rug. They all go for a ride and doctor treats sons to soda and wife and doctor have cokes—then they come back home and mother puts boys to bed."

On the post-test the people and their activities are described more specifically; there is more feeling expressed in their personal relationships and they

seem to enter more fully into the intraction situation. Similar changes were found in nine out of fourteen experimental group patients.

Among these given the MAPS test in the control group, post-tests to all but one patient were administered by a more skillful and experienced examiner. This may have accounted for the greater productivity of control group patients tested by him, since WtU, the remaining member, showed no increase in productivity. (On all other tests WtU showed the highest positive changes among all control group patients). This increased productivity was reflected in more detailed interaction of people in the stories, but the emotional quality of interpersonal relationships did not appear to change. The following story pair (by JzL) may illustrate this point:

Pre-test: Livingroom

Police officer makes his entrance. Got his car parked out in front with door left open.

Post-test: Livingroom

The soldier's coming home, and he notices his father preparing to hang a plaque or picture. He's made because he lost his luggage, and ah—his mother is calling attention of husband to fact that his son returned. (Ending?) Well, he probably would be escorted to his bedroom after his arrival.

The post-test story reflects some increase in definite interaction quality, but the people appear to remain essentially distant, isolated and do not share feelings. The patient avoids the emotional factors in the situation, describing in constrained terms a scene which the omission of emotion renders unrealistic.

Examination of Rorschach test results revealed changes in interaction quality which were less marked than on other tests. On this test, interaction with people and sharing of feelings was inferred from a variety of formal and qualitative indicators which are described on the Rorschach scale (see Appendix D). According to the operational definition of interaction used on this scale, positive changes may be interpreted to mean that patients with higher interaction ratings on post-tests revealed potentially more positive social attitudes, greater social sensitivity, more out-goingness and control, more maturity of affect and an increased ability to see and experience things as other people do, with less opposition to conforming. Any or all of these factors could be considered as involved in interaction changes. Seven out of thirteen experimental group patients and only one out of six control group patients showed changes in some of these characteristics and were given higher quantitative post-test ratings by judges. However, no consistent and uniform changes in interaction pattern emerged for the group. This may, in part, be due to the nature of the test, from which it is as yet difficult to infer more subtle qualities of interaction and specific interaction behavior.

2. Realism

This quality, which was included in the role test scale and the Rorschach scale, was defined as the individual's clear perceptions of the world around him with emotional and intellectual perceptions shared or parallelled by most other people. Since we were treating schizophrenic patients who are characteristically "out of touch" with reality, it was considered important to examine some of the specific behavioral changes which appeared to be associated with reality orientation.

On the role test the "future situation," in which patients were asked to choose a day two years from now and to show what they would like to be doing on that day, seemed to be particularly appropriate for evaluation of changes in Realism.

Among experimental group patients three different types of changes were found in this area:

(1) LeF in the future situation illustrates one type of change:

Pre-test:

(Patient picks a girl from the audience to be with him in the situation. He says he has an automobile company and the girl is his secretary). "I want to dictate a letter to you (to secretary) it goes to General Motors." (Turns to audience and says: "This is supposed to be real.") "Take this down—We can't go along with your set-up, because I must get my cars loaded, no—put instead —we must find your cooperation, because I have a whole lots of cars on the market and I don't want no interference, because after all our company must be happy (?). Have that typed right away and I'll sign it." (The secretary types the letter and hands it to the boss to sign. He signs the letter). "Give it to the boy to take it to the mail right away. That's all."

Post-test:

(Patient picks a girl from the audience to be with him in the situation). "You are my wife, your name is Virginia, and we have a home and a couple of kids. I am home from work at the steel mills, it's after supper and we are planning a house party."

Pt: "I met some old friends of mine today whom I haven't seen in a long time. Let's throw a little party for them. What do you think?"

V: "That would be nice."

Pt: "I would like to show them our place and we could all have fun."

V: "We are proud of it, but we want to make sure they don't tear everything up."

Pt: "No, you don't have to worry; they are not rough, they were in the army with me and they are O.K."

V: "That's fine. What would you like to do?"

Pt: "Have them come over and bring their girl friends."

V: "Would you like me to fix dinner for them?"

Pt: "That's up to you if it's not too much bother for you with the kids."

V: "I could make it on Saturday if we don't invite them too early."

Pt: "They probably won't want to come early. Let's ask them over after the kids go to bed . . . around 9 o'clock and then we'll just have some drinks."

