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SOCIOMETRIC EVALUATION OF GROUP PSYCHOTHERAPY*

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INTRODUCTION

A glance at our psychotherapeutic armamentarium discloses a cleavage between the instruments aiming at diagnosis and those pointing toward therapeutic change. Most of our diagnostic tests fail to involve the patient as a total participant, on his highest level, in the test-situation; thus, these are either indifferent or detrimental to the therapeutic process. Most of our psychotherapeutic methods in current practice, if they aim at making the patient more aware of himself and of others, do not lend themselves readily to diagnostic purposes—because of the unavoidably active involvement of the observer-therapist in the therapeutic process. The sociometric test combines the characteristics of a diagnostic instrument, with those of a therapeutic tool. While appealing to the patient's highest areas of discriminative awareness, and his motivation for change, it is designed to objectify the patient's participation in a simple recordable fashion; this is suited equally to be understood by him, as well as to be used as an instrument of social diagnosis and as a gauge of the therapeutic process.

Sociometry is the systematic evaluation of action, movement and behavior of individuals and of groups resulting from spontaneous, individual attempts at orientation to a social situation. Basic to such a systematic evaluation of social interaction is the spontaneity of the participants—their range and adequacy for the social roles they wish for or must play, their quantitative range for establishing and maintaining relationships, and their capacity to function in particular situations. Moreno (1) has devised instruments for evaluating these characteristics in the form of the spontaneity test, the role test, the acquaintance test, and the situation test; they at-

* Appreciation is due Dr. John G. Rockwell and Dr. Helen Hall Jennings for their invaluable contributions to this study.

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† Mental Hygiene Treatment Group, Psychiatry & Neurology Unit, Brooklyn Regional Office, Veterans Administration, Brooklyn, N. Y.; collaborated in the evaluation of the sociometric data. "From the Veterans Administration, Brooklyn, N. Y."

tempt to determine the various factors which operate in the social behavior of an individual at a particular moment; they are analogous to the microscopic or microchemical study of a cell or of tissue. The sociometric test aims at measuring the gross, macroscopic features of a group structure, determining along a nearing-distance scale the movement of each individual to each other individual in the group, as well as the movement of the group as a whole in relation to other groups. Because the object of study is social interaction and movement, the investigator is required to change his approach from objective "observation" to one of "action"; he has to move freely within the group, as one of its members, in order to study it. By so doing, he himself activates the group in the direction of greater self-awareness, self-expression, and of re-organization. This involves the re-evaluation of the concept of "objectivity", as it is applied to the study of social events (2).

Survey of Literature

By means of sociometric tests it has become possible to study the structure of a group and the position of each of its individuals (3). The most important factor that becomes visible in sociometric study, and what appears to be responsible for the cohesion within groups, is called "tele". Moreno has defined "tele" as the flow of feeling along interpersonal channels. "Tele" denotes the realistic force radiating from individuals within a social setting; it includes the "transference", its unrealistic neurotic counterpart. "Tele" is demonstrable experimentally by comparing chance groups with actual groups. The chance groups were characterized by a low number of mutual relationships, positive or negative. On the other hand, the formal-informal groups revealed a high number of mutual attractions, or mutual hostilities, as well as more complex structures such as triangles, quadrangles and chains.

The fact that people spontaneously group as by a process of choice is "central to the discovery that human society has an actual, dynamic, central structure underlying and determining all its peripheral and formal groupings" (4). Systematic investigation of the spontaneous but often latent choice or rejection process operating in various group-settings has resulted in a theory and methodology of the group-structure and of the individual's place in it, formulated first by Moreno in 1934 (5). Other investigators, following this basic work, applied sociometric techniques to various group-settings—with particular attention to the groups that were studied, the further development of the technique, and to the correlation of the results with those obtained with other methods of investigation.

Newstetter, Feldstein and Newcomb (6) gave particular attention to

the stability of group-structure in a boys' camp by means of a longitudinal sociometric study. Studying girls in a state training school by the application of sociometric techniques, Jennings (7) investigated the personality characteristics, of stars and isolates, by correlating sociometric findings with those obtained in personality studies. Attention to sociometric research and validation of methods were given first by Moreno in 1937 (8), to be followed by a study in deviations from chance expectancy (9) in 1938. Bronfenbrenner (10) in 1945 introduced a method for making sociometric comparisons from group to group, as well as a method for identifying and describing levels of significance.

Problem

The effect of psychotherapy, institutionalization, carryover from psychotherapy and conflicting pressures upon the group-structure is determined sociometrically with the help of an appropriate experimental design. A comparison is made of an experimental group that received therapy for a given period of time, with a control group comparably composed that received no therapy during the same period of time.

After a period of three months, by reversal of procedure, the carryover effect of group psychotherapy in the experimental group who had initial therapy is determined sociometrically. Similarly, the effect of delay in instituting group psychotherapy is investigated by sociometric study of the control group, that had an opportunity to develop a pattern of conformance to institutional living, not interfered with by group therapy during the first three months of institutionalization.

As the groups that were studied are composed of individuals who have presented grave social problems in their homes and communities, this study should bring into focus the problem of the social isolate and social rejectee and his interactions with others. The study of the "social atom" of the group members, and its change over a period of six months, is expected to reveal structural changes, as the result of the effects of personality, institutionalization, and group psychotherapy upon the social behavior of group-participants, as revealed by the sociometric method.

Procedure

The research population consisted of 60 consecutive admissions to the institution between the ages of 16 and 25. They were all first offenders, technically speaking, although in actuality the average history of recidivism was of five years' duration. Their offenses ranged from petty thievery to armed robbery with intent to kill.

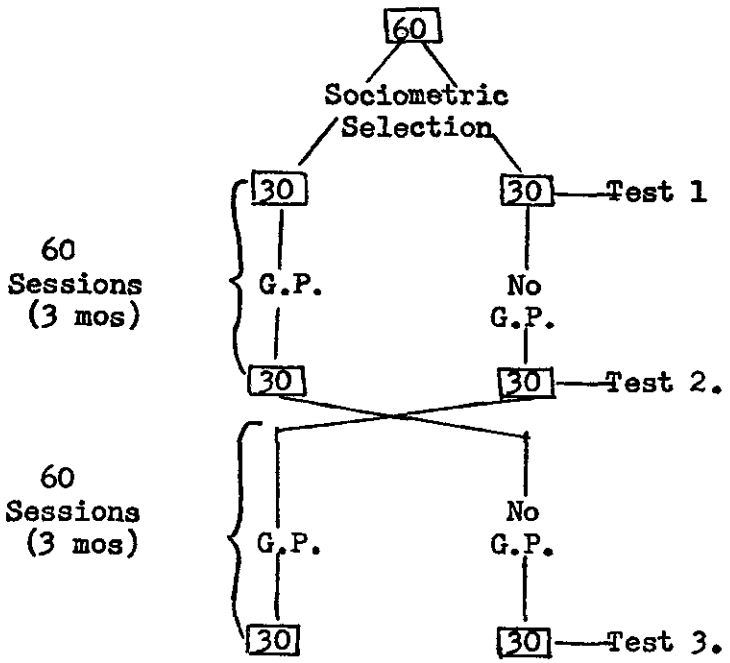
Methodology

*Experimental Design**

The total test-population of 60 consecutive admissions was divided into an "experimental" and a "control" group. Both groups were, as nearly as possible, equal in composition by the application of sociometric classification (10). The experimental group received group psychotherapy three times weekly during the beginning stage of the experiment. During the same time, the control group met together in the library without any attempt at formal psychotherapy.

After three months the regime was reversed, i.e., the control group was placed into group psychotherapy three times weekly, and during this same period the experimental group spent the time together, without receiving formal therapy.

Diagram



The total test-population was subjected to series of interviews and tests,

* Dr. John G. Rockwell of New York University has contributed the advanced type of experimental design used.

which included sociometric tests prior to the start of the experiment—three months later, and six months later.

The present type of experimental design is set up to test a number of implications surrounding psychotherapeutic and corrective practices. Provision was made for the evaluation of these practices, with the least disruption of administrative procedures within the Institution. This design also provided for additional safeguard in equating, in so far as the groups were concerned.

Upon admission to the Institution, the 60 consecutively arriving inmates (excluding those too feeble-minded to read, or those who had demonstrable brain pathology) were placed in the same cottage for a period of several weeks, in order to satisfy administrative procedures and to allow the inmates to become known to each other. They were then assigned to the group-psychotherapy units by sociometric selection. An effort was made to see that each participant had at least two of his main choices (first and second) in his group; and an attempt was made to avoid placing incompatible inmates in the same group. The resulting groups ultimately became more cohesive than those permitted through chance selection (11).

Tests and Behavior Ratings

During the 3 testing periods, the entire research population participated in 17 different tests, and ratings were administered. These aimed to correlate psychological findings, behavior as reported by cottage officers, work efficiency, attitude towards themselves and towards treatment of criminals, and capital punishment. The results of the entire research study are reported elsewhere (12).

The numerous variables were thus brought under control, so that the study might yield reliable information about the factors involved in sociometric selection, group participation, institutional procedures, and conflicting environmental demands.

Quantitative Findings

The quantitative analysis is concerned with the initial group structure and its change throughout the experimental procedure in the experimental and control groups. It consists in the determination of the various sociometric structures, such as the number of reciprocal choices as found in pairs, triangles, chains and more complex group structures, as well as in the determination of the degree of isolation and rejection.

I. *Mutual Bonds:*

An increase of 7% was noted in the experimental group for the time it was in group psychotherapy, whereas the control group showed a loss of 32% during the same period of institutionalization without group psychotherapy. After a period of three months the experimental group showed a loss of 46% of mutual bonds, i.e., after group psychotherapy was discontinued. During the same period the control group showed an increase of mutual bonds, i.e., after group psychotherapy was instituted.

Comparison of both groups for the initial test period demonstrated a gain of 39% of bonds for the experimental group, that appeared to be attributable to group psychotherapy. The second test period revealed a comparative loss of 14% for the experimental group.

II. *Group Structures:*

A. Pairs: The experimental group showed an increase of 114% in pairs, while the control group showed an increase of only 100% at test 2. During the second three months after the experiment, the experimental group showed further gain of 60%, without group psychotherapy, while the control showed a drop of 5%, i.e., with group psychotherapy. Comparison of both groups showed 14% more pairs in the experimental group. This increase over the control group became more marked in the second test period so that the total gain over the entire research period was 152% when compared with the control group.

B. Triangles and chains: Triangular structures were dissolved in both groups in favor of chain structures. In the experimental group there was an initial loss of 14% in test period one and an additional loss of 100% in test period two. The control group's initial loss was 76%, but here with group psychotherapy, the second test period showed an increase of 90%.

Comparison of both groups revealed that the experimental group lost 62% less of its triangles in the first test period than the control group. During the second test period there was a balance of 190% in favor of the control group.

No chains existed in the experimental group in the initial test period. After group psychotherapy one chain had formed involving 11% of the group. Carry-over in group psychotherapy motivated an increase of 155%. The total research period for the experimental group saw the development of chains to the extent where 28% of the group was involved. Institutionalization appeared responsible for a loss of 21% in those involved in chains. When group psychotherapy was administered after a delay, it was noted

that an increase of 64% resulted. The over-all gain resulting from the late administration of group psychotherapy was 29%. In order to maintain statistical accuracy, it is impossible to give demonstration to the significance of change due to the fact that the base starting point for the experimental group saw no chains, and it was only after the administration of group psychotherapy that chains began to appear.

III. *Isolates:*

In test period two, both groups showed an increase in isolates of 175%. In test three the experimental group showed a further increase of isolates of 45%, while the control group showed a reduction of 36%.

Apparently institutionalization and group psychotherapy had a similar effect on the growth of isolationism in the research population when comparison was made between groups. However, carry-over appeared to induce an increase in isolates in the experimental group in test three, while group psychotherapy administered after a delay accounted for a decrease in isolationism, which was significant to a percentage of 81. The overall increase in both groups showed that when group psychotherapy was administered without delay the greater increase in isolationism was noted to be 225%.

IV. *Rejection:*

In test II the experimental group showed an increase in rejection of 125%. There was no change from test II to test III. The control group showed only an increase of 25% of rejection in test II and a reduction of 33% in test III.

Discussion of Results

Group psychotherapy, regardless of time of administration, appeared to foster group cohesion by increasing the number of mutual choices. Exposure to institutional regime without the support of group psychotherapy resulted in a decrease in mutual bonds, and thus in lower group cohesion.

The development of pairs appeared to proceed smoothly at the outset of the institutional experience, regardless of the presence of the variable of group psychotherapy. However, an increased development of pairs was noted when group psychotherapy was administered at the very outset, but this was not statistically significant. The program that featured psychotherapy at the outset of the institutional experience was more than twice as successful in inducing the development of pairs as the program that featured group psychotherapy after a delay. Other structures appeared to deteriorate with time, regardless of group psychotherapy participation, with the

notable exception of the instance where group psychotherapy was administered after a delay. Presumably, the institutional experience was such as to break down existing group structures as triangles. The contrary was true of those involved in chain structures. Here we found that when group psychotherapy was administered without delay, an extreme increase in chain structures was noted. A lesser increase was noted when group psychotherapy was administered after a delay. Apparently, exposure to institutional atmosphere has a deteriorating effect upon the development of chains, which group psychotherapy can offset.

The institutional experience *per se* appeared responsible for the development of isolation in many instances, regardless of group psychotherapy experience. It was noted, however, that many relationships, which had been formed on the basis of superficial criteria, when exposed to the socio-dramatic and psychodramatic investigation were discontinued because the delinquent relationships were inconsistent with the growth and maturation of each individual. In other words, as a transitory step in the maturation of the individual, isolation was fostered because of the lack of opportunities for constructive relationships in an institution. Toward this end, the administration of group psychotherapy at the outset of the institutional experience appeared to exert a greater maturational influence than the administration of group psychotherapy after a delay.

The group psychotherapy experience proceeded more smoothly and effectively when the groups were composed on the basis of sociometric choice (14). It seems that several purposes were accomplished when the groups were given responsibility for their own formation. This procedure appeared to reawaken long since inactive respect on the parts of the group participants toward each other and toward the group psychotherapist. This resulted in increased motivation toward the psychotherapy experience. By immediately structuring the group formation on the basis of choice and of feelings, likes and dislikes of these delinquents were perhaps for the first time expressed and evaluated in a dispassionate manner. This allowed the individual group participants to proceed further into the development of their own independent moral values.

The Relationship Between Sociometric Patterns and Overt Behavior

As part of the extensive testing procedure that was undertaken with the research population they were all rated on the Haggerty-Olson-Wickman Behavior Rating Schedule. This served to afford a somewhat objective and

reliable indication of their behavior outside of the therapeutic situation. In almost every instance the loss of extreme rejections and the establishment of reciprocated bonds of attraction coincided with marked behavioral improvement. In two instances of marked initial rejection the psychiatric status of the individuals concerned was noted to be very poor—with the improvement of sociometric relations (coinciding with participation in group psychotherapy) their mental health (in one stance loss of auditory hallucinatory experiences and incestuous dreams involving nocturnal emission) was seen to improve greatly.

In no instance was it noted that marked improvement in the sociometric condition of the individual occurred without improvement on the behavioral level (as seen by the cottage officers who carried out the ratings).

Relationship of Effectiveness of Group Psychotherapy to Sociometric Changes

Walter was a white 20 year old male of slender habitus. He was in frequent difficulties with authority due to his rebellious attitude. After several trials on probation for stealing cars he was finally committed to Highfields. There his trends of suspiciousness and hostility saw him in frequent difficulty. He was diagnosed as early schizophrenia with strong paranoid trends at the time of admission to Annandale.

He was in constant difficulties with officer and inmate alike. He tended to agitate all others to negative action. A period of institutionalization without group psychotherapy seemed to be without effect in modifying his basic approach to life situations. His sociogram demonstrated little change. Once group psychotherapy was undertaken with him his irrational acts and claims became more apparent to him. He was able to relate to the group psychotherapist in a basically dependent albeit symbiotic manner. One day he brought in a dream that had caused him concern for group analysis. It concerned itself with the beheading of a figure in the woods, the dismemberment of the body and the destruction in the flames of the pieces. His associations revealed this to be a strong death wish toward his father. As he progressed in his psychotherapy, and grew in independence, his dreams grew less disturbing to him, and, toward the end of his group psychotherapy participation, he brought in a dream which indicated a more adequate attitude on his part—one in which his father was seen as a monkey cavorting about a cage in a zoo.

His overt behavior improved to the point that the Classification Committee within the institution recommended a reduction of 14 months in his

time. Now, over a year and a half later, he is still in the community doing well.

Comments

This study is concerned with three variables, each one of which in itself is highly complex. One important variable, the individual response to institutionalization has remained outside the immediate focus of this study. This has been dealt with in a separate study of one of the authors.

The other important variable consisted in the procedures used in group psychotherapy and in the response to it by the individual group participants. This has been dealt with in this study only to the extent of description of an experimental design which was intended to permit to isolate the variable introduced by the therapeutic procedure. Important to mention here is the fact that the members of the experimental and control groups could freely interact, with the exception of the time period (three times per week), during which the groups attended group therapy and control sessions respectively. Although this factor has been of demonstrated influence upon some of the test results, it demonstrates the methodological feasibility of studying interaction of groups with respect to a therapeutic factor introduced into one of them.

For instance a study of the social network of one highly rejected member of the experimental group showed that the majority of his rejections came from a group structure belonging to the control group. To this structure, another member of the experimental group was linked in Test I. In Test II, the cluster of rejections coming from this control group structure was withdrawn, although the control group members were not direct participants in the intensive therapeutic experience which the rejected group member had in group psychotherapy. It appears demonstrated by further follow-up, that the individual who was a member of the experimental group but chose membership in the above-mentioned network of the control group, mediated this withdrawal of rejection. This again does not invalidate the demonstrated deep effect of the group therapy experience upon the change in the rejected member's social atom.

The emphasis of this study was on the third variable, the sociometric test which consisted of a systematic inquiry into the likes and dislikes of the group members for each other. This test served as a therapeutic tool for selecting the participants for the experimental and control groups, and later on, as a means to evaluate the effect of group psychotherapy as well as of institutionalization upon the social status of the individual group mem-

bers as well as upon the structure of the groups as a whole. On the basis of this, a sociometric classification (15) of the inmates appeared feasible based on social and group characteristics rather than on individual diagnostic characteristics. This permitted follow-up of each group member and comparison with individual diagnostic characteristics (as reported in another publication).

The results showed suggestive trends rather than uniformity. However, their reliability beyond statistical chance seemed established by a consistency of many individual sociometric patterns throughout the three test situations, by changes in these patterns which could be mostly corroborated by clinical observation or by psychological tests or both, and by the cluster effects at the extremes of the social attraction-rejection scale which were described by Moreno as "sociodynamic effect" (9). (See illustrations.)

Within these limitations the following conclusions appear justified: group psychotherapy when started early in the period of institutionalization of this delinquent group fostered an increase in mutual choice and pair structures. This was followed by a "carry over" effect into the second period of three months where group psychotherapy was discontinued. (See quantitative analysis.) However, it also appeared to foster an increase in isolation. Furthermore, increased stimulation to express rejection as well as an increase in the number of overchosen individuals is also suggested by the test results. Group psychotherapy thus appeared to have intensified, and at times started, a natural process of reorientation which became visible sociometrically in the form of an increase in the extremes of the social acceptance-rejection scale. Another significant sociometric finding appeared to be the breaking up of more complex sociometric structures (with triangles) as an immediate effect of early group psychotherapy in institutional living.

The sociometric method permitted to foster a spontaneous process of choice for group partners in the therapy group formation. It led to the establishment of therapy groups with the collaboration of the imprisoned delinquents, rather than by assignment along individual diagnostic criteria. This is especially important in the treatment of the intramural delinquents as well as of psychiatric groups, while in the treatment of "normal" groups in the community and in clinics the illusion of free choice in selection of group partners appears to be more frequently preserved. Thus the fostering of spontaneous selection or "spontaneous assignment" was an initial step in

the process of spontaneous therapy. The latter was later on enhanced by the psychodramatic and sociodramatic techniques of group psychotherapy.

The sociometric technique permitted also to serve as a measure of treatment progress and of classification of this progress. The study of the social atom of each group member permitted often, an accurate gauging of the prevailing social status while treatment was going on, in terms of increased or decreased popularity and rejection. In a number of instances, this proved of greater validity than the results of diagnostic test procedures. For instance, several delinquents were paroled on good behavior considerably before their sentence expired. In a few the sociometric test indicated considerable social improvement while diagnostic test results seemed to indicate the opposite. The prison authorities' decision for parole arrived at independently of psy-

LIKES

EXPERIMENTAL					CONTROL				
TEST	Recip. Pairs	Triangles	Cubes	Chains	TEST	Recip. Pairs	Triangles	Cubes	Chains
I	1 pair	1 - 2 \ / 3 1 - 2 \ / 3 1 - 2 \ / 3 4 - 1 - 2 - 5 \ / 3			I	2 pairs	1 - 2 \ / 3 1 - 2 \ / 3 - 4 1 / \ 2 - 3 \ / 4 1 5 / \ | 2 - 3 - 4 - 6		1-2-3-4-5
II	2 pairs	1 - 2 \ / 3-4-5-6-7-8 1 - 2 \ / 3 - 4		1 - 2 - 3	II	3 pairs	1 - 2 \ / 3	1 - 2 | - | 4 - 3	1 - 2 - 3
III	3 pairs			1 - 2 - 3 1-2-3-4	III	3 pairs	1 - 6 / | 2-3-4-5		1-2-3-4-5

DISLIKES

I		I	1 pair
II		II	1 pair
III		III	

	EXPERIMENTAL	CONTROL	
	a. *Percentages in Pairs*		
I	7%	11%	
II	15%	22%	
III	24%	21%	
	Changes		*Signif. of Change*
I - II	+ 114%	+100%	+ 14% for exp.
II - III	+ 60%	— 5%	+ 65% for exp.
I - III	+ 242%	+ 90%	+152% for exp.
	b. *Percentages Linked*		
I	111%	130%	
II	119%	89%	
III	65%	93%	
	Changes		*Signif. of Change*
I - II	+ 7%	— 32%	+ 39% for exp.
II - III	— 46%	+ 5%	— 51% for exp.
I - III	— 42%	— 28%	— 14% for exp.
	c. *Percentages of Isolates*		
I	4%	8%	
II	11%	22%	
III	16%	14%	
	Changes		*Signif. of Change*
I - II	+ 175%	+175%	0
II - III	+ 45%	— 36%	+ 81% for exp.
I - III	+ 300%	+ 75%	+225% for exp.

chological or sociometric findings. Social follow-up had shown that behavior improvement persisted and led in some instances to good social rehabilitation.

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GROUP THERAPY WITH THE BLIND*

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For the past two and one-half years, weekly group therapy sessions have been conducted with the clients attending the Kansas Rehabilitation Center for the Adult Blind. Our experience has indicated that this group structure offers distinctive advantages in helping to resolve some of the problems presented by blind people. I would like to point up those aspects of the group relationship that seem specifically valuable in our work. Only by the method of trial and error was our present group structure developed, for the literature offered no models to follow. Our efforts have always been experimental and fluid, and I presume that many future changes will result from further experience. This report will indicate our present methods and structure with the group and some of the failures and successes from which it evolved.

All of the clients or students enrolled in the Kansas Rehabilitation Center for the Blind attend the group meetings. This state agency, located in Topeka, accepts blind adults for adjustment training and study, from Kansas and some ten nearby states. Our students are a most heterogeneous group. What they have in common is that they are all legally blind and manifest some problems in adjustment. They are usually referred by their own agency workers for adjustment training and/or diagnostic evaluation and recommendations. Their adjustment problems include difficulties in the vocational, learning, social, or personal spheres. Their ages vary from 16 to 65; their I.Q.'s from 65 to 145; their visual handicaps, from congenital blindness to partial sight with travel vision. Their heterogeneity is accentuated by wide differences in ethnic, social, educational, and cultural backgrounds.

Our present group of eight, for example, consists of the following clients: a 25-year-old congenitally blind college graduate; a 44-year-old divorcee who has been blind only a few months; a 42-year-old congenitally blind borderline mental defective who was recently released from 15 years in a state hospital for epileptics; a 40-year-old mechanic who retains vision sufficient for travel—his visual handicap is the result of a self-inflicted gunshot wound

* Presented at Annual Meeting, American Society of Group Psychotherapy and Psychodrama, Los Angeles, California, May 5, 1953.

eight years ago; a 32-year-old congenitally blind male who, until recently, was spoonfed by his mother; a 30-year-old man with travel vision, who is a borderline schizophrenic; a 20-year-old boy who lost his sight at age 7 and who has an I.Q. of 75; a 30-year-old man with practically no vision but who likes to drive cars and whose I.Q. is 80. The clinical and characterological diagnoses of our group show as wide a dispersion as one might expect from such an unselected sample.

The clients live in a dormitory and spend most of their time together or with Center staff personnel. Until nine months ago, the usual period of stay at the Rehabilitation Center was six weeks; however, we are presently studying the value of a three-month term. This change is the result of our impression that we were discharging clients before they received their maximum benefit from our services. Because of the intensive work essential in the rehabilitation of the blind, the number of clients averages five to six, the range varying from three to eleven. The sex ratio differs with each group, but there are usually more men than women clients.

Each new student is seen in separate diagnostic interviews by the consulting psychiatrist and by the Center psychologist who administers and interprets the indicated results. Various prescriptions concerning staff attitudes, Center activities, and sometimes individual psychotherapy, are made from the resulting diagnostic synthesis. These diagnostic studies show certain psychological problems to be unusually common in our clients. Our initial purpose in setting up the group therapy situation was directed at dealing with one of these problems, namely, the difficulty many of our clients manifested in communicating their feelings. This still remains a major focus of our attention, although we recognize that the group experience also affects many other areas.

Let me first clarify the problem that presented itself to us. Blind people seem to have exceptional difficulty in expressing their emotions. Even though our students were in almost constant contact with their instructors and fellows, it was impressive to note the superficiality of their relationships. Especially impressive was the difficulty many of our clients showed in discussing their reactions to emotionally-laden situations. This reticence toward the expression of emotion is, of course, not limited to the blind. Our culture views emotional experience as a most intimate aspect of the individual, and the expression of emotion as something of an exposure of the inner self. Consequently, such communication of feeling is a measure of trust and closeness reserved for close relationships.

As this problem was discussed and studied with people who worked with the blind, especially those who were blind themselves, the following hypothesis emerged as an explanation: namely, that in order for the individual to express feeling with any degree of comfort, he must be quite aware of the manner in which his communication is received. As the sighted person offers some indication of his emotions, he receives permission to proceed from the smile, sympathetic facies, nods, etc. of his listener. We might think of communication of emotions then in terms of a reverberating circuit. The communicator must receive constant stimuli from the communicant in order to proceed with the communication. Of course, the visual cues which are used by the sighted are not available as return stimuli to the blind person. The blind man may consequently substitute other cues not usually necessary for those who can see. For example, I was surprised to hear blind clients talk about my rate of breathing, the shuffling of my feet, or the number of times I coughed. These and other audible cues are then substituted for visual cues relating to the attentiveness, interest, sympathy, and general response of the blind person's listener. It is my impression that often these audible cues are not sufficient to permit free expression of emotion. This inability to assess clearly the listener's reaction may explain the relative blandness we noted in the communication of the blind.

This difficulty in discussing feelings, moods, and emotions has many derivatives in the inner life of blind people I have seen. For example, many of our clients felt that their fears, anxieties, and emotional problems were peculiar to themselves. It is often amazing to a blind person to learn that another blind person feels uncomfortable in a silence, or that his blind friend is fearful when he is lost. While such feelings of uniqueness of emotion are not unusual in the sighted, I believe them to be much more common with the blind, because they are so limited in their ability to observe the emotional reactions of others. More than feeling that some fear or discomfort is specific for them, some of our clients feel that their emotions are mental abnormalities which serve to make them different from others. You can imagine their relief when they learn that their emotions need not be signs of pathology, and that even sighted people have them.

In our first fumbling efforts to work with the problems of fostering emotional intercommunication, we used the group to discuss emotions and emotional problems. In these early efforts, I took an active role as leader and found that the passive tendencies inherent in our clients tended to make the group session into a lecture or fact-centered experience. This was felt to be an unsatisfactory group structure, and it was shortly changed to a volun-

tary group discussion period in which the students were to bring material of their choosing. The effort to make this a fact-finding session persisted. With the next group, the chief instructor informed the clients that once a week we had a group discussion of anything they wanted to bring to it. As leader, I left the topic and direction entirely up to the group. Characteristically it got off to a slow start. They didn't know what to discuss, they didn't know why they should have to take responsibility for choosing a topic, etc. I pointed out how irritated they were since they believed it to be my job to make these decisions. They heartily agreed and went on to a very active and emotional discussion of frustration and their aroused anxieties when they didn't know what was going to happen to them. As a group they were intent on pointing out to me how much more frightening it felt not to be prepared for what is to occur when you are blind, than when you are sighted. I then took the passive position; the group took the active role.

From experiences such as these, our present group structure evolved. It might best be explained as one client recently explained the group session to a newcomer. He said, "We just talk about different things that disturb us and try to understand them." The sessions usually open with my asking, "What are we going to talk about today?" The responses vary from, "Let's talk about why sighted people are so stupid and always make me uncomfortable on buses," to "How would you raise children so they wouldn't be afraid of things hurting them."

In general, the leader's role is that of picking up the predominant feeling or its lack; noticing when the group seems especially aroused about a subject, and wondering about the cause; attempting to bring the more withdrawn members into the discussion; and attempting to separate himself from an authoritarian or teaching role. Intermittently the group will use the leader as an authority, and occasionally the requested information is given, if it is not felt that it will block further movement by the group. However, the leader's role is primarily viewed toward facilitating and stimulating emotional communication among the group members.

Time and experience have taught us a few lessons concerning some factors which serve to inhibit and facilitate group activity. One of these factors is related to the effect of strangers on the group. Periodically we have had visitors in group meetings who are often rehabilitation workers with the blind from other areas. Even if the group had spent time with them during the day, the presence of non-participating visitors served to inhibit the freedom of group expression of emotion. However, if a visitor, blind or sighted,

participated early in the discussion as a member of the group, this blocking effect did not occur. This same response on the part of the group was true even when staff members of the Center were involved. It was important for staff personnel who attended sessions to participate as members of the group, expressing their own reactions to the subjects being discussed. Sometimes members of the group brought staff members into the discussion; otherwise, the leader did this. But it was always important for staff or visitors to participate in order for the group to feel comfortable.

The group leader must also be an active participant and tell about his own experiences and reactions to the group. The group will tend to accept the leader's expression of his feelings as permission to respond with their own. Also, the leader's reactions to situations are often interpreted as the typical response of the sighted as a class. This must be carefully handled, for the group hostility to the sighted might otherwise be almost constantly displaced to the leader.

In general, our experience has indicated that the optimum group size is eight, including the leader. No adequate study has been made in this area, and it must remain a personal impression pending a more scientific evaluation. A blocking effect has seemed to result in groups over ten, and groups with less than five participants seem to be inhibited, possibly due to the more intimate atmosphere.

A few points of technique in working with blind people might be mentioned. It is helpful to frequently interpolate grunts, "uh-huh's," yes's, and various audible cues to substitute for the visual cues which indicate to the speaker that his communication is being received and understood. Of course, this is not only specific in group work but is also important in individual therapy with blind patients. The verbal note of expression lets the blind speaker know your position in regard to his communication.

Another point of value in working with the blind is related to the difficulty in assessing emotional reaction by studying facial expression. The face is generally a poor indicator of emotion in blind people, and especially so in the congenitally blind who learn about facial expression through secondary sources. For this reason I have found it useful to watch the fingers and hands, for movements and evidence of tension, in attempting to assess the emotional state of blind people. In the blind, the fingers are substitutes for the eyes and are most expressive of emotional states.

In the group, it is sometimes helpful for the leader to call by name the next person who indicates he wants to speak. The blind person may not know if someone else is about ready to speak. It is common that an impasse

occurs, in which two people start to speak simultaneously. While this will occasionally be a subject in later discussion, if the leader calls the name of the next speaker, such an uncomfortable situation may be avoided. Also, the quieter participant, who may make two or three small attempts to enter the discussion during the whole hour, will not be submerged by the more vocal members of the group.

Because we have worked with a number of totally separated groups, it is possible to compare the various group experiences. Often some of the group members may stay through two or even three terms. They are the sophisticates, who show the new members the ropes. Having these more experienced members of the group from the beginning seems to have a stimulating and facilitating effect on the newcomers. For they accept the group more easily, since it has the endorsement of one of their fellows. We have had no experience where the residual members transmit negative feelings about the group sessions. The old-timers are viewed as authorities on the group discussions. Often they assume the role of sub-leader, even if in a previous group they were relatively inactive participants.

The group experience might arbitrarily be divided into the following phases. These phases certainly are not discrete but will merge and will vary in intensity and quality with the different groups. The first phase is that of a sort of self-conscious searching about, to understand the limits, goals, and meanings of the group sessions. During this phase the group attempts to get the leader to be active in a teaching role. It usually takes one or two sessions before a sub-leader emerges who grasps the initiative and begins to express the group dissatisfaction and then, possibly, hostility toward the uselessness of presuming that the students can accept the responsibility of initiating discussion. He thus initiates discussion and often persists in doing this for the rest of the group sessions. Often the topic for the discussion is arrived at by group consensus before the session. In fact, it is commonly an important topic for the students during the rest of the week. However, the topic chosen is usually only a starting point for further discussion.

In the next phase, the group will usually direct attention to things in the environment that provoke their anger, worry, or fear. During this phase, many personal experiences will be recounted, and progressively more and more expression of emotion will emerge. The feeling response of the person is often pointed up by the group leader in the early part of this phase. The group will sometimes take over this function itself, however. The sub-leader will often point out the omission of emotional material in the recounted experience or draw out the emotion of the speaker. It is during this stage

of catharsis that the subject matter primarily relates to expression of personal reactions toward blindness.

This phase will merge with the following one, in which the participants will often bring up questions concerning origins of emotions, their causes, and their effects on the individual. Usually there follows a discussion of the means of handling emotion, attempts to control one's feelings, and there is an exchange of various methods for resolving and meeting emotionally-laden situations.

Of course, groups will vary considerably in their pace or tempo in going through these stages. Sometimes a group may spend three or four meetings trying to understand the purpose and structure of the sessions. In our former six-week term, we sometimes had groups who had just gotten into the second phase of catharsis before they left the Center. They would just bcome able to discuss their disturbing experiences and fears, and then they would leave. Nevertheless, it was felt to be of value not to structure the group situation more clearly.

Every group spontaneously takes up at least the following few topics. Of course, each group discusses a number of other subjects which vary considerably from other groups. Those topics that seem to be constant are the following: first, the feeling of hostility toward the sighted. It often comes up in terms of jokes about stupid acts of the sighted in relation to the blind. An example of such humor would be the story of a sighted person who asked the blind man if he could tell the difference between a one dollar bill and a five dollar bill by touch. Or the person who gives directions to the blind man by pointing or saying that an address is next to a red house. This recounting of personal experiences usually becomes very heated. It soon turns into a discussion of feelings of inferiority, separation, and difference from the sighted. Occasionally a member of the group will apologize for the thoughtlessness of the sighted public. The hostility of the group will often turn on him, and he may be considered a renegade. It was said of one such apologist that "You would think Mr. X. is glad that he's blind."

Often the next step is the expression of resentment toward any group members who are partially sighted. I have seen attempts to shame, embarrass, and hurt group members who have some vision. Sometimes group members will recognize the irrational aspects of this anger, and in one such session, rather suddenly, a blind girl said, "Why are we so mad at George just because he's lucky enough to see a little?" This group later decided that their anger was due to the fact that George got the advantages of being

blind and belonged to the group, when he really could see enough to travel. They were all very envious of this state.

Some of the other topics discussed are: the reactions to the limitations of blindness, feelings of isolation and fear when lost, reactions to the necessary dependences resulting from blindness, feelings during periods of silence, the effect of childhood experiences on present reactions; and methods of dissipating anger. The majority of topics either relate to problems of blindness or end in such a discussion.

An illustration of the last group session I conducted might point up the tone of our meetings. One of the members started off with, "Do you know what happened to Bob and me yesterday? A fellow walks up to us and says, 'That's a pretty bad handicap you got there. Have you been saved? If you got saved, you'd get your sight back.'" This experience, which is not unusual with the blind, was met with sympathetic clucks by some of the members of the group. One of the newly-blinded participants, however, became indignant and asked why the speaker hadn't told the intruder off. He stated he had been a little uneasy, but it didn't bother him. Some five minutes later he admitted he wished he were sighted so he could punch the fellow in the nose. The discussion proceeded to a number of personal experiences related to people prying into personal matters. In a short time, the personal experiences had marked emotional valence, in which the need to control hostile impulses was emphasized. The importance of blind people's not expressing hostility because of their dependence on the sighted was the next topic. However, the group agreed that this did not mean that anger was not experienced.

This was followed by a short and rather vague discussion of the guilt some of the participants felt for not having enough religion. There was no full discussion of this guilt, and it is possible that it may come up in a later session. Some previous groups have brought out their feelings that blindness may be a result of their own or their parents' sins.

In summary, the methods and structure of weekly group therapy sessions in a rehabilitation center for the blind have been presented. This structure has shown itself to be of value in fostering and stimulating emotional communication in our blind clients, who have what seems to be an exceptional difficulty in this sphere. The participants in the group session learn to express their feelings with greater freedom. They learn of the commonness of their problems, of the methods used by others in handling emotional problems, and often become more aware of their own methods of dealing with their emotions.

The group therapy experience must be considered an important learning situation. The participant learns that exposing himself to his fellows does not hold the threat and danger he has anticipated. He further receives the benefits of feeling he belongs to a group which, in itself, holds important meanings in terms of growth and personal development. While the elements of growth and maturation are postulated in association with the group therapy experience, no specific data are available to prove this. We see considerable evidence of personality change and social maturation in many of our students. However, all of our rehabilitation activities are directed toward such movement, and we cannot isolate the benefits of the group therapy, although we consider it an integral and important part of our total rehabilitation program.

DRAMATIZED CASE MATERIAL AS A SPRINGBOARD FOR ROLE PLAYING

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INTRODUCTION

Since Moreno developed the method of role playing [including psychodrama (16) and sociodrama (13)] first as a training procedure (12) and later as a therapeutic technique, its potentialities are becoming more and more apparent. A great variety of applications and procedures have been developed so that practically every form of social adjustment has been explored to some degree. Its potential use as a technique in human relations has been advocated for the past several years (1, 2, 3, 4, 6, 7, 8, 9, 15, 17) and there is general agreement on the values the method contributes.

In order to make role-playing procedures a more acceptable training method in human relations programs certain resistances must be overcome. Although an industry will eventually permit this procedure to be used, a trainer interested in role-playing methods often goes through a period of disappointment when he finds the method criticized as childish and unrealistic. At the present time it is generally accepted that role playing is one of the best methods for (a) sensitizing persons to the feelings of others, (b) developing such skills as listening and reflecting feelings in interpersonal relations, and (c) locating each specific trainee's shortcomings. However, it must also be recognized that (a) individuals are made uncomfortable by being put on the spot; (b) face-saving problems for participants may be created; (c) the situations created often are made more stressful than they appear to be in real life; and (d) observers may be bored because they are not trained to react to feelings expressed by the participants and so are unable to recognize what they have learned. Nevertheless, it is most likely that the criticisms of role playing stem from some unpleasant experiences that role playing arouses in certain individuals and thus represent rationalizations rather than true descriptions of its weaknesses. As a consequence, a trainer feels that role playing is unfairly criticized.

Various methods have been introduced to overcome some of the sources of resistance. In some instances special care is taken to prevent face-saving problems. The role players (a) can be praised, (b) can be allowed to criticize themselves, and (c) can be returned to the audience and the process

analyzed in terms of the characters in a play, rather than of the persons who played the roles.

It also takes a certain amount of insight into human relations problems before a person gets the *feel* of role playing. Many persons do not naturally adopt the role assigned, but rather remain as themselves and try to figure out what the character they are portraying would do. Frequently persons acting out roles persist in the initial attitude supplied them because they feel they have been instructed not to change. Such persons are not acting out a role because they are not interacting as would persons in a real life situation under similar circumstances but instead are remaining static.

Moreno (12, 13) has emphasized the importance of the process of "warm-up" as a preliminary to role playing and Enneis (17) has described methods for accomplishing it in mental patients. Experience with role playing gradually overcomes most of the difficulties described so that eventually the values of role playing are appreciated. However, since the time required to accomplish this understanding frequently is not available in industrial settings, it becomes desirable to hasten this adaptation process.