V: "That's fine." (At this point scene was cut off by examiner).

In this situation we can observe a clear shift from a grandiose, quite unrealistic perception of the future (patient is a twenty-two year old Negro with a limited educational background and no vocational skills) to a more possible and realistic perception of the future.

(2) JeL in the future situation illustrated another type of change:

Pre-test:

Take a trip, on a vacation, going to beaches, traveleing on train. Would like to have a friend along he can talk with about jobs, amusements, old times. "Somebody I would be fully acquainted with." Would go to Pittsburg, only relations there. (Bob forces himself as friend into situation; John only very slowly responds. Finally goes to center of room, sits on train. Answers Bob's questions about what he would be doing back home. Pt.: "Thinking maybe my wife wouldn't want to go along on trip. Wanted to have trip by ourselves."

Post-test:

(Patient alone in the situation). "I don't think I'll go home to my wife—I will be in Pittsburg or Cleveland." (Some description and reasons for going to these cities which could not be heard well enough). "I would have some sort of job and rebuild my life—have a lot of pleasure too. Maybe I would marry someone there. Just start life all over again."

Here the change may be described from a vague "floating around" in pleasurable activities to a somewhat more clearly defined and constructive future.

(3) DaH in the future situation illustrates a third type of change:

Pre-test:

"Living at home, one of my buddies. Got my own car. Sits in chair, driving to work. Hi, Bill, how is everything; working now? What are you doing?"

"Oh, I'm working in a machine shop."

"Like it?"

"Oh—what you doing?"

"Oh, working with old job, working on new one."

"Would you like to play cards, or we could go out."

"Yes."

(Gets car. In shop sees machines he has been working on. Punches clock at noon, talks about going home, driving. Sits down. To bed at 10 or 10:30, in bed by 11).

Post-test:

"The main thing I would like is to have my old job back and be set up again like I was before I came here." (Combination description and movement). "It's a week day. Any day from start to finish. I have a girl, I guess. I live in

some room. I live at home, (Gettingup) but have a car—can get up a little later. (Eats breakfast). (Drives to work, takes off coat, starts working, tabulating cards). "Says hello to fellow I know. Noon-time—eat lunch with Jim. What did you do last night, Jim? Did you go to the movie? I think I'll go over to see Mary tonight. Maybe go to show tonight too. (Back to work. Five minutes to five. Rush out to car and drive home. It's about 12 miles. Riding in the car. Get's out of car to go to room. Put on pair of shorts. Fool around for a while. Sit down at my desk. Turn on radio, read paper, look at movie section. Plan my evening. Think I'll take Mary into Chicago tonight to see a movie and take her out dancing again). (Dinner) Fish, I love fish." (Goes upstairs to change. Gets into car. Picks up girl. Both go to movie).

"This could go on forever."

(Cut off by examiner).

DaH on post-test appears to project himself more clearly into a more specific future situation. He conveys the impression of perceiving and feeling the future as more real and "alive."

The majority of experimental group patients showed one of the three types of changes in realism. The control group, on the other hand, did not seem to show changes in reality orientation in the "future situation" on the Role test. This may be illustrated by JzL's test performance:

Pre-test: Future

Like to play golf. Put golf-bag on shoulder. Set up sticks on ground. Take big golf-club and throw ball. Walk to next hole. Aim to get ball into hole at short distance. (Goes through various motions of playing the game).

Post-test: Future

(Long pause). "I would like to be in some sport. Sailboat riding. That would have to be left out." (Meant he could not show it) "Or swimming. I couldn't enact that either."

Examiner: "Anything else you might like to do?"

(LIong pause). "That's all, just sailboat riding."

On both pre- and post-test this patient projected himself into a future play situations. The other control group patients demonstrated a similar absence of change in this area; these patients did not seem to be able to see themselves in the future.

On the MAPS test Realism was again inferred from the content of the stories. The records were analyzed according to the operational definition of Realism described on the MAPS test rating scale (see Sppendix). The following story pair by LuP may illustrate changes in reality orientation found among experimental group patients.

Pre-test: Blank

This man here in center is out in the woods, they were camping and I guess they light upon a great big snake here, and they got no weapons and they

get scared out and this boy goes for help and the father still there and the boy got the man with the gun and saved the father.
Post-test: Blank

E instructs—
All these people are out in the park—they are having a picnic and seem to be enjoying themselves. Girl and fellow trying to decide to play tennis or not. Others—guess they're going to do some—have a race or broadjump or something—lot of things they could do at a picnic—everyone has own thing they want to take part in most.

In post-test story the description of people and the situation is more plausable and could be said to be more parallel to the perceptions of most other people. These changes were found in nine out of fourteen experimental group patients. There is a more logical relationship between the description of people and the situations in which they find themselves. In the evaluation these characteristics were associated with positive changes in reality orientation.

In the control group post-tests were presumably influenced by the more skillful examiner. Two out of five patients showed changes similar to LuP illustrated above. The other three patients appeared to remain unchanged in this area.

On the Rorschach a definite trend of positive changes in reality orientation could be found. On this test Realism, like Interaction, was inferred from a variety of formal and qualitative indicators which are described on the Rorschach scale (see Appendix A). The *t* test comparison of positive changes between experimental and control groups gave a significant difference at the five percent level. According to the operational definition of Realism used in this study positive changes were interpreted to mean that patients with higher ratings on post-tests show a potentially greater ability to perceive reality accurately and clearly, better intellectual organization and logical coherence in their thinking and actions, more emotional control, and greater conformity in their thinking with that of the "normal" group. These Rorschach findings confirm observations on the other two tests and tend to give the qualitative evaluations of Realism additional weight.

3. Expression and Control of Emotions

Qualitative examination of pre- and post-Rorschach tests revealed a definite pattern of change in experimental group patients' ability to cope with their emotions. This quality was not directly included in the quantitative scales, but was, at least in part, contained in the definition and description of Spontan-

eity* as given on the various test scales. This definition, however, did not appear to be sufficiently limited and tended to obscure quantitative changes in this area. While allowance had been made for the free expression of emotion as distinguished from impulsive release, confusion seemed to arise in rating, between control and rigidity, and between free expression and explosive release.

Qualitatively the following trends were found: among that portion of the experimental group in which hostility did not appear to be a primary factor, a trend toward more control with more expression and less anxiety could be observed. Among the remaining portion, with whom hostility appeared to be a central problem, the trend moved toward more control also, but with increased rigidity. This group likewise seemed to demonstrate less anxiety and somewhat better defenses. In the control group, we found a trend of less control with more explosive expression of hostility and aggression, coupled with an apparent change in anxiety from ego-defense to ego-disintegration.

The striking question raised by these findings is the source of increased expression of hostility among control group patients following a period in which they received no treatment. The answer must of necessity lie either in increased frustration (or possible deterioration) due to lack of treatment, factors inherent in the ward situation, lack of motivation at post-testing, or merely coincidence.

The increase in control among experimental group patients is more consistent with theoretical and clinical expectations. N. Haimowitz in a pre- and post-therapy Rorschach study of neurotic patients (46), has furnished some tentative experimental evidence in this area. In her patient group the total incidence of neurotic signs decreased, while the number of individuals characterized by overly high control and constrictive processes increased. She discussed findings of over-control and constriction on the Rorschach, resulting from a variety of therapeutic experiences (such as post-operative brain tumor cases and brain injury cases) and concluded that social readjustment may require repression of a part of the self. General clinical observations suggest that the greater awareness of impulses, achieved by patients in any type of effective psychotherapy often results in initial over-control by repressive mechanisms. However, depending on the nature of the patient's problem and the intensity

*Definition of Spontaneity on the Role Test: Ability to adapt Spontaneously: This refers to the ability to meet new situations in a flexible manner; that is, to seek new solutions and to change attitudes and behavior patterns for more appropriate ones, as required. It is also a freedom from constricting anxiety which enables the individual to express himself "on the spur of the moment." It should not be confused with impulsive, explosive emotional release (see appendix). Spontaneity on Rorschach test: Spontaneity as it used on this scale may be described as: the ability to meet new situations in a flexible manner, that is, to seek new solutions and to change attitudes and behavior patterns for more appropriate ones, if required. It is also a general freedom of emotional expression and response, which should not be confused with impulsive, explosive emotional release.

of the treatment situation, more adequate mechanisms of adjustment may be developed and a more satisfactory balance of control and expression may be achieved. It is interesting to note that after only twenty-five psychodramatic sessions with schizophrenic patients, five out of thirteen patients showed more spontaneous emotional expression combined with more mature emotional control. This raises the question whether a role taking action technique with this type of patient may possibly reduce the fear of "acting out" some impulses and thus reduce the need for total repression.