Multiple Role Playing (11, 15) reduces resistance to the method to a considerable extent in that several groups of persons are simultaneously involved in the role playing and all gain some first hand experience with the process on the first exposure. Further, the analysis of the role-playing process is confined to general results so that the actions of specific persons are not examined. However, each gains some insight into how he should adopt an assigned role.

Audience Role Playing (10, 13) also avoids initial resistance to role playing by placing all persons in a situation in which they cannot be criticized and only the trainer's methods are open to criticism. However, both Audience and Multiple Role Playing fail to permit the analysis and evaluation of specific responses and the effects they produce on other participants. It is only when all persons observe the same process that opportunities to refine skills to a high degree are created.

It has been my experience that role playing is at its best when one merely describes the situation in which the role player finds himself. Thus, when a role is assigned by the statement: "You are Jim Smith and you find that you are getting all of the unpleasant jobs because others in your group refuse to do them, etc.", the person is not asked to identify with someone else, but rather he is required to develop his own feelings. Feelings and attitudes can be aroused in any group of persons if they are placed in conflict or emotion producing situations. If we take a cue from the situational de-

scription, we may even go a step farther. Why not begin with a dialogue in the manner of the preliminary interview used by Moreno and gradually introduce persons into a situation in this manner? When a dialogue is supplied, there is no likelihood of embarrassing a person by making him wonder what to say or do. Once this is done, one can go on directly into role playing by merely supplying some additional circumstances.

In approaching role playing by this route, one actually begins by presenting case material. Groups are interested in case problems and have learned to accept them as training materials. The dialogue serves merely to dramatize the case and thus builds on familiar and acceptable ground.

The dialogue has a further advantage in that no instructions are given about feelings. If these are indicated in the instructions supplied in setting up a role, the person sometimes feels obligated to tell about them. However, in real life one often carefully avoids speaking freely about his feelings. When a dialogue is used to set up the case, the feelings become a kind of background experience, which is the way feelings develop in real life situations. Under these conditions the role player is much more natural in deciding what he wants to tell another and what he wants to withhold. Thus he gradually becomes a real person while living the dialogue. Once a high degree of involvement is introduced by way of background experiences, the role playing proceeds in a natural manner.

In following this procedure one can develop feelings which are unlabeled and vague. As in real life, such feelings can become clarified provided the proper relations between persons are established. These deeper and confused feelings are difficult to create in role-playing methods in which a person is told about his feelings, since this method of introducing feelings actually clarifies them.

Using a dialogue to set the stage for role playing is a method of "warm up" and should not be confused with the *Skit-Completion Method* (9) or the *Hidden Theme Situation* (17). The Skit-Completion Method utilizes dialogue which carries a situation to the point of an unresolved conflict. From this point on the participants must make up their own lines and complete the case. In the Hidden Theme Situation, a person walks into a situation in progress, and he must relate himself to it in a meaningful manner. The procedure described in this paper used the dialogue to create a closed incident. From this point on one of the participants relates with one or more other persons. These subsequent contacts are entirely role-played and are new incidents influenced by previous ones.

In order to describe the procedure for using dramatized case material

as a springboard for role playing, it is desirable to present a specific example. In this manner the sequence of steps in the procedure can be clarified.

The Personal Interview Case

Selecting the participants: For this particular case three persons are selected from a group by the trainer. One of them is asked to play the part of Ken Hardy, the supervisor in a drafting room, and a second person is asked to play the part of Walt Henderson. Walt is asked to take a seat at a table in front of the group and to assume that he is working over a drafting board, whereas Ken is asked to approach Walt from behind when the trainer gives him the cue. A third person is asked to play the part of Robert Welch, head of the Personnel Department. He is given a set of instructions and is asked to leave the room during the reading of the dialogue.

Role for Robert Welch: You are head of the Personnel Department of the Wilson Construction Company. Your department does all the hiring, and must O.K. all recommendations for changes in pay rates. You have the authority to turn down recommended increases, make changes in job classification and are in a position to influence personal policy. Your door is open to employees who want to discuss company matters or even their own personal problems. You or your staff interview all employees who leave the company.

Walt Henderson of the drafting department has just called you and wants to see you on what he called "an urgent matter." You've asked him to come right down. Just to prepare yourself on factual matters you looked up his record. He works for Ken Hardy, a drafting department supervisor, whom you regard highly and Ken has given him a very good rating. The record shows Walt Henderson to be a top-notch draftsman who turns out a lot of work. He has 8 years with the company, which is about average for the drafting room. Walt Henderson is married and has one four-year-old daughter. As his hobbies he has listed fishing and sailing. You will be seated at your desk when the door opens and Walt Henderson walks in. Naturally you will want to learn from him what he considers an "urgent matter".

Preparation for the reading of the dialogue: After Robert Welch has left the room the trainer points out that a dialogue involving Ken Hardy and Walt Henderson will be read. It is pointed out that this dialogue will serve to dramatize an actual case. The work place is a drawing table in a large drafting room of the Wilson Construction Company. There are 30 drafts-

men in the office and two supervisors. Walt Henderson, a draftsman, is working busily as his supervisor, Ken Hardy, comes by. It is 10 o'clock Tuesday morning.

Dialogue: (Trainer gives Ken the cue to approach Walt's work place).

Ken: How's the work going, Walt?
Walt: Fine. All caught up.
K: Even that set of specifications of Joe's that I gave you to check yesterday?
W: Yep. Took it home and worked on it there so I wouldn't be too rushed today.
K: Well, now, I don't want you to have to be taking work home Walt. I didn't know you were going to do that or I'd have asked Fred to help Joe out on it instead.
W: Oh! That's O.K. I didn't mind doing it. I knew Joe was going to have a rough time getting it all done by noon today, anyway.
K: What are you working on now?
W: Some plans for that little boat I told you I was going to build.
K: I see. Think you should be doing that on company time, Walt?
W: Well, I don't know. I've done all my own work and put in 3 hours of my own time last night to help Joe out. And besides I don't have my own equipment at home to do this drafting. What's the harm in it?
K: It just looks bad to be doing something like that on company time. You know that as well as I do.
W: Well, when I have my work done and more, what does the company expect me to do—twiddle my thumbs?
K: Now let's not get hasty. We went through all this last year when you got both of us on the hot seat with Johnson (department head) over that garage of yours that you drew up here. Remember?
W: Sure, I remember. And I still don't think it's anybody's business what I work on here so long as my own work is done and I don't bother anyone else.
K: That's what you think. Now let's get this straight. Nobody's telling you what to do before or after office hours, but when you're here drawing pay you're supposed to be earning it. And I don't want another mess like the one we had on that garage of yours. Understand?
W: Yes, but I don't see why we have to set up such rigid rules. Just because Johnson doesn't know how much work I turn out is no reason why you should take your cue from him.
K: Look Walt, I'm not taking my cue from him. I didn't like the idea of you doing your own work here either, but I decided to let it pass. Then when the chief caught you at it and you didn't have the good judgment to be a bit more careful—well, you've just got the wrong attitude.
W: How can you say that? You know perfectly well I turn out more work for the company than anyone else. Is it my fault if you can't keep me busy?

K: Walt, I know you're a top-notch draftsman, but a good employee is something more than that.

W: Yeh — a good employee is a yes-man.

K: Not at all. A good employee works well with others. He's got to follow rules so that he doesn't set a bad precedent. Suppose the others brought their own work down here?

W: Well, make them do their job first.

K: How can I if they say I let you work on your personal things?

W: But I do company work at home and more than make up the time.

K: Walt, am I supposed to let you choose when and where you do company work? What a mess that would make if I had to keep track of everyone's homework. Anyway we've never asked you to do work at home. When we have more to do than you can handle during working hours we'll pay you overtime.

W: Ken, I'm not asking for overtime. All I want is to be treated as an honest person. I've never gypped the company out of anything and whenever the company is behind schedule I've worked like the devil to help out. Now I've got a personal problem and all I'm asking is to borrow some of the facilities. Is that unreasonable?

K: I can see your side, Walt, but we can't give favors to some and not to others. I've just got to make a rule and remember you've forced me into it. There will be no more personal work done during company hours. I'll let you finish this job, but that will have to be the end. I am not going to have the others say I play favorites. Sorry but that's it. (Ken leaves Walt's desk).

Preparation for role playing: The trainer summarizes the dialogue and says, "The preceding dialogue has given Walt an unpleasant experience. What will he do?" Walt is then given a sheet of paper which gives him the additional information shown below. He is asked to leave the room and study the situation. It is also important that Walt be requested not to discuss anything concerning the case with Robert Welch who too is outside the room.

In order to give Walt time to study his material the trainer should spend a few minutes discussing with the observers what Walt is likely to do next. Observers generally agree that Walt is pretty angry and anticipate that something is going to happen.

Additional information for Walt Henderson: You, of course, were disturbed by this conversation with Ken Hardy so at noon you called your friend Bill Alden and told him about it. He informed you that there was an opening in the drafting department in his company (Jones Bros. Inc.). You asked him to check up on details. In the afternoon Bill's boss, Mr. Hansen, called you and said he was very anxious to have you come and

work for Jones Bros. He told you that he would take you on Bill's recommendation and the salary he quoted was five dollars a week more than you are now getting. From his description of duties he gave you it appears that the work is about the same as you are now doing. When you expressed interest Hansen asked you if you could start next week. That would be next Monday. Since Jones Bros. has another applicant for the job he asked you if you could give your decision to him right away. You asked him if you could have until Wednesday morning so as to have time to talk it over with your wife. Hansen said that would be O.K. He suggested that you give Wilson Company a good excuse for quitting so suddenly because he wanted to stay on good terms with the Wilson Company.

After this talk you thought a bit and decided it would be nice to work in Bill's office. You have often compared companies and although you had sometimes thought of making a change you could find little difference between companies. Since you have 8 years with the Wilson Company you have some seniority and retirement benefits. Now you have a reason for quitting. You know your wife will go along with any decision you make. The important thing to do now is to go to the personnel office and let the company know about your decision. You therefore called Robert Welch of the Personnel Department and asked to see him on an "urgent matter". Welch asked you to come right down.

Role Playing between Robert Welch and Walt: After Walt has been given enough time to read his part, the trainer terminates the discussion about Walt's probable next move and asks Robert Welch to come in. He is introduced to the group as the head of the Personnel Department and is asked to be seated at the head of the table which is to serve as the desk in his office. He also arranges a chair for Walt, which is so placed that the group can see and hear both. The trainer then says to Welch, "I believe you are expecting Walt Henderson to come in and see you about something." When Welch indicates that he expects Walt and that he understands what he is to do, the trainer goes to the door and calls in Walt Henderson. He makes sure that Walt understands his situation and then indicates Welch's office and the chair he will take. From this point on the case proceeds without script.

Possible Outcomes: Welch's interview with Walt Henderson may result in Walt's decision (a) to quit, (b) to stay with the Company, (c) to stay with the company provided certain understandings are reached with Ken Hardy or (d) to remain with the company provided certain concessions are

granted him. The latter three possibilities are the most likely to occur, particularly if Welch shows that he regards Walt as a desirable employee. The last two of these conditions are definitely the most frequent and they require further interviews. Welch usually indicates in the interview what he considers the next step to be taken. Since all persons involved in the case now have the necessary background, any combination of the three persons can meet for the next interview. The leader therefore requests that the interview decided upon by Welch and Walt be conducted. Any other interviews called for after this one should also be held in order to complete the case.

In case Welch shows an inclination to let Walt quit, it is desirable to interrupt the interview and either ask Welch if he feels Walt has made up his mind to quit and that nothing further can be done or whether he feels it is desirable to let Walt quit because of the attitude he has expressed. The observers should then be asked if they agree with Welch's opinion. In nearly all instances most observers will disagree with Welch. This difference in the observers' and Welch's viewpoint is due to the fact that the observers have heard the dialogue and understand Walt's behavior. When Welch recognizes that the observers disagree with his opinion the trainer should point out to Welch that the observers apparently know something that he does not know, otherwise they would not be so positive in their disagreement with him. After explaining that the group was familiar with Walt's problem, Welch can be asked to continue the interview to see if he can learn more about what happened to Walt. Welch usually is interested in continuing the interview and if he declines, one of the observers can be asked to take over. In the event that this observer is successful in drawing out Walt's feelings, it should be pointed out that the observer had an advantage when he played the part of Welch because he knew what to look for.

Subsequent interviews: Perhaps the next step is for Welch to decide to interview Ken Hardy. Before beginning such an interview the person playing the part of Hardy should be asked to assume he has not heard the discussion and role playing but to imagine that only the dialogue has taken place. If, in this interview, Welch takes Walt's side, it is unlikely that Hardy will consent to change his point of view or to make concessions. If, however, he indicates that Walt has been offered a new job and raises with Ken the problem of whether the company should try to keep him, Ken may volunteer some of the things that might be done to induce him to stay.

If Welch can get Ken Hardy to tell him about the initial incident, face-saving problems will be avoided. However, Welch must not indicate that Walt has criticized him and he must let Hardy criticize Walt.

In case Hardy sees things differently after talking with Welch another interview is indicated. Hardy may wish to interview Walt and, if successful, this might close the incident. If the interview is unsuccessful, Welch might wish to have a final exit interview with Walt.

It is possible that after talking with Walt, Welch might decide to bring both Hardy and Walt together. This is destined to lead to difficulties since both Hardy and Walt will be in face-saving situations and will get into an argument. However, some Welch's will elect to do this. On one occasion when the three met in Welch's office, Walt and Hardy were seated side by side and argued over every point brought up so that Welch was squeezed out of the picture. Failing to keep them from contradicting each other, he finally got up and sat between them. When it is apparent that such a meeting is failing the leader should terminate it and discuss the difficulties.

If, in talking to Walt, Welch suggests that Walt see Hardy before making the final decision then an interview between Hardy and Walt is indicated. If Hardy handles this interview well the problem may be solved. However, it is more likely that another argument will result and Walt will decide to quit.

Analysis of the interviews: The analysis of the interviews will raise a great variety of questions which should be put to the observers for discussion. Differences of opinion will be present which will cause good discussion. Some of these questions are as follows:

1. Is it wise to let Walt quit? Was he too unreasonable in his demands?
2. Was Welch able to get at Walt's real reason for quitting? Should he have obtained more expression of feeling and, if so, how could he have accomplished this?
3. Does Walt really have another offer of a job or has he been bluffing? (Observers disagree on this. The person playing the part of Welch also is in doubt. This raises the question of whether or not Welch should have determined this in the interview and whether he should have found out also whether Walt had already committed himself on a new job. As long as Walt has not accepted another job there is reason to believe that he wants to stay.)
4. Did Welch do the right thing about subsequent interviews after talking to Walt? (If other approaches are recommended, the discussion leader may go back to this stage of the problem and permit

an alternative decision to be tested by role playing. Various persons in the group might wish to try playing Welch.)

5. What caused Hardy to either agree or refuse to make concessions? Did Welch's approach influence Hardy's attitude?
6. What kinds of concessions should Hardy make? Which of these are reasonable and practical in real life? (This question will reveal differences in attitude in the group.)
7. Did Hardy exaggerate the problem he would have with other employees in his group if he gave Walt certain privileges? Could a group be made to accept special treatment for Walt. If so, how?
8. What are reasonable concessions for a company to make on problems of this kind? Should there be rules to cover this sort of thing?
9. Did Ken or Walt deviate most from their initial attitude as expressed in the original dialogue? Can you explain why this happened? (Discuss in what way each showed an attitude change.)
10. If different persons had played the roles would the result have been the same? What kinds of differences would you expect in using other participants?
11. What general conclusions can we draw from this case?
12. What are some other situations to which the same conclusions would apply?

Discussion

The initial participation in this problem is easily obtained because the dialogue supplies the lines. It is only necessary to choose persons who have no difficulty in reading. Thus the reading of the dialogue raises no problem of getting persons to participate. Once the conflict between Hardy and Walt is created all persons are so interested in the outcome that the next step of having an interview between Welch and Walt is accepted as readily as participation in a discussion. No one ever seems to recognize that some kind of training procedure is being introduced. Walt has had an experience and is so willing to talk that it would be difficult to keep him quiet. Welch, although he has been kept on the fringe and so might have reason to be uneasy, does not feel he is on the spot for Walt has asked to see him. He therefore does not have the problem of planning an interview. Thus the second stage flows so naturally from the dialogue that no one seems concerned.

After the interview between Welch and Walt has been completed, all three persons are sufficiently involved so that any of the subsequent interviews follow so naturally that there is no awareness of the artificiality of role playing. Thus the final interviews become the most life-like roles.

One observer described the process of introducing the role-playing process as being as smooth as the take-off of an airplane.

The unique feature of the role playing by this method is that it sets up real experiences to talk about in role playing. When experiences are described in a set of instructions they are not like those established in real life. However, by the time the dialogue is finished and Welch and Walt have had their interview, all of the content of subsquent interviews comes from an experience with another person.

The reasons for developing this type of an interview arose primarily from a desire to create situations which duplicated true counseling situations. One cannot tell a person through instructions that he is insecure and expect him to behave as a really insecure person. When we instruct a person by such a procedure we are diagnosing his difficulty and this would be an untrue aspect of a counseling case. However, if one can create a situation in which a person is made to feel insecure, then we can get insecure behavior without the person being aware of his real difficulty. It seems that the present approach would lend itself to developing role-playing cases where feelings can be left at an unclear or confused level. This is an aspect that is needed if role playing is to become complete reality practice.

Summary

The present paper is a further development of Moreno's work (13) and describes the use of a dramatized dialogue as a method for setting up role-playing situations. This approach (a) avoids some of the resistances to standard role playing and (b) permits a lifelike way to present the essential background experiences which are needed in role playing. The dramatized dialogue has an advantage over instructing role players in that the nature of feelings need not be spelled out and instead can be left to the way the participants actually feel. The approach permits the development of feelings which are consistent with the participant's normal reactions and so allows these feelings to manifest themselves naturally in interpersonal relationships. When participants are instructed, the feelings they are to portray are described and to this extent they are diagnosed. This method of developing background material does not duplicate real life situations, and the persons so instructed are not always clear in the degree to which they should reflect the instructions that are given when they subsequently role-play an interpersonal relations episode.

Once a case has been set up by the dramatized dialogue, role playing involving any of the persons in the dialogue can take place. Thus any one

of them can be interviewed by a third party or a counselor and the skill of this person can be measured in terms of how well he draws him out. This is similar to the preliminary interview preceding a psychodramatic session. Following such interviews, subsequent role-playing episodes can be conducted in order to complete the case. Thus each scene may set the stage for another and the nature of these will depend on the decisions reached in the preceding scene. This process continues until the problems and issues raised are decided. This flexibility adds further to making the process a near duplicate of real life conditions.

The illustrative case supplied presents a dramatized dialogue in which a supervisor disciplines a draftsman for doing personal work on company time. Each has very good reasons for taking the position he does. The dramatized scene leaves the draftsman in a disturbed frame of mind.

He is then privately instructed and told of an offer of a new job. Before accepting it he is asked to see the personnel director and this interview is role played.

As a consequence of this interview, another is usually needed to close the issue. The nature of this next interview will depend on the outcome of the preceding one. It may involve the personnel director and the supervisor; the supervisor and the employee; a second interview of the employee by the personnel director; or all three of them. If any other subsequent interviews are needed to close the case these can also be role played.

The analyses of the sequence of role-playing episodes is similar to that used in connection with standard role playing. The approach has been found to be highly effective with persons unacquainted with role playing and avoids many of the unfavorable reactions to the role-playing approach in human relations training.

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PSYCHIATRIC SOCIAL CLUB THERAPY*

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The shortage of qualified psychiatrists has become a constant refrain wherever mental hygiene is considered, and the high cost of psychiatric treatment proverbial. Solutions do not seem readily available.

It is not alone the shortage of trained psychiatrists which seems a crying need. What looms even larger are the needs of preventive psychiatry. A few authoritative sources crying in the wilderness do not supply the coverage needed. Moreover as Binger and others have cautioned, there is even a danger of "wild psychiatry" when psychiatric principles and tenets are bandied-about in nondescript sources. How, then, can authoritative precepts be disseminated under the required conditions?