In this qualitative discussion of group trends, we have shown the specific areas of behavior and personality structure which appeared to be most directly affected by psychodramatic group treatment. These observations, it is hoped, will clarify the meaning of the quantitative changes seen in role taking ability and stimulate more accurate future research in this area.

In this study the effects of the psychodramatic group therapy experience seemed to be demonstrated in changes in social communication (role taking ability and interaction quality), reality orientation and emotional control. The changes seem to reflect the combined influence of the productive emotional atmosphere and environment provided by a group therapy situation, a give-and-take learning process (learning with "auxiliary egos"), and role-taking action. These aspects of experience can be theoretically related to the three points of view of role learning presented in Chapter I. The "dynamic" theory of Weiss stresses the emotional atmosphere, Moreno's "interaction" theory stresses the co-learning process, and Mead's "mechanistic" approach stresses role taking action. Thus our findings tend to confirm the writer's belief that all three theories are involved in the process of role development and role learning and may be productively integrated in a treatment approach.

Evaluation of Findings for Individual Patients

For the majority of individual patients, changes on the role test were not paralleled by Rorschach changes, in spite of similar findings for the group as a whole on both tests. Different results on these two tests had been expected at the beginning of the experiment, as stated in two of the hypotheses:

Participation in twenty-five psychodramatic group therapy sessions will result in quantitative and qualitative changes in "role taking ability" as measured on an action test, a role test,

and

Participation in twenty-five psychodramatic group therapy sessions will not result in quantitative changes on a test designed to measure "basic personality structure," the Rorschach.

It was felt that no changes would occur in twenty-five sessions in the "unconscious" processes—the personality potentials and the basic pathology which are revealed by the Rorschach. Greater changes had been expected in the conscious behavior, as evidenced by increased communication skills and changes in interaction quality.* Quantitative analysis, however, unexpectedly showed significant results in some areas measured by the Rorschach and less significant results in some areas measured by the role test.

Only two experimental group patients (of the thirteen for whom both tests were available) showed the expected quantitative changes: one with marked increase in role test score; the other with the expected lack of change on the Rorschach, but a reduced role test score.** The remaining eleven patients showed the following distribution of change:

Three patients paralleled positive role test score changes with positive Rorschach score changes.

Eight patients had Rorschach score changes in opposition to role test score changes:

Four patients had positive role test changes and negative Rorschach changes.

Two patients had positive Rorschach changes in the face of no change on role test scores.

Two patients had positive Rorschach changes with negative role test changes.

Qualitative examination of individual records revealed similar discrepancies in overt and covert behavior. In other words, psychodramatic treatment appeared to effect each experimental group patient, but according to our measuring instruments and qualitative observations, the majority of these patients seemed to show either greater changes in overt behavior or in "unconscious" processes, but not in both. This may, in part, be associated with the time of post-testing, which was chosen to indicate some effects of treatment, but was not considered to be completion of treatment.

While the degree and direction of change for individual patients' Rorschach and role test scores was not consistent, final scores for overall role test performance and Rorschach Reality area were comparable in nine (out of thirteen) cases. That is, if a patient started with a similar low score on both overall role taking ability and reality rating on the Rorschach (for example 2.4 and 2.7), scores in both areas tended to increase at the end of treatment; if a pa-

*"If we are aware of the consistently intervening variables between the needs of an individual and the adaptation he makes to them in reality, we do not expect reality behavior necessarily to correspond with fantasy or pathology. It would be a mistake to question the validity of either reality behavior or test data. Each has its own validity, as each is a valid sample of the individual's behavior." (54, p. 625).

**In the small control group all changes were minimal and these changes occurred in parallel. (Three positive, one negative).

tient showed a relatively great discrepancy between his initial role score and reality score (for example 1.5 and 4.2, or 4 on both), the relatively much lower score increased, while the higher score remained relatively unchanged. This is graphically illustrated in Figure 1. Patients ViD, AlK and EuB were chosen as examples, since they most clearly demonstrate these test findings. This observation raises important questions about 1) the relationship of the schizophrenic's role taking ability to his perception of reality, and 2) the particular effectiveness of psychodramatic treatment in orienting the patient toward reality adjustment.