It is to be noted that in the process of evolving new techniques and implementing broadened viewpoints, often inconspicuously and unobtrusively the needed instruments are created and gradually put into operation. In this instance also a beginning has already been made, as yet insufficiently noted by workers in the field. As if impelled by the logical trend of development Dr. Louis Wender of New York has had a patients' therapeutic social club for a number of years. Many Chicagoans have taken cognizance of Dr. Low's (1) Recovery group. Dr. Max Witte in Independence, Iowa, has more recently organized such an association which calls itself "Society on Leave" (2) which was the subject of the leading article in a recent issue of one of a leading women's magazine. In London, under the leadership of Joshua Bierer (3) and the Institute of Social Psychiatry, seven or eight such social therapeutic clubs are functioning actively, even partially subsidized by the government. Alcoholics Anonymous, in many respects the counterpart of these psychiatric social therapeutic clubs in the area of alcoholic addiction, is now well-known to most people. The writer, too, has attempted such an organization which has limped along for several years.

Accustomed as we are to a certain frame of reference in matters of mental hygiene and with regard to mental and emotional disturbances, the idea of an organization of patients who have suffered from severer grades of these disorders is apt to raise a quizzical eyebrow, which leads to a con-

* Paper presented at the Second Institute of the Midwest Section of the American Society for Group Psychotherapy and Psychodrama, Chicago, June 7, 1952. This paper emphasizes psychiatry in the open community.

sideration of certain stubborn, if not easily recognizable facts. An association of the erstwhile and even presently mentally and emotionally ill seems to be something different. But it *seems* different only because of prejudices. It is the more silly in that such illnesses may be more widespread than all others combined. For if you merely glance at the formal statistics (and statistics do not begin to tell the whole story) you will discover that over half of all hospital beds in the United States are in mental hospitals; about one family in every five contains some member with serious mental disease and about one person out of every 18 is destined at some time in his life to spend some time in a mental institution.' That does not not include the vast numbers of people who are very ill with such disorders who are never hospitalized and who never come to the attention of a psychiatrist.

Functions of a Therapeutic Social Club

The Stigma: The first great task of the therapeutic social club in preventive psychiatry is to combat the stigma (8). In the light of the great prevalence of emotional pathology its eradication and even its amelioration is a task of major social importance. The stigma is without doubt the greatest and most colossal single obstacle in mental hygiene and in the treatment of mental and emotional disorders. Consider: how is it possible to treat any individual for something which he contends he does not have. This would be difficult enough in the treatment of any bodily ailment such as heart disease or halitosis but in a disorder such as of the mind and emotions it is well-nigh impossible. One of the greatest initial difficulties in inducing any patient or other person to join a social therapeutic club is this fear of being associated with mental patients. What will people think? The weight of mass opinion as can be seen here is almost irresistible. Relatively few people do their own thinking and what is believed by the mass of people carries the deciding weight; and yet as regards the stigma of mental disorders, generally so prevalent and widespread, its real foundations are only the ancient belief in demoniacal possession. What is so difficult to convey to most average persons is that just as there is no sharp line between good physical health and ill health there is even a far-lesser demarcation zone between good mental health and mental poor health or psychosis or neurosis.

To the mental patient this concept is all-important if he is to gain or regain his self-respect and feel himself an integral member of human society. The first task of the therapeutic social club is to desensitize the pa-

tient to the stigma and to build up in his mind a sense of self-esteem as a a human being. This is by no means easy as the sicker the patient is the less strength of conviction does he possess and the greater the impact of mass opinion. The objection to identifying with such a group is constantly voiced by the newer and less steadfast members.

The desensitization to the stigma is largely implemented by the group psychotherapy proper which is one of the principal functions of the club with which the writer is associated, but as can be appreciated the organization as a whole is an instrument of group psychotherapy. In this club group psychotherapy is mediated through a textbook (7) in which a chapter is devoted to the effects of the stigma. The general round-table discussions and expositions, incidental conversation further clear the air in this regard.

How far and how well the patient can be freed from the thralldom of the stigma can be demonstrated by one rather amusing incident.

A young woman, a former patient of a state hospital visits the club, having been invited by one of the regular members who is an alumna of the same institution as herself. This visitor is obsessed by the question, which she anxiously and repeatedly asked of the therapist, whether she suffered from a schizophrenic psychosis or not. This anxiety may have been provoked and stimulated by the group psychotherapy session at which she was an onlooker. Naturally, I dodged and hedged, as she was apparently not yet able to assimilate this fact. After the meeting was over and the resurgents had departed the therapist found himself waiting for a street car in the company of this questing young woman and George, a first line resurgent. In the midst of a three-cornered and amiable chat the young woman pouted and exclaimed:

"I'm angry with you, doctor!"

"Why, what have I done?"

"You didn't answer my question whether I'm a schizophrenic."

Now I felt my back to the wall and further evasions by this time seemed pointless, so I replied, "Yes, you are a schizophrenic."

Whereupon she burst out in a flood of childish tears. A little distressed, I attempted to reason the matter out with her, but to no avail. Then, taking another tack, I said: "Well, look at George here, he isn't worried or going to pieces because he has been classified schizophrenic."

Very politely and gentlemanly George interposed, "I beg your pardon."

She looked up incredulously. "Oh, George is *not* a schizophrenic!"

The knowledge and conviction that mental illness is not shameful, contagious or culpable goes a long way toward recovery and opens the door to treatment.

Public Education: As far as public education in mental hygiene and preventive psychiatry are concerned, the club itself constitutes a living

embodiment and a demonstration of the fact that mental illness is not the supernatural, horrendous, incurable thing often believed. In the club's own activities they demonstrate the truth of these assertions. Public lectures, exhibitions of psychiatric films with therapist acting as commentator further the ends of public education. Several of these organizations also issue periodicals.

These educational aspects constitute a "grass-roots" activity starting from the roots of the population and not as a superimposition from above downward, from the "brain-trusters" and professors, and hence far less suspect. Effective coverage of the general population is thus brought into view.

Club Educational Activities: In addition to the aforementioned activities the club implements other education facilities for its own members. Art classes, classes in literary composition and other activities are thus made possible.

Treatment: Paul Federn (4) has emphasized the need that the psychotic has for someone to relate to in his environment outside the hospital. This need is generally ignored, but anyone who takes the trouble to follow patients more or less closely in their posthospitalization period as is done with members in a social therapeutic club cannot fail to be impressed to what a marked degree relapses can be thus avoided and retarded through the relationships formed in the club. The importance of this observation cannot be overemphasized. The family to which the patient is returned is by no means always a help in this aspect of the management of the post-psychotic. Federn goes so far as to state: "No patient can be cured unless the family wishes it, even less in the presence of the family's unconscious or conscious hatred. No physician can cure any severe case when bed, rest, and care are lacking, or when intentionally or not, antagonisms develop to the task of bringing back the psychotic ego to normality and reality. Experience must be drawn and conclusions made from patients treated under the best conditions and with the least opposition."

What the members get out of belonging to the club is a sense of belonging and acceptance, by no means always true even in the bosom of the family. To that extent it husbands and nurtures that necessary sense of social interest, almost and practically the crucial point both in the development and abatement of the mental disorder. So true is this observation that a number of the members of the club with whom the writer is associated, who for various reasons have drifted away from it, nevertheless keep up a fairly intimate mutual friendship, visiting each other at their

respective homes, and still occasionally inquiring about the club, which information drifts back to the writer by a kind of grapevine consisting of a chain of common friends, members and erstwhile active members of the club.

This will have indicated the further potential usefulness of social therapeutic clubs. To date relatives of members of Resurgo Associates have shown amazingly little interest in the organization, and this may be taken as a further commentary on Federn's observation of the role of the family in the incidence of mental disorders. But potentially the club is a contrivance ideally suited to the task of drawing in the relatives and making them cognizant of some of the dynamics of the patient's psychosis with consequent amelioration. For, if you think of the locus of morbidity as not only the patient himself, but also the entire family constellation, the importance of that facility becomes apparent.

Specific Psychotherapy: As already stated the whole organization and its activity is a group psychotherapy project on a fairly large scale. But the sharp focus of group psychotherapy are the sessions particularly devoted to that end.

Recreational Facilities: The club is ideally suited to provide some of the recreational facilities. Beach parties, picnics, house parties, trips and a variety of other enterprises are projects which gain much in their therapeutic value because they are cooperatively planned and executed.

Functions of the Club Advisor

The club must at first be led and later advised by a psychiatrist, who will also be the therapist. Early in the history of the organization it is necessary that he watch over practically every detail of the organization, suggest necessary measures, initiate and help carry out most of them. As the organization matures and acquires the strengths, skills and capacities to conduct its own affairs the adviser can retire more and more to his specific role of therapist and consultant.

Some Common Objections to Therapeutic Social Clubs

In the minds of the uninformed the concept of therapeutic social clubs almost inevitably gives rise to the misapprehension that such organizations would segregate the patient among others sick individuals of his kind, with a consequent danger of further contagion and the loss of any chance at amelioration of the condition. But mental and emotional disorders are cer-

tainly not contagious in the same sense that measles and small pox are contagious.

But as far as segregation is concerned every organization in some measure segregates its members, and one can even be organized and thus far segregated for the purpose of eliminating, say, race-segregation. To that extent a doctor who joins a medical society segregates himself or the individual who takes his seat in the United States senate. Not to attribute to a mental patients' organization the same potentialities inhering in concerted action, which is the implement of operation of any association of individuals is to lend face to the stigma.

Another common objection is to the effect that a club of this character would foster dependency on it, and just as soon as the patient is reasonably well he must with all dispatch depart from the club, and that the best position it can possibly occupy would be that of an unavoidable evil. In dramatic contrast to this misapprehension is the inspiring example of Clifford Beers who, recovering from his psychosis, founded the National Mental Hygiene Society. Commenting on a paper by this writer which alluded to the subject of therapeutic social clubs the discussant (5) remarked: "As social scientists we should avoid the fostering of another special group of citizens, especially in many instances where all traces of the illness have disappeared. It comes close to defining people as World War I and World War II veterans, or ex-convicts, or ex-baseball stars, or even ex-bathing beauty winners." Again we see the most insidious effects of the stigma, that anything tainted with this nameless horror can only be tolerated at best for the least possible amount of time. Abstract this nameless superstitious terror and you can reason that anything which restores and helps restore mental health and peace of mind and points to a harmonious and healthy way of life has the capacity to strengthen one's mental powers and moral fiber. If it fosters dependency on such guides that, in all reason, would be no indictment whatsoever. On that basis and for such purposes one must find it reprehensible to be dependent on church and religion, or our institutions of justice.

That is well borne out by members of the social therapeutic club with which the writer is associated. Those members in whom can be generated that requisite spark of motivation and social interest are the very ones who constitute the backbone of the organization, who are most dedicated to the aims and objectives of the club. The sicker they are the more apprehensive are they about the advisability of associating with other mental patients and the harm it can do them by being reminded of their condi-

tion and status; they merely dip in daintily as convenience, freedom from their fears, and pleasure, dictate, and just as daintily make their exit. Now and then one is able to retrieve one of these through the operation of a variety of factors. The fact is, that two of the staunchest members who can always be called upon for cash or arduous services are men who have never been hospitalized and who to all intents and purposes have no mental or emotional difficulties. They are husbands of patients. One of these, a fine, well-educated young man, never misses a meeting if business or other affairs do not prevent it.

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A ROLE PLAYING WORKSHOP FOR BUSINESS AND GOVERNMENT ADMINISTRATORS; ITS RESEARCH IMPLICATIONS

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The Washington State Training Directors Society requested the University of Washington to set up a one day institute in role-playing techniques as applied to employee development. The Extension Division asked the writer to serve as Director of the institute. The institute was planned as a workshop for a one day session and a brochure was subsequently circularized among business and government trainers, supervisors, and executives. The fee charged was ten dollars. On November 14, 1952 some seventy management people from the Northwest Region and Canada attended the workshop.

This paper has been written to describe the procedures for demonstrating the range of modern role-playing techniques pioneered by J. L. Moreno[1] and to point out the opportunities which accrue from such ventures in applied sociometry. The opportunity to create group situations make such workshops a testing ground for new methods. Moreno's audience participation technique and "audioplayer"[2] emphasized as multiple role playing and audience role playing by Norman R. F. Maier and his associates were presented for the first time to training people in this region.[3]

Another opportunity presented by such workshops is the formation of a larger circle of acquaintanceship and climate of opinion which may bring about access to research within many of the on-going organizations represented. A previous paper by the writer indicates that such opportunities are real and may be capitalized.[4]

Training procedures for the one day schedule follow:

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1 J. L. Moreno "Das Stegreiftheater" 1923 (The Theatre of Spontaneity, 1945, p. 23-24) and Psychodrama Vol. I. 1946, also, Group Psychotherapy, Vol. V, 1-2.

2 *Op. cited.*

3 N. R. F. Maier, Principles of Human Relations, John Wiley and Sons, 1952.

4 Delbert C. Miller, assisted by Clara G. Rubin, Seattle Civil Service Commission, Harold A. Lang, Washington State Personnel Board, Charley H. Broaded, Fisher Flouring Mills, "Introductory Demonstrations and Applications of Three Major Uses of Role-Playing for Business and Government Administrators," SOCIOMETRY, February, 1951, 14:48-70.

WORKSHOP IN ROLE-PLAYING TECHNIQUES FOR EMPLOYEE DEVELOPMENT

I. *The Morning Session*

Objective of the Morning Session: To give maximum participation to conferees in role playing skills as role-playing is applied to the problems of establishing an employee development program.

8:30- 8:40 Members Assemble. Each Person is Assigned a Table Number and a Classification Number (1—6). Six Persons are Assigned to a Table.

8:40- 8:50 Introduction. Basic Principles of Role-Playing and Group Dynamics.

—Welcome. Appreciate opportunity to be with old friends, make new ones.

—Purpose.

1. To acquaint you with role-playing and group dynamics techniques.
2. To train you so that you can apply them.
3. To utilize the full range of acquaintance and experience which you bring.

—Role-Playing is reality practice.

Practice of a human relations situation. Today we shall practice some situations that often occur in business life and require social skill or adjustment.

—Role-Playing is a method of learning. How often have you heard it said that "you just don't know what you would do until you have been in the situation." Such a person is saying that *feelings and attitudes are important* and that *stresses* in some situations determine behavior.

—Most methods of learning leave out feelings and attitudes of people and overlook the stresses in many situations. These are important in determining how we act. They make the big difference in the effectiveness of training.

—Contrast with Lecture and Discussion

Lecture is a telling process and its effectiveness depends on the ability of the learner to understand and a desire to apply.

Discussion is a talking over process and allows for self analysis, growth, and commitment to act. Usually discussion is better than lecture but there is always the danger of rationalization and that behavior is nothing but words, words, words.

Role-playing is a doing process involving feelings and attitudes in a situation requiring social skill. The role-playing training room is a practice field. *Mistakes don't count.* In fact, they provide a wonderful way to grow.

—This workshop is soon to become a practice field. You are here to learn all you can about role-playing. The quickest and most effective way is to use role-playing methods.

We want you to know that we have planned that *everyone will be in a role-playing experience before the day is over.* This will not require acting experience and you don't have to worry how you will do. There is never good or bad role-playing as such. There are only consequences for study. No one will be criticized or coached.

—Since this is an intensive program, we have planned appropriate breaks. We want you to have a good time and learn a lot. We will do our best to stay on or near the schedule and assure you that no matter what happens to throw us off we will get those coffee breaks.

—Some of you have seen role-playing, been in a role-playing situation, and perhaps trained employees in role-playing.

We are going to ask each of you at the tables to introduce yourself to one another if you have not already done so. I shall ask the person with a number one at the bottom of the name plate to be your chairman, and the person with a number two at the bottom of name plate to be your recorder. (Ask chairmen to rise and introduce themselves.)

I shall ask your chairman to see that each person gives his name, his work, and his Company or Organization, and indicates his experience with role-playing. I would like to know:

A. How many have had no direct experience with role-playing.
B. Those who have seen it.
C. Those who have been in a role-playing situation.
D. Those who have used it in training.

I will ask your recorder to get this information in each of your groups.

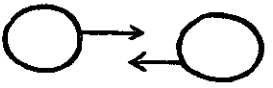
8:50- 9:00 Group Introductions. Group Reports from Recorders. (Have recorders introduce themselves.) Place results on blackboard.

Number of persons who have had no direct experience with role-playing	21
Number of persons who have seen it	23
Number of persons who have been in a role-playing situation	8
Number of persons who have used role-playing in training others	18
	70

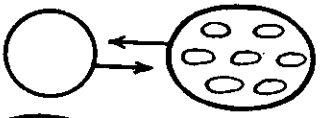
(Note: Wide Range of experiencing indicated.) The Director indicates that he will take wide range of experiencing into account and will see that each step is carefully explained.

9:00- 9:10 Types of Role-Playing.
—Role-playing focuses on two or more persons in a structured situation. The situation may involve only two persons. (Place the following on the Blackboard.)

A. Supervisor-Employee

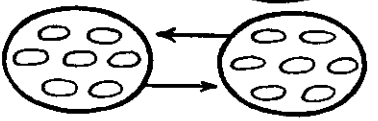


B. Supervisor-Group of Employees

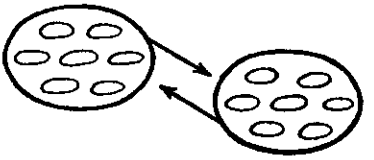


C. Two Groups of Employees and/or Supervisors

Staff-Staff
(on same organization level)

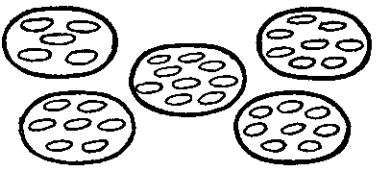


Staff
/
Staff
(on different organization level)

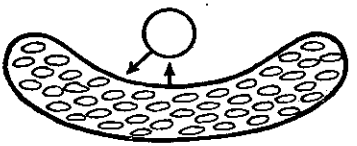


When the group is concerned with how to present a problem to top management or another staff group the use of the technique may be termed: ANTICIPATORY ROLE-PLAYING

D. . A Large Number of Face-to-Face Groups
MULTIPLE ROLE-PLAYING



E. An Audience of Unlimited Size
AUDIENCE ROLE-PLAYING



—Design B and C have been used in the first situation which have been structured this morning. We shall employ each of these separate designs in situations which you shall view today.

Ordinarily, you would not move into role-playing abruptly. You would develop problems which were real to the group and after they felt comfortable in working with one

another you would slowly introduce role-playing. We have neither the time nor I think the need for such subtlety. I am assuming you are blooming extroverts or will be once you are in a role.

9:10- 9:25 The Problem of Gaining Acceptance of an Employee Development Program.

—I have designed a series of three scenes around one of the most crucial of all training problems . . . namely, the presentation of the training program for acceptance or rejection by the interested parties.

The situation has been described as follows:
The BBB company, a medium-sized company of 1000 employees and 100 supervisors has tried a number of employee development programs. The general feeling is that most of them were flops. The personnel department has been asked by the President to prepare a brief prospectus for a new employee development program explaining what it will accomplish and how the training will be carried out.

(—Appoint a Personnel Director and three members to serve on the Training Staff. The man selected for the personnel director should be able to talk well and have had some experience in training. I always decide in advance if possible who this man shall be. He is a key person in the demonstration.)

—Brief the Personnel Director and his staff as follows:

The President has talked with the Personnel Director and told him that he is worried over absenteeism and turnover in the Company and wishes to know if a new program for training employees and supervisors would be effective in meeting the problem. The Personnel Director has assured him that he thought it would help. The President has asked him to come in with key people in his department and to explain their plan to the Executive Board. He has told him that he may meet with opposition and should be prepared to meet it.

—Brief the Personnel Director as follows:

You have decided on a short induction program for all new employees, periodic lectures on company policies and products, and a conference training plan for supervisors. You have delegated each of these programs for development to members of your staff.

Your problem is how can you sell this program. What opposition are you likely to encounter on the Board? How will you meet it?

—Ask Personnel Director to repeat essentials of above. Ask him to assign his staff members to training plans.

—Direct training staff to practice their planning for ten minutes and then excuse to outside room for a continuation of their work.

9:25- 9:35 Appoint Six Members to Executive Board

—Ask audience to help fashion roles. Structure different viewpoints, some favorable and some unfavorable to training.

Suggested Roles

—President: Wants an employee development program. He is worried over the absenteeism and turnover among employees of his company. He believes a good program could help reduce the rate of absenteeism and turnover. However, he will not force it on the Board.