Figure 1 also furnishes an example of divergencies encountered between test scores (both pre- and post-tests), and the amount and direction of change. Comparison (by inspection) of patients' initial and final test scores did not suggest any relationship between initial standing and score change. This may indicate that in this selected group of moderately disturbed patients the initial degree of disturbance, as measured by the role test and the Rorschach ratings, did not appear to influence the amount of gain a patient could derive from the treatment situation. The relationship of initial disturbance and prognosis for treatment is an important question for investigation in future research. The present study tentatively suggests that patients with widely varying degrees of disurbance can benefit from psychodramatic treatment, but our data did not reveal what specific personality characteristics may be associated with more or less favorable changes.

The lack of a consistent pattern in individual performances raised the question of the possible relationship between selection criteria and score changes. However, comparison by inspection of the direction of change for each patient on all tests with each patient's medical and social history, disclosed no commonalities between criteria items and individual test changes. (See Table 6 in Appendix E.) Similarly, case histories and interview material were examined for relationships between individual test changes and specific characteristics of schizophrenia (considered in the selection procedure under mental condition), and again no commonalities were found. Hence, in this small sample of schizophrenic patients, individual changes in role taking ability or related personality aspects did not appear to be influenced by specific environmental conditions, educational background, number and duration of hospitalization, former shock treatment, or type of diagnosis. This would seem to indicate the possibility that an action therapeutic approach with the emphasis on communication through role taking might be effective for a variety of schizophrenic patients with differing degrees of illness (as measured by external criteria).

The questions raised by the preceding observations, then, would seem to be:

Do the divergencies shown reflect merely the variability which is supposed to characterize schizophrenic performance or can this divergency of test results be accounted for in different ways?

Do the role test and the Rorschach really measure different areas, as hypothesized, or is the potential appearing in the test designed to measure performance and vice versa?

Does the treatment tend to affect each individual in a different way; that is, does each individual take out of the treatment situation what appear to be his greatest needs at the time of treatment?

Do processes of change in schizophrenia appear at different levels, such as behavioral and "unconscious," or at different times, with little relationship between the different levels?

The quantitative and qualitative findings (Chapters III and IV) did not yield conclusive evidence in support of our basic hypotheses. However, analysis and interpretation of the data demonstrated definite trends of change in some areas of role taking behavior and in basic personality structure (particularly, reality orientation). These "positive" trends seem to sustain our original assumptions, as well as our principal hypothesis, that a psychodramatic group therapy approach is effective in the treatment of schizophrenia, and seems to have wide implications for future research in the theory and practice of interpersonal relationships.

CHAPTER V

SUMMARY, CONCLUSIONS AND IMPLICATIONS

In this study two related questions were investigated: a) the effectiveness of a group action method (using role-taking techniques) in the treatment of schizophrenic patients, and b) the influence of role-taking ability on total personality adjustment. The more specific purpose of the study was to measure the effects of a psychodramatic group treatment method on the role-taking ability of schizophrenic patients. The experimental design and instruments were developed as a means of checking on the hypotheses that a limited number (twenty-five) psychodramatic treatment sessions will result in changes in role-taking ability (as evidenced by performance on a Role test and the MAPS test) and in no changes in basic personality variables (as measured by the Rorschach).

The study was carried out in a state mental hospital, from the population of which thirty male schizophrenic patients (all veterans of World War II) were selected as subjects. Selection criteria included the following: psychiatric diagnosis of schizophrenia with special characteristics of inadequate social development and communication; no discernible organic involvement;

average or above average intelligence; twenty to thirty-five years old; and a maximum total hospitalization of three years. These subjects were divided into three groups; two psychodramatic treatment (experimental) groups, and one control group. Both treatment groups were conducted in the same manner by the same therapist (the experimenter), and each met twenty-five times over a period of two months. All thirty subjects were given three tests: the Rorschach, the MAPS test, and a Role test. These were administered before the onset and after the completion of the treatment sessions, in order to measure changes in areas of role behavior, judged significant, within the experimental group and between the experimental and control groups.

The quantitative data were derived from ratings by three judges for each patient on scales based upon the testing instruments. Inter-judge reliability was determined by Pearson *r*, and found satisfactory. Tests of three hypotheses were sought in the pre- and post-therapy comparison.

The first hypothesis was concerned with changes in role-taking activity, as measured directly by the patients' performance on a role (action) test. Three judges rated role taking performance on eight scales which comprised this role test. Three of these scales related to areas which were felt to be most crucial and were consequently given separate treatment. (Realism, Interaction, and Spontaneity). For each patient pre-test scores were subtracted from post-test scores, thus yielding different scores. A *t* test comparison of these difference scores between experimental and control groups yielded statistically significant results (at the five percent level of confidence) only on the Realism scale. On the scales of Interaction, Spontaneity and all eight categories combined the differences between groups did not meet the usual requirements of statistical significance (*t* for Interaction and combined categories was between twenty and thirty percent level of confidence, *t* for Spontaneity was between forty and fifty percent level of confidence). However, certain additional tests of significance discussed in the text indicate a more definite trend than these figures may suggest toward confirming the hypothesis.

The second hypothesis was concerned with changes in role-taking ability, as measured by inference from the MAPS test. Due to significant examiner differences a part of the test data did not lend itself to statistical analysis. The hypothesis was tested on a section of the MAPS Test data which dealt with the patients' choice of story figures (on the basis of their outgoing and withdrawing characteristics); on this section no statistically significant examiner differences were found. It was felt that the outgoing-withdrawing quality, as evidenced by story figure choice, was involved in role-taking ability. In order

to determine whether experimental and control group patients differed significantly in their choice of outgoing or withdrawing figures, three *t* tests were applied. All *t* tests resulted in differences at the ten percent level of confidence and thus indicated that at post-testing experimental group patients chose definitely more outgoing story figures, and definitely fewer withdrawing story figures, than the control group patients. By inference these findings show changes in role-taking ability and tend to confirm the second hypothesis.

In the third hypothesis it was postulated that no change would occur in basic personality variables, as measured by the Rorschach. Again three judges rated the patients' test performance on Realism, Interaction and Spontaneity scales (based on judges' evaluation of Rorschach records). A *t* test comparison of difference scores (pre-test score minus post-test score) between the experimental and control groups on the Realism scale and the combined Realism, Interaction and Spontaneity scale, yielded statistically significant differences (at the five percent level of confidence for Realism, between the five and ten percent level of confidence for the combined categories) for the two groups. The *t* test comparison of Interaction and Spontaneity scales did not show significant differences between the two groups, but indicate a trend in the direction of "positive" changes. These findings were contrary to expectations and suggest that trends toward changes in role-taking ability are accompanied by similar trends toward changes in some basic personality variables.

While the quantitative results presented are inconclusive, the consistent tendency on all three tests in the direction of "positive" changes in the treatment groups, as compared to insignificant changes in the control group, lends some weight to these findings. Furthermore, qualitative evaluation and interpretation of changes in the categories of Interaction, Realism, and Emotional Control confirm and strengthen these quantitative findings. Qualitatively, the specific aspects of role taking behavior which seemed to be most affected by psychodramatic treatment were found in:

1. Four areas of interaction:
   a. Social techniques.
   b. Ability to enter into relationships and develop them.
   c. More "mature" choice of social relationships, and
   d. Ability to share feelings.

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

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

These results lend themselves to various conclusions, implications, and questions for future research.

The findings of the study seem to support the assumption that role-taking is not a mechanical skill superimposed upon personality, but an essential part of personality formation and adjustment; that the development of role-taking ability, especially for individuals in whom the skill was never adequately developed or has broken down, may be as important an aspect of treatment as the development of strictly emotional processes.

In the first chapter the question of the development of role behavior and role learning was discussed and three fundamental points of view were advanced: the "dynamic" theory of Weiss; the "interaction" theory of Moreno; and the more "mechanistic" theory of Mead. From our statistical findings and the qualitative discussion of Interaction and "identification," some support for each of these theories can be derived, and any "new" theory of role behavior would seem to require an integration of these points of view.

Overall support is seen for the hypothesis, in the first chapter, of the feasibility of group treatment for psychotics (specifically, a dramatic "action" approach for schizophrenic patients). In our sample, we found that many of the patients had limited language facilities and showed immaturities of social behavior similar to that of children and young adolescents. Thus on action approach, using non-verbal channels of communication, was felt to be highly appropriate for these patients. We do not have conclusive evidence that it is communication through the non-verbal channel of action which seems to be particularly effective, but comparison of an action and non-action approach might furnish needed information on this subject.