—Vice President: Manufacturing. "Interferes with production."

+Vice President: Sales. "All for it. It has paid off in training salesmen."

—Sec'y-Treasurer: "Costs too much." If convinced it would be profitable for the company he might swing over.

—Plant Manager: "Training can be done best on the line. Most of the training stuff the foremen get at training meetings doesn't apply on the line."

? Vice President: Engineering. Open Role.

—Direct Executive Board members to practice roles briefly. When director is satisfied that all members understand their assigned roles, he acknowledges his satisfaction and asks Board to wait for further instructions.

—Direct all audience members to act as observers. Give the following directions:

"Make a check list of things you will watch for as attitudes and feelings clash. These will be the basis for your group sessions which follow immediately after the role playing. Here are some suggested questions for your list.

What appeals did the training people use?

Which seemed most effective?

Which seemed most ineffective?

What might have been tried?

What attitudes most frequently blocked acceptance?

What should the Personnel Director do now?

9:35-10:10 Executive Appraisal

—Call in Training Staff and present to the Executive Board. Direct Practice of the situation. As situation proceeds di-

rector might watch for a good chance to employ soliloquy, especially in case of Personnel Director and President.

—When scene is cut: Ask Personnel Director how he feels about the opposition. Would you have used a different approach? Ask him to identify each of the Executive roles.

10:10-10:30 Small Group Sessions Discuss Outcomes

—Ask small table groups of six to discuss outcomes as they see them. Assign a chairman and a recorder to each group. Appoint no. 3 as chairman and no. 4 as recorder. Ask recorder to get a picture of the discussion around the questions on their observer check list. (Have chairman introduced.)

—Ask Training people and management people to remain on the stage. Ask them to *exchange roles* (Moreno's Technique of Role-Reversal) and discuss the training problem.

10:30-10:45 Coffee Break

10:45-11:00 Reports from Group Sessions

—Have Recorders introduce themselves and report. A report from the stage group on the effect of changing roles may be heard.

11:00-11:40 Supervisory Appraisal

—Dismiss Training staff to outside room. Tell them they must prepare to meet a critical group of first line supervisors.

—Appoint five supervisors. Ask audience to help in structuring roles.

Suggested Roles

—Supervisor: "I have never felt anything they have done on the training program applied to my job."

+Supervisor: "I think it helps get promotions."

—Supervisor: "We don't have time to go to meetings and get out production."

—Supervisor: "The programs don't get to the real problems."

? Supervisor: Open role.

—Call in training staff and introduce to supervisors. Ask group members with assigned numbers 1, 2, 3 at each table to identify themselves with the training group, those with 4, 5, or 6 to identify with the supervisors as the situation develops.

—Practice situation. When scene is cut ask Personnel Director how he feels about this opposition. Would you use a different approach? Do you recognize the Supervisory Roles?

11:40-11:55 Discuss by asking audience members to reverse their role and discuss at their table as if each represented the reverse

role from that in which they had identified themselves during the role-playing situation. Ask role-playing participants to remain and to do the same.

11:55-12:00 Director Summarizes.

"The objective of the morning session has been to give you an opportunity to participate in role-playing skills as role-playing was applied to the problem of gaining acceptance of an employee development program.

"You have seen a personnel director plan with his staff group how to present an employee development program to a top management group. That was Design B. (Point to Blackboard showing types of role-playing.)

"You have seen this training staff present its employee development program to a top management group. That was Design C. (Again, point to Blackboard.)

"You have watched the training staff present its program to a group of first-line supervisors. This was another variation of Design C where the staff was appearing before a lower organizational level.

"Finally, you practiced audience role-playing when you identified with the training staff or the supervisors as directed. This is one kind of Audience Role-Playing or Design E as shown on our Blackboard.

"You have in addition participated in small groups, some of you as chairmen, some as recorders. Most of you have sat as observers in preparation for your group discussions of the presentation by the training staff of its employee program to top management.

"You have been intimately a part of many role-playing and group techniques being used widely today in training and conference situations.

"We said that role-playing is a doing process involving feelings and attitudes in a situation requiring social skill. Have you felt engaged in the situations presented? Have you felt that they might actually occur in real life as you saw them? Did you gain any insight into why the behavior occurred as it did? Did you feel that you would like to have tried some other approach in the situation you observed?

"If you can answer Yes to some or all of these questions you have achieved the full benefits of the morning session. After lunch we shall go on to the learning about the skills you have seen so that you may know how to extend the use of role-playing techniques in your organization."

II. *The Afternoon Session*

Objective of the Afternoon Session: To give maximum opportunity to conferees to acquire essential skills for the application of role-playing techniques to employee development problems.

1:30- 1:45 Securing the Problem Census

—Emphasize: You are getting ready to lead role-playing. Each step will be described. The first step is to find role-playing situations that relate to the real problems faced by the

members of your group. One way to find such situations is through a problem census. Let us demonstrate this.

—Ask one table of six persons to appear as panel. Secure answers to:

What are the Major Personnel Problems or Problem Areas that Business and Governmental Agencies are Grappling With? Get conferees to *illustrate with cases.* Point out how these could be developed into role-playing situations.

1:45- 2:00 Preparing Role-Playing Demonstrations

A. Principles.

—"While role-playing rapidly enlists the interest of the trainee group and while the leader's responsibility for the success of the training decreases as the group assumes much of this responsibility, there is still need for those using the technique to develop such skill that the maximum value will accrue from its use.

"Skill in the use of this method seems to lie in four areas.

1. In the selection of scenes to be played and the setting up of those scenes so that the important points will be dramatized;
2. In cutting off the scenes after the major points have been dramatized;
3. In leading the discussion immediately following the scene so that the major points dramatized become the focal point of discussion.
4. In setting up other scenes growing out of the original diagnostic sets."

—Distribute and Discuss Principles for Preparing Role-Playing Demonstrations.

"1. Create a problem for which there are differing viewpoints.
2. Create a situation in which these viewpoints are relevant.
3. Supply instructions which give each an objective or motive. (This may be done orally or in written instructions.)
4. Furnish each with enough factual information so that the facts of the case do not become an issue.
5. Make all roles as nearly alike in reasonableness as possible.
6. Make the true reasons for the behavior expressed by one participant be due to reasons that are not obvious to the others."

Emphasize importance of *stress* in situations.

—Distribute Role-Playing Improvisations by Percival M. Symonds. (See his "Role Playing as a Diagnostic Procedure

in the Selection of Leaders," *Sociatry,* March, 1947, pp. 43-50.)

B. Demonstration of a Simple Role-Playing Situation of Design A.

II—Demonstration: Two men are appointed, given written instructions, and asked to leave the room. One is assigned the role of Mr. Jones of the Personnel Office; the other, Mr. Smith of the office force. They are given statements of a problem confronting them.

Read roles to audience. Call in the two men. Ask them to practice the situation described in their instructions.

2:00- 2:30 Writing of Role-Playing Demonstrations by Groups; Group Reports.

Ask those whose number is 5 to act as chairman at each table. Those who are no. 6 to act as recorders. Have chairmen introduce themselves. Instruct them to direct groups in the writing of some original role-playing situation. After writing, recorders introduce themselves to audience and read their group's improvisation.

2:30- 2:45 General Description of Steps in a Typical Role-Playing Session.

2:45- 3:00 Useful Techniques

Distribute Some Useful Techniques. Refer to uses made in our work shop today. Ask conferees to describe uses of Role-Playing Techniques they have made.

Some Useful Techniques[5]

1. Scenes which move in sequence.
2. Replaying of scene after observations.
3. Replaying of scene by people who were out of room but who received some briefing.
4. Technique of role reversal. Participants exchange roles.
5. Small buzz sessions around table following role-playing.
6. Soliloquy Technique.
7. Self analysis after role is played.
8. Commentator from the side. At ringing of bell or other signal, participants stop briefly while commentator asks a leading question or directs attention to a certain development. Role-playing immediately resumes.
9. Skit completion. Role play completion to a skit which creates a situation and supplies a background.
10. Audience identification with roles. Members of an audience are asked

[5] J. L. Moreno, Psychodramatic Production Techniques, the Technique of Role Reversal, the Mirror Technique, the Double Technique and the Dream Technique, Group Psychotherapy, Vol. IV, March 1952, p. 243-73.

to identify themselves with certain characters in the skit or in role-playing demonstration. Audience members are then asked to reverse role and discuss with another member who has been identifying with an opposite role.

11. Audience role-playing. Develop an unfavorable attitude in all members of an audience. Introduce some other experience, let the group react to the new events, and record the changes in attitudes produced by the added experience. By giving various kinds of new experiences one can discover which of them tend to alter attitudes most effectively. Behavior is measured by asking members to fill out a questionnaire. This questionnaire requires persons to record a number of opinions, and thus information is obtained on how different persons feel about the situation in which they are placed.
12. Buzz sessions are employed to prepare questions to be answered by speakers prior to their appearance or after the speaker has spoken.
13. A tape recording of an actual situation such as a foreman and steward discussing a grievance (or a labor-management negotiation session) is played to a group. Analysis of roles is made and a replaying of roles is carried out using the same situation.
14. A human relations case may be read by the group. Parts involving feelings and attitude differences may be role played.

3:00- 3:15 Coffee Break

3:15- 4:15 Practice in Multiple Role Playing

—Distribute to each table the instructional material prepared by Norman R. F. Maier and L. F. Zerfoss for the New Truck Problem as described in their article in Human Relations, 1952, *5,* No. 2 or in Maier, *Principles of Human Relations,* pp. 148-153. Six roles are played at each table. The same situation and the same roles are used at each table. Those persons who are "left over" may be appointed observers. Brief observers to watch:

The way foreman puts the problem.
The extent to which he entered the discussion.
Evaluation of things he did to help the discussion along.

—Practice the New Truck Problem at each table. It takes about 30 minutes for groups to reach a decision.

—Analyze Results on the Blackboard. Get Observer reports.

—Director Summarizes:

"The objective of the afternoon session has been to give you an opportunity to acquire some essential skills in applying role-playing techniques to employee development problems.

"You have seen how a problem census will bring live problem cases to attention and how these may be built into a role-playing situation. You have studied the principles for preparing role-playing situations. You know the kind of situations which lend themselves to role-playing improvisation.

The steps in a typical role-playing session have been outlined and are in your hands. Fourteen useful techniques have been discussed and many demonstrated. They are available for your use in training.

"You have seen how role-playing may be applied to few persons or many persons, from a supervisor-employee relationship to a mass audience relationship.

"Role-playing is a powerful technique. Its possibilities in training are very great. In the field of psycho-therapy under the pioneer work of Dr. J. L. Moreno, role-playing is more than a technique. He has made it a psychiatric treatment for individuals and groups. Already applications have been made in industry and government to counseling and employee interviewing. You may read about these developments in such Journals as SOCIOMETRY and *Group Psychotherapy*. Undoubtedly, some of your professional journals are beginning to report findings to you.

"From here on its up to you. Practice by taking first steps. Use the best stereotyped situations which others have shown to be valuable. Gain skill and then you will find that you will be able to create role-playing situations and lead in their analysis.

"We have fifteen minutes for questions and discussion."

4:15- 4:30 General Question and Discussion Session.
4:30 Dismiss Workshop

CONCLUDING REMARKS

The procedures in the workshop were carefully checked in committee meetings of the Washington State Training Directors Society to ascertain their correspondence with the needs of the prospective conferees.

Their expressed general satisfaction indicates that the skills presented are the ones they desired. A program sheet was distributed as shown:

> "The Washington State Training Directors Society and the University would like your suggestions concerning future workshops. Please number in the order of their importance to you the conference topics listed below."

	Number of first place votes
a. Audio-visual aids	6
b. Methods of evaluating training programs	7
c. Program planning and gathering source material	5
d. Techniques of selling top management—getting ideas across—art of persuasion	12
e. Conference leadership	3
f. Organization and management	6
g. Merit rating	0
h. Employee communication programs	7
i. Opinion and morale surveys	1
j. Other	5

The largest vote was for "techniques of selling top management." This indicates that their own major occupational problem is one of role taking.

The social scientist who takes the role of training director probably does so with misgiving unless he has larger vision. It is in his code to advance research and knowledge. He knows that merely creating group situations does not of itself do this. There is still the challenge to explore the social processes and the results of role-playing situations. The research possibilities are many and they are multiplied by a researcher who can create group situations as well as measure their accompanying processes.[6] The study of attitude change has many fruitful possibilities within industry. The use of a neutral audience playing the role of employees in X Company, with before and after measures of morale or job satisfaction, could provide the sociometric laboratory in which many poor policies from a human relations point of view could be discarded without damage.

It can be predicted that when trainers are researchers and researchers are trainers, social science will take another step forward in its usefulness as an applied science.

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[6] J. L. Moreno has developed the theoretical implications of this view in his provocative statement, "Current Trends in Sociometry", Feb.-May, 1952, 15:146-163.

PSYCHODRAMA: DESCRIPTION OF APPLICATION AND REVIEW OF TECHNIQUES[1]

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The purpose of this report is the description of Psychodrama as it is used by psychiatric case workers in a state hospital setting. Experience at Pontiac State Hospital indicates that a knowledge of patient reaction to roles and techniques is essential for the psychodramatic director, and that until he has developed such knowledge treatment can be hampered needlessly. It further indicates the importance of group structure and that a definite relationship exists between the make-up of the group and the therapeutic results. With these factors in mind sessions are described and an assessment made regarding the best use of roles and techniques and the type of group most likely to produce maximum therapeutic results. Psychodramatic techniques are defined, and the nature of the group and the effect of the group on the individual will be discussed. As roles assigned and techniques used are also of importance, an effort will be made to determine the roles and techniques preferred by psychotic and non-psychotic patients and the therapeutic value of these roles and techniques for particular categories of patients.

To give the reader a more complete understanding of this important therapy and its use, a few cases are briefly cited, and the results obtained with seventy-five patients indicated. It is not the purpose of this study to prove the value of Psychodrama. As is true of other types of therapy this therapy is fraught with dangers if misused and is of great value if properly used.

Today psychiatric case workers are becoming more and more active in the area of treatment and one finds them working successfully with a wide variety of patients, both as individuals and in groups. One method of treatment which is becoming increasingly widespread in its use and which falls well within the available skill of the psychiatric case worker but which is only used by them to a limited degree is Psychodrama. This is, however,

[1] Abstract of a thesis presented to the University of Michigan School of Social Work in June, 1952, based on data secured at the Pontiac State Hospital, Pontiac, Michigan. The program was inaugurated by the author and has since the time of its inception been directed by the author who is Social Service Director at that institution.

a therapeutic method which they can use successfully in a diversity of situations.

The program was inaugurated as it was felt that something was lacking in the treatment program. Many patients manifested incapacities for verbal communications, many were unable to make an adjustment to an ordinary group of persons and many seemed to be so alone. It was felt that these needs must be met by some type of therapy whereby patients could be treated in groups as large masses of the hospital population had these needs and staff was limited. After considerable research and discussion it was decided that Psychodrama might best meet these needs, and plans for such a program were immediately instigated. The program was inaugurated and is operated by the Social Service Department, and the Clinical Director of the hospital acts as psychiatric consultant.

Sessions are conducted each Wednesday and Thursday afternoons for a ninety minute period and are attended by approximately twenty patients. Patients attend the session to which they are assigned week after week or until such time as they are discontinued for any one of a number of reasons. The Wednesday and Thursday groups are, however, made up of different patients. The majority of the patients are brought from the closed wards by the Nursing Staff while others, who reside on open wards and have ground privileges, come alone. There is an air of pleasant informality as the patients seat themselves in clusters, pairs or alone. The director opens the sessions with a few questions or a statement of a situation, and after some discussion and consultation several people start for the stage. A few chairs are placed about a small table, and Psychodrama is in session.

Sessions are made up of the following three major categories of people: The patients (actors and spectators), the director, and the auxiliary egos. The patients are discussed at length in another part of the study. Discussion of the participants is at this time being limited to the director and the auxiliary egos.

The director is responsible for the therapeutic functioning of each session and must draw from the patients a plot which will meet the emotional needs of the actors and the audience. In order to function adequately in this capacity there should be an awareness of dynamics and an understanding of group reactions. Flexibility, awareness, understanding, neutrality and friendliness are essential characteristics of the director. It is also important that he not have too much self-ego need as he probably functions best when he remains as unobtrusive as possible and works with a minimum expenditure of emotional energy.

The auxiliary ego is a participating actor who helps with the portrayal of the therapeutic scenes. Over and above being an observant and understanding person who is dynamically oriented, it is essential that this member of the psychodramatic team be able to act. Warm, out-going, and flexible personalities who are capable of spontaneity and who have a minimum of personal difficulties are usually most at ease on the stage and may be of greatest help to the patients. One proof of the success of the auxiliary ego may be the patient's acceptance of him in his particular role. With a good auxiliary ego, remarks such as, "You are exactly like my father" or "How did you know what my wife was like?" are not unusual. If scenes are to go well the director must know his auxiliary ego as well as he knows his patients.

The actual operation of Psychodrama consists of three phases: preplanning, dramatic presentation and post-session evaluation. Prior to the session the psychodramatic staff meets in the office of the director to plan the session. This is an important part of the session as it may be the foundation upon which the other two parts are built. Sessions can be aimed at observing the patient and at treatment or education, and plans are dependent upon the primary focus.[2]

In order to assess the therapeutic value of scenes it is necessary to discuss the status of each patient in term of his illness and his adjustment to the hospital, to his family and to the Psychodrama group. The staff also makes use of the patient's case history and records of his progress in Psychodrama as they are of use for diagnostic evaluation and serve as guide posts in the treatment process. Just as diagnostic plans and treatment goals are essential to case work, so they are essential components of Psychodrama.

During the early days of Psychodrama, scenes were planned on a casual and symptomatic basis and were directly related to situations and individuals involved in the patient's illness. Participation resulted from such planning, but the results were not always therapeutic as our sessions are held too infrequently to handle the anxiety evoked in the individual patient and in the group. As soon as this was noticed, reality scenes were limited in number and like-reality, imaginary, or make-believe scenes were devised for use during part of each session. By this means it was possible to temper the anxiety and hold the patient from one session to the next. Such scenes bring about more ready participation and a greater degree of spontaneity,

[2] This may represent a more rigid view of conducting sessions than is accepted by others.

and afford the patients the security of anonymity. When they have become sufficiently secure in the group they can then say, "that is my story", "that is what my mother is like", "that is why I am here".

Once the scene has been devised the assigning of roles is the important issue to be faced by the pre-planning group. The casting of scenes is closely related to the creation of situations, and care must be exercised in the selection of personnel so as to allow for the proper expression and satisfaction of the patients' needs and provide the proper therapeutic atmosphere and direction for the successful enactment of the devised scenes. Individual patients or the group can for definite therapeutic reasons be permitted to devise or cast scenes, but such scenes must be carefully used as patients will at times use them to push themselves or others deeper into illness.

The acting or dramatic presentation takes place in the hospital auditorium, and this phase of Psychodrama is completely spontaneous. "The level at which the patient is spontaneous is the working level of the treatment."[3] At times the level will be the delusions of the patient, at times it will be a situation completely removed from the patient and at other times it will be real persons and real situations with which the patient is faced. Both reality and make-believe situations can relate to the past, the present, or the future, and the patients can portray the scenes as seems indicated, that is, alone or with others.

During sessions spontaneity must be constantly "regenerated." Support must be given to inhibited patients, and withdrawn patients must be helped to become a part of the group. This phase of Psychodrama reveals the individual on the stage and the group in action. Participation is both on and off the stage, and the group is often stimulated to discussion regarding the nature of the problem being presented.

Session discussion varies with different therapists. At Pontiac discussion takes up very little time as it is felt that dicussion is most successful when it is brief and leads into spontaneous scenes on the stage. The director should limit his part in session discussion and must at all times have an awareness of the feelings of the patients as they express themselves either verbally or by means of facial expressions.

Immediately following the dramatic presentation the staff meets to evaluate the planning session and the presentation. The discussion usually centers around response to scenes and participation in scenes, group response to the individual actor and the scene, and the discussion which resulted. Patient movement and group structure is carefully noted, and the director,

who is always strategically located during sessions, presents observations of audience reaction as well as actor reaction.