Group action techniques of psychotherapy are not new, either in terms of historical phenomena or of contemporary therapeutics. Nevertheless, few fields have so little to show in the way of statistical results of controlled studies. This, of course, is due in part to the problems confronting any study in which the human factor plays such an important and unpredictable role. Secondly, a group activity presents its special problems of grouping, controls and duplica-

*The qualitative findings do not lend themselves to relatively simple summarization as does the quantitative material. Therefore, the reader is advised to refer to Chapter IV. The following implications and conclusions are based on both, qualitative and quantitative findings.

tion of activity and environment. A population sample large enough so that testing might produce more definitively significant conclusions would introduce numerous variables, the simultaneous control of which would be extremely difficult.

The lack of suitable instruments for the measurement of these areas peculiar to dynamic research in an action technique is perhaps as great a difficulty as the original impediments facing such a study.

> Methods of research which are appropriate to the dynamic, social problems of group therapy are still in a very primitive form. The development and refinement of such methods, including basic theoretical concepts, is certainly one of the most important tasks which confronts us. In the meantime, however, we must use whatever makeshift tools are available, provided they meet our basic needs . . . More and more we find that research problems in clinical work must be approached dynamically and that we can no longer postpone a direct research attack on the movement and change processes which are the crux of so many clinical problems. (19, p. 85).

Some comfort can be derived from the natural sequence of exploration followed by evaluation; from the fact that instruments seem to evolve from the need for interpretation. But though the difficulties can be readily visualized, and perhaps partly because of that fact, a group action technique (and specifically, of course, psychodrama) is a challenging field for research.

The findings of this study itself raise many questions, and illuminate areas relative to the subject in which further research might prove profitable. For example:

1. Can we experimentally demonstrate that the development of role-taking ability involves a favorable emotional atmosphere, a "spontaneous" co-learning process and the actual activity of taking the role of another person? Our study suggests that all three factors are involved. Might not an investigation of children's role taking behavior throw some light on this question?

2. Is the psychodramatic technique, with its action method and non-verbal communication, particularly effective for children and psychotics, or can it be used with equally beneficial results for more verbal, more socially skilled neurotic patients? In our small sample of schizophrenic patients, both the initially very withdrawn and the initially more out-going and verbal patients showed some marked change in their quality of social communication and/or some areas of covert behavior. Does this indicate that a wide variety of emotional disturbances may be amenable to this treatment approach?

3. Are our more significant findings of changes in reality orientation (particularly on the Rorschach) due to a better understanding of the meaning of

this quality and the higher reliability of judges' ratings of reality orientation on this test? A clearer and more precise operational definition of different role-taking qualities might well yield more conclusive evidence in a similar investigation. Are the more significant changes in reality orientation a result of studying schizophrenic patients for whom reality adjustment is a major problem? Or, is the psychodramatic treatment method particularly effective in this area? All three possibilities may be involved and further research should clarify this question.

4. Is the interrupted treatment period responsible for the greater variation of individual responses to different tests? Or, do the role test and the Rorschach actually measure different areas of behavior? Then individual differences on test performance would merely reflect individual differences in response to treatment. Our findings suggest that basic pathology and personality potentials may appear on a test designed to measure performance, and vice versa.

These questions suggest how much there is to be done in this field, and in the larger field of interpersonal relationships. It is the writer's belief that intensive exploration of the phenomena which appear to characterize interpersonal relationships will lead to a better understanding of the factors involved, and more meaningful measurement of the problems investigated in this field.

The major conclusion and implication of this study seems to be that schizophrenic patients, whose history and pre-treatment condition indicate some deficiency and/or difficulty in social relationships, appear to respond to a psychodramatic group treatment approach by developing an increased interest and a more realistic perception of the outside world; and by showing greater ability in dealing with their personal and inter-personal problems. Further, the statistically significant Rorschach changes of the treatment group, as compared with the control group, suggest that psychodramatic treatment may affect some fundamental personality processes as well as overt role-taking behavior.

These changes, on a test presumably measuring personality structure, further imply that an "action" therapeutic technique does not merely stimulate expression of infantile needs and increase "acting-out" behavior, but leads to better personality integration and a gradual "working-through" of problems. In such a setting, "acting-out" is not the unproductive expression of resistance that it is in a non-action therapeutic situation. Acting out is the raw material of an action technique, and from this expression of emotional conflict the patient is led through action and reaction to productive, positive action-behavior.

This article will soon be printed in Monograph form and will include appendices and tables referred to in this article.