An Analysis of the Participating Patients

As is indicated by Table I the seventy-five patients were almost equally divided between men and women, fifty-eight per cent of the patients fall into the classification "schizophrenia" and the majority of the schizophrenics were categorized as catatonic or paranoid. The majority of the patients admitted to the state hospital fall into this category. Most therapists consider individual therapy with such patients difficult. The developcent of a relationship is considered essential to individual therapy, but the literature indicates it is not necessarily an essential component of Psychodrama. In view of this the staff was particularly anxious to determine the effect of this type of therapy on the large groups of schizophrenic patients in the hospital. What the table does not show is the degree of illness, and this is important to an understanding of sessions and session results.

TABLE I

Diagnosis and Sex of Participating Patients

Diagnosis	Sex		
	Male	Female	Total
Schizophrenia:			
Simple	2		2
Catatonic	8	7	15
Hebephrenic		4	4
Paranoid	8	9	17
Mixed	3	3	6
Total	21	23	44
Primary Behavior Disorders	4	3	7
Psychoneurosis	3	4	7
Involutional Psychosis		2	2
Manic Depressive Psychosis	1	2	3
Constitutional Psychopathic state	3		3
Miscellaneous	5	4	9
Total	37	38	75

Most of the members of the group can be described in terms such as deteriorated, out of contact, chronically ill and lacking in ego strength. A number of patients had for some time been unable to look after their own physical needs, were being spoon fed or tube fed, and were impossible to "reach" in individual therapy. Fixed delusions, marked hostility, ambiva-

[3] Moreno, J. L., Psychodrama, Vol. I, (New York: Beacon House, 1946), p. 322.

lence, deep depression, and overactivity are also terms which might well serve to characterize the group. In the majority of instances very sick patients were selected for participation.

The patients ranged in age from fifteen to sixty-three, the largest grouping being between fifteen and twenty-five among both males and females. There were seventy whites and five Negroes. The nationalities represented were all inclusive, with no one group predominating. None were foreign born or first generation Americans. As a group the patients can with a few exceptions be described as coming from middle class homes. Deprivation was almost wholly emotional in character. Fifty per cent of the working group came from factories, but professions such as social work, teaching, etc., were represented. There was only one representative of the farm group and the remaining patients were office workers. The average person in the group was economically better off than the average hospital patient. From the standpoint of education, the group was typical of the rest of the hospital population. Eight per cent of the patients are college graduates, thirty-five per cent attended grade school for from four to eight years and fifty-seven per cent are high school graduates. The majority of the patients included in the group were single. This was due to the fact that many of the patients were quite young, and is another area in which the group was not typical of the general hospital population. This factor was important as it "colored" the material brought up in sessions. If sessions were being conducted with an older group of patients from the standpoint of age, marital problems would probably be much more prevalent. Sixty-three per cent of the patients were ill less than five years and thirty-seven per cent were ill more than five years. The majority of the patients fell into the five to ten year group. Approximately two-thirds of the patients were attending Recreational Therapy and Occupational Therapy during the time they were included in sessions. One-third of the group was being seen by the psychiatrists and two-thirds by the social workers. One-third of the group received a short course of electro shock therapy. For six per cent of the patients Psychodrama was the only form of treatment.

An Analysis of Group Structure

For therapeutic results patients should be brought together in such a way as to have a well integrated group and not a crowd. A therapy group must be specially planned but different therapists have different ideas regarding the best way of grouping persons for therapeutic purposes.[4]

[4] For detailed information regarding group formation see the following publications:

After careful consideration of the various types of group formations a decision was made regarding the type of group which should be of most value in a state hospital setting. Table II indicates the composition of this group which included one patient diagnosed psychoneurosis who ultimately was determined to be a hebephrenic schizophrenic but whose diagnosis was not changed. She was deteriorated to the place where she was unable to look after her own needs and seemed to be unaware of her surroundings. The group also included one very depressed patient, two overactive patients, and two patients with fixed delusions. One of the patients was very aggressive, hostile and punishing in his reactions, one was ambivalent and several were markedly anxious.

TABLE II
THE FIRST THERAPEUTIC GROUP

	Schizophrenia			Psycho-
	Catatonic	Paranoid	Simple	Neurotic
Sex:				
Male	3	2	1	2
Female	2	3		3
Age	25-30	25-35	26	25-30
Education	High School	High School	High School	High School
Social Level	Average	Average	Average	Average
Problems:				
Marital Difficulty	3	1		3
Difficulty with Parents	2	1		2
Unable to accept Hospitalization		3	1	

In spite of careful selection this group was not ideal. The simple schiozphrenic did not at any time become a part of the group. It was also found that the marital and parental problems could be handled with ease at one session, but that it was difficult to work in feelings about hospitalization. The three patients with these problems in common clustered together and isolated themselves from the rest of the group.

This group did not at any time become "well integrated." The Mutual

Teicher, J. D., "Experiences with Group Psychotherapy", *U. S. Naval Bulletin,* Vol. 44, (1945) pp. 453-755.

Gray, William, M.D., "Group Psychotherapy in a State Hospital", *The Journal of Nervous and Mental Diseases,* Vol. 108, No. 6, (December 1948), pp. 487-488.

Moreno, J. L. (ed.) "Group psychotherapy". Beacon House, 1945.

Moreno, J. L., *Who Shall Survive,* (New York: Beacon House, 1953).

Group completely overshadowed the Unitary Group, and the relationships within the Unitary Group were not strong. Throughout the two months this group remained together, the character of the group remained largely as indicated in Figure 1.

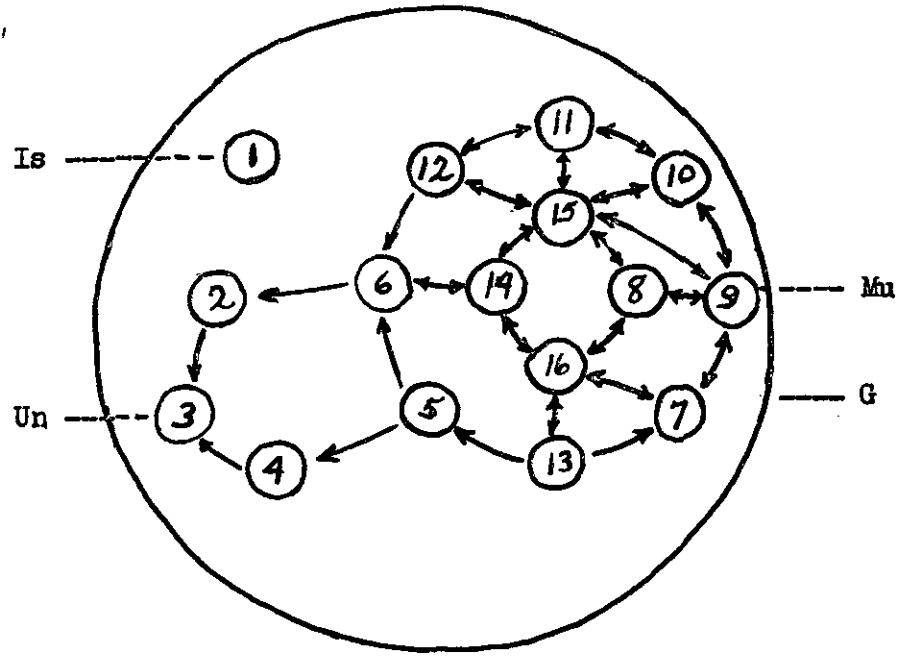

FIGURE 1

SOCIOMETRIC STRUCTURE OF FIRST GROUP

G—the group Is—isolate Mu—mutual Un—unitary

This group probably was therapeutic for all except the isolate, but only parts of each session seemed to be helpful to the Mutual Group and the Unitary Group. Only patients five and six seemed to receive help from the scenes planned for each group. These patients were drawn together by parent-child feelings. This is not an infrequent tie and depending upon the background of the individuals concerned, it can vary in character from hatred to love or from rejection to overprotection. It is practically always therapeutic as other members of the group act as regulators, give support, act as counter-irritants, and keep the situation running smoothly.

After eight sessions two of the patients in the Mutual Group were placed on convalescent status and were replaced by middle-aged schizo-

phrenics, a male and a female, whose chief problems at that particular time centered in the area of hospitalization. With these two additions the group, except for the one isolate, became a whole. The five had sufficient strength to feel secure in discussing their problems, but as three they were reticent to face a group of twelve. Unification came about as the two individuals added to the group were strong personalities who had special ties with several members of the Unitary Group. They were mature individuals who were accepted as parental figures. The maturity is important as age alone does not bring about acceptance by the group on the parental level. After two sessions the group functioned as indicated in Figure 2.

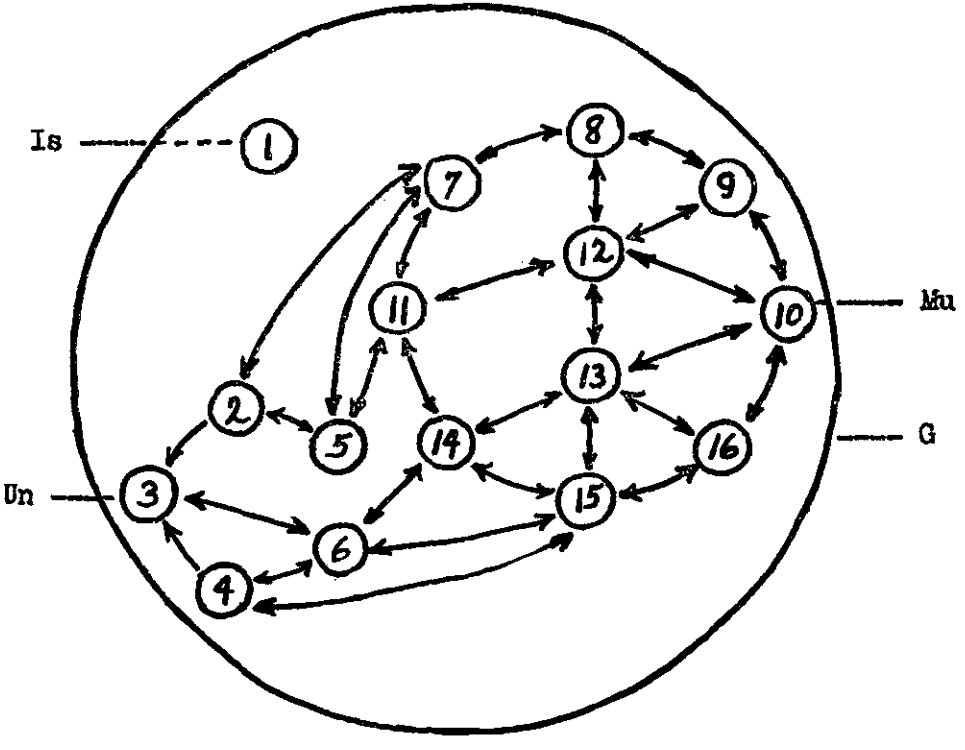

FIGURE 2

SOCIOMETRIC STRUCTURE OF GROUP AFTER REPLACEMENT OF TWO PATIENTS

G—the group Is—isolate Mu—mutual Un—unitary

Figure 2 shows how the group became increasingly cohesive and how patient to patient transference developed between a large group of patients.

Some group therapists believe that a patient who has thus developed a relationship with another patient in the group has taken the first step in breaking his own psychological isolation.[5]

Transference, however, is not indispensable in Psychodrama and treatment can proceed quite well when transference is negligible and even absent. "The function which transference performs in the psychoanalytic treatment of psychoneurosis and which it fails to perform in narcissistic disorders is replaced on the psychodramatic stage by new factors which operate on the interpersonal and on the role-to-role level . . . this inter-role and interpersonal feeling has been called 'tele' instead of 'transference'. By means of the tele, a situation has been created in which an attempt to guide and to cure can be made in the case of the mental disorders which psychoanalysis openly eliminated from its therapeutic field.[6]

Patient to therapist transference was limited in the group. Except in a couple of instances, the therapist seemed to be outside of the picture. Transference to the auxiliary egos was more widespread.

When the group was small, therapy resulted irrespective of the type of patients in the group. It, however, seemed essential to function with a larger group, so sessions were carefully analyzed, and it was possible to select fifteen groups which, from the standpoint of therapeutic results, seemed to be ideal.

In making the selection the following factors were taken into consideration:

1. Group cohesion.
2. Spontaneity.
3. Degree of "ego strengthening" noticed in patients.
4. Reduction of symptoms of illness on the part of the participating patients.
5. Increased insight on the part of the patients.
6. Increased ability to deal with the environment.
7. Development of healthier defenses.
8. Changes in social behavior.

The psychodramatists analyzed each patient within each group taking into consideration the before-mentioned factors and on the basis of these findings, made a decision regarding the value of the group.

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[5] Klapman, J. W., *Group Psychotherapy Theory and Practice.* (Gruen and Stratton, New York: 1946), p. 62.

[6] Moreno, J. L., *Psychodramatic Treatment of Psychosis,* (New York: Beacon House, 1945), p. 3-4.

Fifteen ideal groups, that is, groups wherein the therapy seemed potentially at a maximum were selected. Five groups were chosen from each of the first three years during which sessions were in progress. In these groups the following factors existed.

1. Approximately an equal number of patients of each sex.
2. Group varied in size from twelve to twenty-two patients.
3. Patients with tendency to punish and those with tendency to be protective equal in number.
4. Patients with fixed delusions made up no more than one-fourth of the group.
5. Overactive and depressed patients equal in number.
6. Narcissistic patients made up one-sixth of the group or less.
7. Even number of patients participated in sessions.
8. Problems varied widely.
9. Psychopaths and primary behavior disorders limited in number.
10. Diagnosis primary behavior disorder made up one-fourth of group or less.

Groups with the above characteristics were cohesive in character, and even though certain patients had a tendency to isolate themselves there was in each case a certain number of patients who reached out toward these individuals. In these groups good balance existed, patient to patient transference and patient to auxiliary ego transference probably existed for approximately one-half of the patients. Patient to director transference was limited. Positive tele existed for all of the patients in the group.

Fifteen non-cohesive, less therapeutic groups were also selected and analyzed. Here, too, five groups were chosen from each of the first three years sessions in progress. These groups differed from the therapeutic groups as follows:

1. Uneven distribution of the sexes.
2. Several psychopaths in group.
3. Uneven number of patients participating in sessions.
4. Personality characteristics manifested by patients did not balance one another.
5. Primary behavior disorder in group in larger proportion.
6. Narcissistic and overactive patients made up approximately one-half of group.

Transference seemed to exist for very few of these patients and positive tele was also less frequently found. This review of sessions indicates that a careful selection of patients may be essential.

An Analysis of Roles and Their Use in Psychodrama

A role is the part played by the patient actor and it can be real or imaginary. The enactment of the role is valuable both therapeutically and diagnostically. During role playing the patient may forget that he is playing a role and show what he would really do in a given situation. This is very important since when a person is writing out an incident or telling about a happening the situation is naturally colored by the emotional reactions and re-evaluations of the narrator. It is through seeing an incident or by complete spontaneity that the reality situation can be accurately observed.

In assigning roles it is important that the needs and the abilities of the individuals be considered. Scenes are "taken over" or "fall flat" if improperly cast. Understanding of a role does not necessarily indicate ability to enact a role and on the other hand some patients are able to enact roles for which they seemingly have little background. It must also be remembered that certain patients enjoy particular roles and some have need to objectify roles and define them within themselves before enacting them. The observance of patients during sessions leads to a gradual understanding of the type of role most helpful to the particular individual, but a prior understanding makes for more rapid results. With this in mind the roles used by the seventy-five patients included in this report have been tabulated and studied.

Seventy-seven per cent of the reality roles[7] were enacted by psychotic patients and twenty-three per cent by the non-psychotic group. Psychotic patients seem to have difficulty imagining situations and are so taken up with the delusions which are reality to them that they do not improvise. They are very sure regarding their delusional material and they apparently do not resist expressing that which is reality to them. On the other hand, borderline psychotics and the non-psychotic patients are fearful regarding exposing themselves and have to gradually warm up to the psychodramatic situation. As they see the reactions of the group to improvised roles, they, however, gradually develop sufficient security to enact reality roles. It is not unusual for such a patient to enact reality but earmark it make-believe and at some future date explain that the situation portrayed was an incident in which he had actually found himself.

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[7] In this section of the study "reality" refers to that which is presumed to be reality for the patient. The delusions of the paranoid schizophrenics are classed as reality since for the patient they are real.

When a psychotic patient is cast in imaginary roles, he is either unable to meet the role, enacts it in an inadequate manner or falls out of character and takes on a reality role. The handling of the situation seems to be dependent upon the amount of ego strength that can be mustered for the occasion. On the other hand if non-psychotic patients are pushed into portraying reality before they are emotionally ready for the portrayal, they temporarily drop out of sessions or are uncomfortable in the sessions and become a negative influence in the group rather than a therapeutic influence. These situations should be avoided, as inadequate enactment of roles may be of only limited value therapeutically. In such instances audience attention is lacking and as a result the patient actor is left with a feeling of frustration and a feeling of inadequacy.

It is reasonable that the psychodramatic director should, when casting new patients, think along the lines of improvised roles for the non-psychotic and reality roles for the psychotic. As early as possible a decision should also be made concerning the needs of the patient. Casting so as to demonstrate defenses is also common and invariably leads to considerable group discussion. In assigning roles and in encouraging spontaneity special attention must be given to the patient who has a tendency to intellectualize.

Role assigning is just as important a part of Psychodrama as is group formations, techniques and plot. Role-playing is not a mechanical skill superimposed upon personality, but it is an essential part of personality formation and adjustment, and as such it should be given careful consideration. Through role portrayal psychotic patients are given an opportunity to share their private world with others, and all of the participants come to know that they can be themselves without fear of rejection or reprimand.

An Analysis of Techniques Used

The techniques devised by J. L. Moreno are in use at Pontiac State Hospital, but in a few instances they have been somewhat modified so as to meet more adequately the needs of the particular setting. These techniques are clearly explained in Moreno's book, "Psychodramatic Treatment of Psychoses."

The *Substitute Role Technique* is frequently used and is helpful when working with patients who are suspicious of acting themselves on the stage.[8] This technique was successfully used with a middle aged woman diagnosed involutional melancholia with agitation and depression. She was unable to

[8] Moreno, J. L., *op. cit.*, p. 6.

enact her own situation so was asked to be her mother who operated a boarding house. In this role she was at ease and seemed to enjoy going on the stage. During the third session the patient brought up the fact that one of her roomers was promiscuous. This story was also her own story. As a young girl her illegitimate pregnancy was followed by an abortion, and as she approached middle life she worried about this incident and felt sure her family would find out and would no longer love her. Psychodrama gave this woman an opportunity to freely express her feelings about the incident, and the discussion of the audience helped her to see that she had the love of her family and would not necessarily lose it because of the incident.

Another valuable technique is called the *Mirror Technique*. In this technique an auxiliary ego takes the part of the patient and, so to speak, mirrors his actions. This gives the patient an opportunity to see himself as others see him and helps him become a more objective individual.[9] One paranoid schizophrenic treated by this technique had been ill for five years. She was paranoid toward her family and toward the hospital, jealous of other patients and extremely demanding. An auxiliary ego took the part of the patient and acted in just as jealous and unreasonable a manner as the patient. After intently watching herself for several sessions the patient asked, "Do I really act that bad?" The discussion that followed helped her to develop insight, improvement followed, and the patient is now living in a Family Care home and making a good adjustment.

The *Projection Technique* is particularly valuable when working with paranoid schizophrenics and frequently helps to break down the paranoid ideas of such patients. The fixed delusions of the patient form the plot, and the patient selects the characters and acts as the director.[10] This technique was successfully used with a young paranoid schizophrenic who suggested and directed a series of scenes in which auxiliary egos took the part of his parents and his wife. During these scenes the patient's delusional ideas regarding these people received objectification, and the group discussion which followed also proved valuable.

The *Double Ego Technique* is valuable when working with ambivalence as it tends to objectify the struggle which is going on in the mind of the patient. In the stage situation one auxiliary ego plays one desire while the other one plays the opposite.[11] A psychoneurotic who was resistive to

[9] *Ibid.*, pp. 8-9.

[10] *Ibid.*, p. 9.

[11] *Ibid.*, pp. 10-11.

leaving the hospital was successfully treated by means of this technique and came to understand her mixed feelings regarding being a wife and mother.

In the *Technique of Role-reversal* the patient exchanges roles, like husband with wife or father with son, he takes several parts; he moves about the stage and acts for each person important to the scene. This technique is particularly valuable when working with narcissistic individuals and is the technique of choice when patients are portraying situations which are strongly felt by them.[12] This technique is being successfully used with a manic depressive who has psychopathic tendencies. During sessions she freely gives vent to her feelings about her family and the hospital. She enjoys the sessions and will not permit anything to keep her away. She says Psychodrama has helped her, and her ward behavior has improved. This patient also serves as a good example of the group acting as therapeutic agents and establishing limits for patients who are particularly aggressive and tend to take sessions over. The comments of the other patients have undoubtedly been valuable to this particular patient.

In the *Symbolic Distance Technique* the patient enacts a role very different from his own role and is gradually led down to his own role. This technique is particularly valuable when working with children.[13] A young boy and girl from broken and inadequate homes were treated with this technique. Individual therapy was helpful and ward behavior improved, but the children were afraid to leave the security of the hospital as they felt sure they could not get along in a home situation. As the problems of these children were so alike they were cast as brother and sister and treated together. Following the portrayals the group discussed why the children acted differently in the various situations. From these scenes the children finally came to realize that they could get along in some types of home situations and expressed willingness to accept a family care situation.

In the *Auxiliary World Technique* the patient is permitted to decide where he wants to be and what he wants to be and is accepted on that level.[14] This technique can be of value to the patient, but in a state hospital setting it is not practical. As such hospitals are large and of necessity have a number of very stringent rules patients who create worlds of their own and live in them cannot be accepted on their own level and permitted to freely function on that level.

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[12] *Ibid.*, p. 11.

[13] *Ibid.*, p. 10.

[14] *Ibid.*, pp. 11-12.

It is not unusual for observers to question how these techniques are helpful. The explanation given is simple. The psychotic experiences of the patients are incapable of adequate expression in the world of reality and as a result they remain vague and confused without any anchorage. In Psychodrama these ideas are objectified by the establishment of an "imaginary reality" particularly tailored to meet their needs. The social and cultural atoms produced are satisfying to the patient and serve to channelize whatever delusions may be present.[15] The patient is at ease in this new world, and with proper usage spectacular results can be expected.

Movie technique is an important, specially constructed technique which deserves mention. During the early days of sessions a sixteen millimeter movie was produced. All of the patients included in the group were interested in the movie and most of them seemed to derive benefit. Patients who paid no attention to their personal appearance dressed with care, a very depressed patient cried almost constantly controlled her tears, a hebephrenic patient tried to control her laughter, and another patient who was very overactive developed an awareness of her actions by seeing herself in the movie. The patients asked to see the picture again and again and made comments regarding one another's condition as evidenced by the movie. This first movie proved such an excellent therapeutic tool that several other short movies have been made, each focused toward the needs of particular patients who in regular sessions did not seem to show improvement. This particular technique is far reaching in its effects, and it is felt that it should certainly be more widely used and its effects explored.

Observations Regarding Effects of Psychodrama

Even though it is not the purpose of this study to prove the therapeutic value of Psychodrama it is felt that the results which can be expected should be indicated. The Pontiac State Hospital findings regarding Psychodrama are in agreement with the results obtained not only by psychodramatists but by practitioners of the various forms of group therapy.

In Psychodrama there is an acting out of drives and there is less caution and greater abandon than there is in an individual situation. Within a short time patients may expose their hidden feelings about themselves and repressed hostilities toward family, teachers, hospital personnel and others in their environment. The emotional ties in this group relationship may be strong, and through them the patients are encouraged and enabled

[15] *Ibid.*, pp. 3-5.

to experience feelings and attitudes which previously they had feared to reveal. They may also find value in their common need for help and in the fact that they have mental illness in common. "The discovery of similar feelings and attitudes in other patients serves to lessen each patient's sense of isolation. It enables them to share their sense of guilt—the largely unconcious guilt arising from the intensified but forbidden instinctual drive underlying their symptoms."[16]

Psychodrama may give the psychotic patient an opportunity to share his private world with others and to find his way back into normal social relationships. It helps him understand the hospital, and through it very disturbed patients are gradually raised to the group level, and symptoms of anxiety may be reduced. Teen age patients diagnosed primary behavior disorder receive help which it would have been difficult for them to receive on an individual basis. The group permits human contacts without the need for deep emotional relationships and provides a setting wherein frustrating experiences can be relived in a satifying and positive atmosphere.

Sessions also provide ample opportunity for interpretations of underlying problems, the development of emotional awareness and insight, an exploration of reality and a strengthening of the ego. It provides a unique learning experience and is usable by those who find verbal communication difficult. As much of the material imparted to patients during sessions finds its way back to the wards, the results may be far reaching.

From a statistical angle the results obtained are of limited value, but for the sake of completeness they should be noted. For tabulation purposes the patients were divided into the following three categories—no change, partially adjusted and adjusted. The group headed "no change" includes those patients who have remained actively psychotic, no change having been noticed in the psychosis and those who have continued to come into conflict with their environment and to be lacking in social and economic adaptability. This group also contains three patients who have markedly improved, but who for the purpose of this study are classed in this category as improvement does not seem to have been even partially effected by Psychodrama. The group headed "partially adjusted" includes the patients who have improved and are now able to fit into the hospital setting with comfort, or are able to fit into a Family Care home or their own home without too much strain and without being an overwhelming

[16] Freud, Sigmund, *Group Psychology and the Analysis of the Ego,* (London, England: Hogarth Press, 1940) p. 65.

burden on others. In most instances initiative is lacking and adaptability is possible but with effort. The patients included in the adjusted group are all gainfully employed if male, or if female, are gainfully employed or are able to care for their homes and families in an adequate fashion. They show no particular evidence of previous illness and are responsible members of society.

This tabulation shows that sixty-five per cent of the patients included in the study are adjusted, whereas twenty-two per cent are partially adjusted, and thirteen per cent are unchanged. A determination regarding the present condition of the patient was made by studying case records, interviewing hospital staff members and talking with members of the patients' families.

It is of particular interest to note that out of a total group of forty-four schizophrenics only three remained unchanged and thirty-four are listed as adjusted. Since the majority of these patients were severely schizophrenic, having had severe traumatic experiences in early life, they had not had adequate opportunity to test reality. It is felt that Psychodrama helped by giving these individuals an opportunity to test reality in a permissive and accepting atmosphere. These individuals apparently did not have a sufficient backlog of self-assurance to permit their facing trauma and as a result broke with reality and took refuge in narcissistic withdrawal. In view of this an effort was made to help them develop self-awareness. Because of the nature of the illness they also may have need to try people out over and over again, and in Psychodrama they can do this not only with the therapist but with a group of people, a society in miniature. They can learn how a number of people react to them, not just a single individual.

Psychodrama is certainly feasible and applicable in a state hospital setting. It is particularly valuable to the large group of schizophrenic patients who react slowly to individual therapy, and it is also valuable to other types of mentally ill patients. Psychodrama has a place in the treatment program of a mental hospital, warrants continued study and should be widely used.

A Case of Paranoid Schizophrenia Treated Psychodramatically

It was June 30, 1948 that the first Psychodrama session was held at the Pontiac State Hospital. The first words spoken at the opening session were:

"I am Mrs. Rosenbaum, the wife of a doctor. I go to Recreational Therapy, and I should not be in a hospital."

In themselves these words are not particularly meaningful but when they are fully understood and coupled with what the patient would say today, we realize that they are dramatic, and that they were spoken by an acutely ill individual. They were spoken by a thirty year old woman, diagnosed paranoid schizophrenia who had been mentally ill for five years and who had a fixed delusional pattern. Her name is not Rosenbaum; this was a part of her delusional make-up, and today she answers to her correct name. She has attended Psychodrama since the first session, has been a regular participant and has in many respects markedly improved. Excerpts from a few of the sessions will indicate the developments which can be expected with such patients and show how a few of the techniques referred to in the previous chapter are put to use.

After working with this patient for a short time, it became evident that the functioning level was severely impaired by the psychosis but that there was no impairment of abstract thinking. Intellectually this patient remained intact, but in areas involving her emotions she was very sick and was unable to use her intellect to aid her in solving her conflicts. She was a very fearful and insecure person who had, over a period of years, projected her conflicts onto the soma, but prior to hospitalization had reached a stage where these somatic complaints no longer adequately met her needs. As a result it was necessary for her to take refuge in psychosis. The underlying conflict probably was strong latent homosexuality.

Individual therapy was attempted but was not successful. The psychiatrists had regular interviews with the patient for a period of several months as did the psychiatric case worker, but the patient did not improve. She incorporated the therapists in her fixed delusional system and became more and more difficult to handle. During this period she started to wash obsessively and began to complain that people were "Psychologically" having sexual relations with her and were trying to take her sex powers from her. She also developed delusions regarding her children and doubted her maternity. It was at this time that she was referred for psychodramatic treatment. At the time that Psychodrama started, individual therapy ceased. Attendance at Recreational and Occupational Therapy had been regular and continued so.

It was felt that Psychodrama might help Mrs. G. Her psychotic experiences were incapable of adequate expression in the world of reality, and as a result they remained for her vague and confused subjectivity without any anchorage. In Psychodrama it was hoped that her psychotic ideas would be objectified by the establishment of an "imaginary reality". She

was to be accepted as Mrs. Rosenbaum and an auxiliary ego was to portray the role of her imagined doctor-husband. On the stage the auxiliary egos assisted her to realize the roles in which she envisioned herself and which she had not been able to see actualized. The narcissistic element in the ego of the patient caused her to welcome a situation wherein she could realize herself to an extent far exceeding the bounds of the reality principle. During sessions she was given ample opportunity to project her psychosis as it radiated from her ego in the form of fixed delusions.

The patient actively participated in each session and seemed to enjoy taking part in other people's scenes as well as enjoying being in scenes of her own. She indicated that members of the group understood her and that this was not true of anyone else. The Projection Technique was routinely used with Mrs. G. She particularly enjoyed scenes where she would be talking with her husband about his patients, scenes where she as the wife of a prominent physician would be called upon to be on committees and scenes where she and her husband would be discussing the care of their children. She was very insistent that the actor taking the part of her husband act in a manner becoming to a doctor and a gentleman and became extremely angry whenever this actor fell out of character.

Throughout this time Mrs. G. was responsible for developing the psychodramatic process, and she remained the center of treatment. Her scenes were complete plots, having definite characters, and they continued from week to week with remarkable continuity. The patients making up the group quickly sensed that the patient should be called by her delusional name and completely accepted Mrs. G.'s "imaginary reality." By this means it was possible for Mrs. G. to see her psychotic experiences objectified. Her reality world was so unreal that she needed an imaginary world to serve as an anchor and prevent her being permanently reduced to a level of false signals and symbols. She was given this on the psychodramatic stage where she felt comfortable, and the result was a channelizing of the delusions and the prevention of further deterioration.

After a time Mrs. G. explained that she was having to go under an assumed name as her husband wanted to avoid publicity and asked for permission to go on the stage and explain to a friend why she felt this way.

Friend: (Auxiliary Ego)—If he loves you, he would not mind the publicity if you only get well.

Mrs. G.: (Patient)—Not ordinary publicity. I wouldn't want my name spread all over. When I was on Hall A, I talked to my sisters and they understood my point of view. I want you to be truthful.

I wouldn't say anything about my name if I only knew the reason why I was not called by it.

Friend: (Auxiliary Ego)—Does your husband come to see you?

Mrs. G.: (Patient)—No, but I believe I know the reason, he must have a good reason. Why should a patient be interested in my name? If a patient made a statement that her husband was a certain person, I would either believe her or believe that she was out of her mind and she did not know what she was talking about. I am legally married to Doctor Rosenbaum by proxy or something. G. is not a part of my life. My name isn't G. It makes sense that I should be called Rosenbaum. However, if there is some reason why I am not and a psychiatrist explained it, I think I am intelligent enough to understand it.

During scenes such as this the patient freely verbalized her feelings regarding her name and also managed to manipulate the scenes so as to explain why her husband permitted her to have such difficulties. Her presentations were so real that it was easy to feel with her. These scenes also clearly showed that her libidinal connection with Mr. G. had been completely withdrawn. She at times presented him as dead and at other times as never having existed. Such delusions are considered by Doctor Otto Fenichel and others as evidence that the libidinal connection with the person has been withdrawn.[17]

Home scenes with Mrs. G.'s psychodramatic husband continued even though scenes concerning her name were being enacted, and when it seemed as though her ego was stronger some of the unpleasant things which might develop for the wife of a physican were gradually inserted. At first these angered the patient, but after a period of time she made an effort to handle them. After a period of six months, Mrs. G. expressed doubt regarding her marriage to a doctor and said she might at one time have been married to the man who is her husband. This ambivalency regarding her identity continued, and it was decided that the Double Ego Technique or some variation of it might at this time be valuable.

Mrs. G.: (Patient)—My days are good with an understanding doctor for a husband.

Husband: (Auxiliary Ego)—You did not give me a hug.

Double Ego 2: (Auxiliary Ego)—Never can please a man.

Double Ego 1: (Auxiliary Ego)—Why in heck does he kiss me. He is so dirty, I hate this.

Mrs. G.: (Patient)—A doctor can't be dirty. Someone was; I feel confused.

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[17] Fenichel, Otto, *The Psychoanalytic Theory of Neurosis,* (New York: W. W. Norton and Company, 1945), p. 417.

Double Ego 2: (Auxiliary Ego)—Sometimes he is darned nice, sometimes so awful. It used to be he was always awful. I hated him.

Later in the same scene the patient said:

Mrs. G.: (Patient)—I am not Mrs. G. Who are you? (Patient became angry, started to slap husband.)

Double Ego 1: (Auxiliary Ego)—How did he talk me into this? Being Mrs. G. is hell.

Double Ego 2: (Auxiliary Ego)—He promised to love me for ever and ever. I promised too, but I can't love him.

Mrs. G.: (Patient)—I don't seem to remember.

Double Ego 2: (Auxiliary Ego)—I don't want to remember.

Mrs. G.: (Patient)—I am so confused about my husband. Do you want more coffee?

Husband: (Auxiliary Ego)—Yes, you make such good coffee.

In these scenes the patient expressed one set of ideas, and the double egos tried to express some of the ideas the patient had pushed out of consciousness because of the discomfort they caused her. By so doing, the ideas which the patient ordinarily expressed and also the ideas which were bothering the patient but were ordinarily unexpressed, were permitted objectification. In this way scenes were enacted concerning religion, the patient's feelings about her husband and her relationship with him, her attitude toward her children and her hospitalization. The patient finally reached the place where she was able to say that she once knew her husband, and asked how she could have two husbands and not have had a divorce. She also expressed concern over why she was in a hospital and asked to have court scenes portrayed.

In the court scenes the auxiliary egos taking the part of the husband and the lawyer were other patients. The lawyer, a very paranoid patient, wanted to represent Mrs. G. as he felt she should not be held in the hospital. The husband was chosen by Mrs. G. as she felt he looked like a doctor. These scenes were therapeutic to all three patients—ego building for the husband and a help toward the development of insight for both Mrs. G. and the lawyer.

Following the above described scenes the patient appeared very worried and agitated and said she had something to say to the director that she did not want the entire group to hear.

Mrs. G.: (Patient)—I once knew a Mr. G. Could I be married to him and not know it?

Director:—I doubt it, Mrs. G.

Mrs. G.: (Patient)—Something is wrong with the world and with

me. I feel so empty; life is empty and has no meaning. How can I go on?

During the sessions the patient freely expressed her ideas, her feelings and her emotions. She explained her feelings in terms such as empty and meaningless. After a time she developed a little insight into her identity, but was not yet strong enough to cope with this, and without her delusional husband she felt abandoned, felt that life was empty and had no meaning. She just was not ready as yet to go on without her delusions, and her words empty, meaningless and abandoned reflected the withdrawal of her libido from the object.

The following scene serves to explain the patient's feelings toward her husband:

Admission Clerk: (Auxiliary Ego)—I talked with your husband and he said your name was G.

Mrs. G.: (Patient)—You mean the infection I had at one time. What would be a psychological term for a psychological infection in the disguise of a male or female. A person doesn't learn to hate an infection. After getting over it there is the relief from the infection and it is like relief from the infection of syphilis. Would you make a statement that you hated it?

Admission Clerk: (Auxiliary Ego)—I might be that kind of a person.

Mrs. G.: (Patient)—A psychological infection is very similar to a real infection or a physical infection.

Admission Clerk: (Auxiliary Ego)—I really don't know too much about these things; I am just the admission clerk. What is it you wanted to know?

Mrs. G.: (Patient)—I want to know why the name of the infection is on all my clothes instead of my own name.

Admission Clerk: (Auxiliary Ego)—The only thing I know is that your husband's name is Mr. G.

Mrs. G.: (Patient)—I would rather not discuss the infection.

Following the scene the patient referred to her husband as an infection, and when other patients pointed out that Mr. G. was her husband even though she did not like him, she asked to leave the session (first such request) and said she felt very ill. She further explained that she must see a psychiatrist or she would die as the infection was so severe.

The following week Mrs. G. refused to act with a man and this continued for five sessions. She also seemed nervous and did not seem to want to be in scenes. She spent most of her time asking questions about her husband, always referring to him as an infection. She also complained

about not being able to sleep, about severe pain in her back and asked over and over again "How can I go on facing life?"

At this time the patient's delusions regarding her name seemed to be breaking down but were at the same time constantly being reinforced by occurrences on the ward. If it had been possible to use the Auxiliary World Technique, it is felt that this patient would have improved much more rapidly. With Psychodrama sessions only once each week the patient was not able to sustain progress. She, however, continued to be ambivalent regarding her name and to bring her difficulties to sessions. It was also noticed that she was less able to defend herself when discussing her name.

At this point it was decided that each scene should be approached from a different angle. A number of patients, several of whom were quite delusional, were very anxious to help Mrs. G. and started making suggestions. One suggestion was that Mrs. G. be asked to visit another patient and that the patient express a similar problem to her own. Such a scene was portrayed and Mrs. G. was asked to take the patient's children to visit him as he refused to see his wife, denying her identity, but was anxious about his children. Mrs. G. completed her role easily and well and in so doing made a couple of comments which expressed her true feelings particularly well.

> Mrs. G.: (Patient)—Yes, I took the children to visit, and it seems that if he could only talk to someone who believes in him and not continually harp at him that he didn't know what he was talking about, it would be good for him. It was as if he were starved for someone to talk to who would not antagonize him all the time. It was just as if he were thirsty.
>
> Friend: (Auxiliary Ego)—Don't you think they gave him a chance to talk?
>
> Mrs. G.: (Patient)—Yes, but if you were thirsty for a drink of water and they gave you pickle juice, how would you feel? He recognized me but said he was not married to me. He certainly isn't crazy; he isn't insane. Maybe he will eventually reveal to you what is wrong; he is an intelligent man.

Another scene wherein the patient was faced with the same problem went something as follows:

> Friend: (Auxiliary Ego)—For the children's sake I think he should be snapped out of it.
>
> Mrs. G.: (Patient)—Maybe snapping him out of it is wrong. Maybe he has some inner idea that does it, and it should not be tampered with.
>
> Sister: (Auxiliary Ego)—Tom was saying that he might be ill because I have been neglectful.

Mrs. G.: (Patient)—You would not be the kind to do that. I doubt if any man would lose interest in his wife because of that. Maybe he has some inner ideal that he wants that you don't have. Well, maybe there is nothing in you that could satisfy him. Maybe he has been starved psychologically.

Friend: (Auxiliary Ego)—Do you think it would help if she got out of the old house dress and got a permanent?

Mrs. G.: (Patient)—I doubt if dolling up for him would really make any difference. Maybe it is some type of longing that no woman could fulfill. To put it psychologically he has been starved for a certain type of conversation; maybe it is like a hunger in him he has never realized. If you would find out what that inner hunger was, and if you could fulfill it,—. Sick people crave for something.

Throughout these scenes she was very kind and understanding with the patient and became belligerent when others took his problem lightly. As these scenes progressed she continued to express her innermost thoughts, and it was soon evident that she realized the similarity between her problems and the problem being presented on the stage. She was on a number of occasions heard to say: "I wish I could help him; his problem is so like my own." Within a short time after making this statement she was begging the group for help for herself, and on one occasion she asked that she be permitted to have a scene wherein she would be interviewed by a psychiatrist.

Mrs. G.: (Patient)—I need some sort of psychological help.

Psychiatrist: (Auxiliary Ego)—Is there anything pressing on you at the moment?

Mrs. G.: (Patient)—I just don't seem to be happy. I know I have my hobbies, and I am a mother, but I don't seem to be happy. That man makes me feel physically sick.