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In Memoriam

Marion Reed Smith, although nearly seventy years old when she entered our circle, made in rapid succession two contributions:

1) The "Silent" Auxiliary-Ego Technique in Rehabilitating Deteriorated Mental Patients, *Group Psychotherapy*, Vol. III, No. 1, 1950, p. 92-98.
2) Sociometric Changes in a Group of Adult Female Psychotics Following an Intensive Socializing Program, An Exploratory Study, *Group Psychotherapy*, Vol. IV, No. 3, 1951 (In collaboration with John E. Bryant and Doris Twitchell-Allen).

There are those whose immortality rests in books, objects and works; then there are others whose immortality enters the heart and mind of the people they meet. They are the most deeply remembered. Such a one was Marion Reed Smith.

These words are written in the memory of one who was an objective scientist, a loyal friend, a devoted mother, an ardent grandmother, and above all, a flaming spirit.

ZERKA T. MORENO

ANNOUNCEMENTS

Moreno Institute

The spring courses at the Moreno Institute, 101 Park Avenue commence on February 9, 1953. Registration takes place February 2 through 6; late registration permitted.

For detailed information on training courses, workshops, seminars in Beacon and New York write to Moreno Institute.

AMERICAN PSYCHIATRIC ASSOCIATION

109TH ANNUAL MEETING

May 4-8, 1953

Hotel Statler, Los Angeles, California

During the meeting a symposium "Scientific Foundations of Group Psychotherapy" will take place on Thursday, May 7, in the morning. Chairman: Winfred Overholser, M.D.; Secretary: J. L. Moreno, M.D. Program:

1. Edgar F. Borgatta, Ph.D. and Leonard K. Supple, M.D., New York City, "Some Research Findings Bearing on the Validity of Group Psychotherapy as a Diagnostic and Therapeutic Approach."

2. Howard Newburger, Ph.D., and Gerhard Schauer, M.D., "Sociometric Selection in Group Psychotherapy."

3. Dr. Gertrude Harrow, "Modification of Certain Asspects of Behavior of Schizophrenic Patients by Psychodramatic Group Therapy."

4. Dr. R. J. Corsini and Dr. Rudolf Dreikurs, "Purposes, Results, Methods and Mechanisms in Group Psychotherapy."

Probable discussants: Dr. Louis Wender, Dr. Joseph Abrams, Dr. Jerome Frank, Dr. Florence Powdermaker, Dr. Max Day and Dr. Nathan Brecker.

A Round Table on Group Psychotherapy and Psychodrama, May 7, 8:00 p.m. Participants: Drs. Carl Whitaker, Robert Drews, J. L. Moreno, Hugh Mullan, George Bach, Max Witte, Abraham Schwartz, James Enneis, Walter Bromberg, Paul Jordan.

American Society of Group Psychotherapy and Psychodrama, Annual Meeting, *May* 4-5, *Hotel Statler, Los Angeles, California.*

May 4, Monday Evening, 7:00 p.m., Presidential Address, to be followed by an open Psychodrama Session, conducted by J. L. Moreno.

Discussants: Dr. Helen Jennings, N.Y. and Dr. Robert S. Drews, Detroit.

ANNOUNCEMENTS

May 5, Tentative program: Morning Session, Chairman, Dr. Rudolf Dreikurs: "Psychodrama with Children," Drs. Zelda S. Wolpe and Charlotte Buhler; "Psychodrama with the Child's Real Social Atom," Adaline Starr; "Learning Sensitivity through Psychodramatic Training Session," Dr. Melvin E. Allerhand; "Psychodrama in Private Practice," Dr. William E. Moore.

Afternoon Session, Chairman, Dr. Wilfred Hulse: "Group Psychotherapy with the Blind," Dr. Louis S. Cholden; "The Group as a Medium of Therapy," Drs. Raymond F. Bodwin, Max Bruck and Paul Jordan; "Group Psychotherapy in a Naval General Hospital," Dr. Earl A. Loomis, Jr.; "Comparative Approaches in Group Therapy," Danica Deutsch; "Definition of Group Psychotherapy," Dr. Rudolf Dreikurs.

Committee on Arrangements for above meeting: Drs. Robert Haas, Zelda S. Wolpe, Charlotte Buhler, George Bach, Abraham Schwartz.

The Midwest Section of the American Society for Group Psychotherapy and Psychodrama Training Courses

Announcing a Training Course in Theory and Practice of Group Psychotherapy. For further details write to the above at 6 N. Michigan Avenue, Suite 1700, Chicago 2, Illinois.

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