Psychiatrist: (Auxiliary Ego)—When did this start?

Mrs. G.: (Patient)—Months ago.

Psychiatrist: (Auxiliary Ego)—Did anything specific happen?

Mrs. G.: (Patient)—No, my husband is honest and he would tell me.

Psychiatrist: (Auxiliary Ego)—Did this happen rather suddenly?

Mrs. G.: (Patient)—Well, I can't blame it on him. It isn't entirely his fault. I seem to have lost all interest, and I can't stop being jumpy. He just is not what I expected.

Psychiatrist: (Auxiliary Ego)—Do you think the problem lies within yourself or do you think it is within your husband?

Mrs. G.: (Patient)—I just don't know, but I am miserable when I am with him.

Following this scene the Projection Technique was again used. As the

patient expressed increased dissatisfaction with being the wife of a physician scenes wherein divorce or separation seemed to be the only solution were also inaugurated. The patients in the audience were given an opportunity to discuss these scenes, and a variety of opinions regarding divorce and separation were brought out.

This was followed by a series of scenes enacted by staff members wherein a young woman worked with two men at one time, one on each side of her on the stage. The one man was educated, a gentleman, the delusional husband of the patient. The other man had the characteristics of the patient's real husband; uncouth, unkind, unable to hold a job and disinterested in his home. The scenes moved very rapidly, involved all three individuals and showed the wife's feelings of ambivalency, her desires to have a professional man as her husband and her developing psychosis as the problem became more than she could handle. On one occasion the patient said, "I have the feeling something like that happened to me."

Mrs. G. interrupted one of these scenes, suggested a divorce as a possible solution and asked to see scenes showing the actual procedure for obtaining a divorce. The week following the portrayal of the divorce scene the patient motioned to the director and asked that she come close to her. The patient then said to the director:

> "I now realize that I am not Mrs. Rosenbaum. I don't like being Mrs. G. and want to get a divorce as soon as possible. You may call me by my real name from now on, and will you please arrange for me to get out of the hospital as soon as possible so I can get my divorce."

Five days later a letter was received from the patient's sister stating that a letter had just been received from the patient which showed marked improvement. The letter said that the patient seemed more clear than she had at any time during the period of her hospitalization and that she now knew her real name. For the first time in over two years the patient had signed a letter using her real rather than her delusional name.

Eighteen months were spent in helping this patient accept her real name, and two years have elapsed since the date when she admitted her true identity. She is still aware of her true identity, has not developed additional delusional patterns, and at this time an effort is being made to help her come to grips with reality concerning some of her other delusions. Throughout the course of treatment constant emphasis has been placed on having the patient feel accepted, understood and liked by the group.

This patient has from the first swiftly and smoothly moved from one

role to another. Each of her roles have a certain duration and logically lead into other roles. Techniques vary from time to time, and the director always has in mind making use of the technique which will at the time best serve the needs of the patient. Constant care is maintained that new delusional material not be developed. This is the factor which made individual therapy difficult, but it is possible to handle it in Psychodrama with a minimum of difficulty as relationships exist on an interpersonal and on a role-to-role level.

Treatment was hampered and movement slowed by the infrequency of sessions. It should also be borne in mind that only a small proportion of the time allowed for each session could be spent on this particular patient as the other patients in the group had problems just as pressing as those of Mrs. G. However, in spite of these factors movement continued. This case situation shows that the stage is a setting wherein the psychotic individual can gradually have reality interjected into his delusional system. While working on the stage, the patient is also able to manipulate scenes and gradually gain some measure of control over his problems. It is at all times important that the psychodramatic situation be flexible and move with the patient. It is at times necessary to change scenes at a moment's notice, and at all times the techniques being used and the roles being portrayed must be such as to meet the needs of the patient.

THE DEFINITION OF SOME PROBLEM AREAS FOR RESEARCH: A THEORETICAL FORMULATION OF SOME PROBLEMS OF RELEVANCE TO DIAGNOSTICS*

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The problems of diagnosis which psychotherapists face are not unique to their discipline. The essential expectations associated with the diagnostician are that from an available set of information: (1) *he must infer what the situation is;* and (2) *he must generalize* (i.e., reduce to a meaningful set of variables) *the forces operating to define the situation.* When these expectations are fulfilled, the outcome of the situation may be evaluated in terms of (a) the inducement of certain changes in the situation, or, (b) no inducement of changes in the situation (i.e., allowing events to run their normal course without his intervention). The evaluation of the outcome of the situation is not necessarily associated with diagnosis, but in conception at least, is the logical extension of the process implicit in the two stated expectations. This evaluation cannot ordinarily be made with understanding unless both expectations are fulfilled adequately. (Some exceptions exist, such as the discovery of a "cure-all" which supersedes the development of a set of specific treatments to a sub-classified set of conditions.)

The task of the psychotherapist includes meeting the first two expectations associated with the diagnostician, and then, on the basis of the evaluation of the likely outcome of a given situation, if certain changes are induced by him, *he must induce those changes.* This inducing of changes is ordinarily identified as the *therapeutic procedure.* The psychotherapist might equally well be able to evaluate the outcome of a given situation when no therapeutic procedure was introduced. Other disciplines parallel the task of the psychotherapist in their own ways, and within their own limi-

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tations. One of the immediately obvious limitations that may occur in a discipline is that the inducement of changes is not possible. The meteorologist, for example, can do little to induce changes in the weather at this time. The astronomer has even less possibility of manipulating changes in his subject matter. The sociologist has other types of limitations imposed, moral and legal, which prevent various types of inducing of change. This in no way precludes the existence of a *scientific* discipline, nor the evaluation of outcomes of a situation. It does, however, often exclude the parallelism to the therapeutic procedure of the psychotherapist in these cases. The parallelism is quite exact in other cases, however, such as that of improperly operating machine which is brought to the attention of the engineer.

What distinguishes the various disciplines is largely a matter of experience (although some like to think of the physical sciences as less complex), and the efficiency with which a "clinician" in a given field operates is to some extent directly a function of how long investigators have been at work in the field. A point of most obvious importance is that in the more highly developed disciplines there is but little difficulty in deciding what the relevant information is in any given case; the social and psychological scientists, and the medical men, are mere fledglings in this respect, since it is often as difficult to determine what data are relevant as to analyze them. One characteristic of the fledgling status is that it is often much easier to produce a "sensitive" person than tests which will allow a relatively insensitive person to do the same work. The usual explanation for this is that the person can be exposed to a wealth of materials and thus become "sensitive" to certain characteristic patterns, which may involve a multitude of variables, while the test usually deals with a few variables only. In more developed sciences such sensitivity is of little point. The variables are well defined, their specification precise, and the tests for them can be administered by any trained person. The undesirable aspect of the training of the social scientist to be "sensitive" is that it cannot be considered in any way dependable. Some persons, or many persons, exposed to the materials, will not become "sensitive," and there is no objective way (probably more correctly, applicable way) for screening these persons. Our objective, thus, for diagnostics in psychotherapy, as well as in any other field, is in the objectifying of the techniques utilized. In practical terms, this boils down to examining constantly the relevance of the information which is available, and obversely, specifying the relationships involved, so that tests may be applied with increasing reliability by greater and greater proportions of persons exposed to training.

At this point we shall begin to focus on the *psychotherapist as diagnostician,* but it will be obvious to many that the frame of reference we choose is for practical purposes identical to that ordinarily defined for social psychology. It should be noted that the variables of psychotherapy *are* in any case restricted to a given society—to a relatively homogeneous set of values which determine the objects of the therapy. Such a restriction does not normally apply to other sciences.

Psychotherapy is concerned principally with the gathering of information about a single person, and in this article we want to emphasize a particular kind of information, that gathered from the person himself. Before entering the detailed analysis of this particular kind of information, it seems advisable briefly to show a general schema of information which can be obtained about the person. This is presented as Figure 1.

The information about the person which is available to the diagnostician may be characterized as being of at least four types.

(1) The diagnostician has training and experience which leads him to expect certain relationships either overtly or "intuitively". Selective attention to information is in part determined by the societal values system of the therapist.

(2) Information directly obtained from the patient.

Information about the person which is available to the Diagnostician

Physical and physiological observation—lead to a purely medical diagnosis. Observation of behavior	Overt contextual behavior . . . what the person does.	Verbal content of the behavior . . . past, present, and future references.

(3) Information obtained from other persons.

Overt contextual behavior . . . what the other persons do which may be relevant to the person.	Verbal reports of the behavior of the person . . . past and present references.

(4) Information obtained from written reports.

Medical history.	Ordinary written behavioral records, such as school reports, test reports, etc.	Observational and reconstructed records from institutions, and from sources (2) and (3) as soon as the person becomes of diagnostic interest.

FIGURE 1. Schema of sources of information which are available to the psychotherapist as diagnostician.

(1) *Information which the diagnostician brings to the situation through his own training and experience.* The diagnostician has been exposed to a wide variety of case materials and generalizations in his field. By virtue of this, given a certain amount of information, the diagnostician may (on a rough probability basis) predict certain concomitants. This, for example, is usually done quite effectively in the area of "background factors." Often the diagnostician operates at a more generalized level, with hunches and clues, responding to stimuli at a subliminal level. In addition the therapist is a member of a society in the light of whose values expectations concerning the situation and its outcomes are made. This is often not assessed by the therapist as a variable.

(2) *Information obtained from the person directly.* At one level, this information will consist of observations of the person as a biological organism: (a) his physical characteristics and (b) his physiological state. This is the information which becomes the current entry in the medical history. Such information is of particular importance to the psychotherapist as a diagnostician in at least three ways: first, location of physical or physiological disorders may supplant preliminary erroneous diagnoses of mental disorder; second, location of physical or physiological disorders may give clues to types of mental disturbances to be expected as concomitants, either as bases predisposing mental disturbances or as resultants of the mental conditions; third, and equally important, if no physical or physiological disorders are uncovered, the diagnostician may have some confidence that he has *properly* delineated the area of investigation as the "mental" sphere.

At a second level, this information will consist of observations on the behavior of the person. Two important foci of attention may be distinguished here. First, the diagnostician may pay attention to *what the person does.* In this, the diagnostician may observe *how* he answers questions rather than the content of what he says. The diagnostician may be able to observe *how the person behaves* in any number of loci, including his own office, the person's home, place of work, or ward. Behaviors relative to different situations and to other classes of persons are of importance here, and the emphasis of observation is on the profile of interaction which the person displays, and *how he responds* to a range of situations. Second, the diagnostician may pay attention to the content of the verbalizations of the person. This content may be the person's interpretation of past events, his "life story," his interpretation of the present situation, or his aspirations and expectations for the future. The emphasis of attention to content which the diagnostician may give will vary greatly, depending on his training. Classi-

cal Freudians, for example, have a rather complete and well defined frame of reference to guide their observation of the content of the person's verbalizations. Both these foci, the "how" and the "what" of behavior, will be a part of the diagnosis which is made, but the emphasis and admissability of data will effectively lead to different diagnoses. On the one hand, approaches which emphasize what the person does, such as Moreno's or the Adlerian, and the diagnosis may be the description of the current behavior of the person and what his problems in interaction are. On the other hand, the classical Freudian approach may lead to a diagnosis initially, but this may rest largely on the interpretation of symbols. Since different diagnoses are possible merely on the basis of orientation, one of the areas of research which should receive immediate attention is the interrelationship of the overt contextual behavior of the person and the content of his verbalization. We shall elaborate on this.

(3) *Information obtained from other persons.* The information gathered from other persons may again be logically split into two classes. On the one hand, the diagnostician may be interested in the other persons themselves, as an important part of the milieu of the person. He may assess the social situation directly on the basis of observations of the persons involved. On the other hand, and this is more commonly the case, the diagnostician will be interested in the verbal reports about the behavior of the person. These will include the report of contacts and anecdotes involving the person, as well as general appraisals of his behavior. To some extent, this secondary source of information is the easiest to tap, and much of the case history of the person is written from such materials. However, there is nothing inherent in information of this kind to make it more reliable than that of the person himself; that is, it must be evaluated in precisely the same manner as data gathered directly.

(4) *Information from written reports.* This information will ordinarily consist of: (a) a medical history which can be gathered from the relevant files, and (b) an accumulation of records of education, tests, etc., to which most persons are exposed. Further, the written records will include any institutional reports which may have been accumulated, such as social worker reports, police records, periodic reports from the records of mental institutions, and so on. Finally, the written records will include the multitude of data which are gathered from the secondary sources (other persons or the person's recollections or reconstructions) as soon as the person becomes of diagnostic interest, as well as tests and observations currently obtained.

This written material is almost always of widely varying reliability, since it is essentially a historical record equivalent to the current data, but lacking the immediate possibility of checks or of the therapist's own observation. In one sense written records have to be accepted in the diagnostic-therapeutic situation with even greater care than is used for primary source data.

Our presentation of the sources of information which are available to the diagnostician has been brief, and the purpose of presentation is to indicate our interest here in the proper context. We now turn back to the central point of development, to the information which is obtained from the person directly, in particular to the observation of his behavior.

To begin with, let us identify *what a person does* at any given time as an *action,* and since we will focus on this action, let us call it the *focus action.*[1] Secondly, the data with which we are interested are the actions of the person, i.e., *what he does.* The person is of diagnostic interest only if he has been brought to the attention of the psychotherapist, and this he can do himself, or others, as members of the family or society at large, may do it for him. The actions of the person which are of interest in terms of prediction and manipulation are those which are manifest, that is, observable. The psychotherapist is, of course, particularly interested in the fact that a person feels, for example, "depression." However, the therapy will necessarily be oriented toward the production of *socially acceptable* patterns of behavior in the person, rather than to the relief of "depressions." If the relief of depressions is accomplished, so much the better. The focus of relieving the depressions becomes primary only when it is determined that this is the most efficient method of producing socially acceptable patterns of behavior in the person. Our attention, thus, will focus at all points on *action,* and we shall elaborate this as a general problem area of research.

Given a focus action, for a given individual, we may postulate relationship of other actions to it in particular ways.

Consider the focus action as a future event. Further, consider the conditions of the focus action "well identified", that is, having high reality content in terms of probable occurrence (e.g., an appointment, an election, etc.). If we wish to predict this event, there are a number of reasonable things which we can do, the most direct of which is to ask the subject what he will do. We expect to predict what he will do from what he says he will

[1] This concept was discussed in: Edgar F. Borgatta, "An Analysis of Three Levels of Response," *Sociometry,* December, 1951.

do with a reasonable degree of certainty because *we expect,* in terms of the value system: that the subject is not a liar; that the subject knows what he will do; and that he answers our intended question. That this expectation is not unwarranted, even on a gross level, is demonstrated by the ordinary efficacy of the public opinion polls on such matters as elections, and on the individual level is characteristic of all interaction between persons. Error is expected, but there is an expectation that the error will be within certain reasonable limits. The sources of error are not discussed here. Note only that we may define the situation as one of the subject, in given actions which refer to a focus action, predicting the focus action, and that the accuracy of his prediction may be viewed as some function of the accuracy of his perception of the conditions under which the focus action occurs and the accuracy of his perception of what he will do under the conditions. In some ways, this is the simplest type of relationship in the generalized problem area. Schematically, let us identify relationships of this type, which we will call *type a,* as follows:

Event prior to focus action — Ego predicts what he will do in focus action.	• • • •	Focus action: the future event, conditions well identified.

type a

It is immediately obvious that one extension of the problem area is in reversing the temporal sequence: that is, in making the focus action the past event and allowing the subject to "predict" what he has done. Let us call these relationships *type b.* It is evident that *type a* and *type b* have elements in common: the first is the specificity of identification of the conditions of the focus action; the second is the directness of prediction which is requested of the subject, that is: "What will you do?" "What did you do?"

Focus action: the past event, conditions well (completely) identified.	• • • •	Event after the focus action — Ego predicts (states) what he did in the focus action.

type b

It should be noted that *type b* is the common question of fact which occurs in most surveys, and in the gathering of background information under myriad circumstances. This is the "factual" question. (Conditions are completely identified in the sense that the focus action *is* the concrete situation.) Not only are persons collecting case histories interested in the accuracy of the *type b* prediction, but an organization such as the Bureau

of the Census is constantly plagued with the estimation of accuracy in reporting of questions of fact.

For the sake of simplicity we will deal only with the temporal organization indicated in *type a* and allow all cases with the *type b* temporal organization to exist by inference. We do this only for one reason, namely, that the testing of empirical hypotheses is ordinarily a forward procedure in time. Thus, test of past action prediction is difficult. This area of investigation is vast, however, and especially pertinent in terms of diagnosis which depends on the identification of crisis situations, of particular relationships between persons, of particular experiences, etc. The *type a* case we have identified is relatively simple and straight forward, and represents one class of behavioral situations which are common. The direct question asks for a prediction, and the attitudes of the subject are inferred on the basis of the response. Note that we have at the same time the prediction of the focus action itself. For research purposes at least, and most often out of necessity, we may wish to examine the attitude and then infer the focus action from the attitude. We may do this in a number of ways, an exhaustive list of which is not presented here. We may detach the subject from the direct prediction by asking: "What should be done under the conditions well identified?" "What should you do under the conditions well identified?" From the responses we may infer the attitude of the subject, and from the inferred attitudes we may predict what he will do. We are no longer asking the subject for a prediction of his own behavior and accepting this prediction with a degree of confidence *as a prediction.* We expect a relationship to exist between the reference to the focus action in the prior event and the focus action. However, we are more modest in predicting the focus action since we recognize the greater amount of indirection involved. Let us call these relationships *type c* and identify them schematically as follows:

Event prior to focus action: Ego responds with an ethical or normative evaluation concerning the focus action.	•	Focus action: the future event, conditions well identified.

type c

It is evident that in the inference made we assume projection on the part of the subject. It follows that a logical extension of the problem area in this direction would be the elimination of the requirement of the refer-

ence to the focus action in the prior event, in which case we would be dealing with the prediction of the focus action on some "deductive", and presumably projective, basis. In this case, however, we would need to be careful not to deduce the relationship in a vacuum. A relationship *without* face validity should be established first, and then this could be used for predictive purposes. However, the predictability of the focus action *could not* then be used to explain the focus action or the prior event. This is a fallacy which some applications of projective techniques have frequently involved. Let us call these relationships *type d.*

Event prior to focus action — Ego's action need not be manifestly related to the focus action.	• • • • •	The focus action: the future event, conditions well identified.

type d

Returning to our original *type a,* it is seen that another avenue of extension of the problem area is in redefining the conditions of the focus action. Let us make the focus action a future event, conditions *not* well identified. Let us make the focus action a future event in which the element of reality is at least partially removed and ambiguous for the subject. With this contingency placed on the future event, the subject must make certain assumptions before he can make a prediction. The statement of the question is twofold: "Assume that such and such is the case. What would you do?" The conditions postulated for the future event are either uncrystallized or are contrary to fact for the subject. Let us call these relationships *type e* and represent them as follows:

Event prior to the focus action — Ego predicts what he would do in the focus action.	• • • •	Focus action: the future event, conditions *not* well identified.

type e

When the reality factor and the crystallization of the conditions are high, *type e* converges with *type a.* Additional types are obvious, but the identification thus far has brought us to a particular point for this presentation. In attitude testing the conditions of the focus action to which a question refers are often either uncrystallized or contrary to fact for the subject. This, in many ways, is a necessary characteristic of investigations which attempt to predict behavior in a social structure context, where the behavior predicted is identifiable only at a point of choice or decision, that

is: "Given the circumstances, what does he do?" Presumably the expected behavior is not self-evident nor universal. Since the circumstances do not exist nor are they immediately impending for the subject in the questions asked the factor of reality or of crystallization of conditions is by definition absent.

Given an interest in relationships of *type e* the researcher or diagnostician finds additional limitations placed on his access to the focus action. Since the reality factor is low, to identify the conditions which are relevant for the future event becomes difficult. On the one hand, if the detail of the conditions is spelled out the danger of creating an idiosyncratic situation is present. Further, the specificity of the details makes the situation less real for the subject. (This may be viewed as the obverse of the idiosyncracy statement). On the other hand, if detail of the conditions is not spelled out the danger of dealing with superficialities is present. An almost "natural" solution to the limitation is to reformulate the problem, that is, deal with a *class* of conditions under which future events will occur. Under the redefinition, we are interested not in what the subject does under a given set of conditions, but what a subject *generally* does under given sets of conditions (classed). We are interested in classes of behaviors (actions) under sets of conditions. Taking this tack there may be some degree of confidence that there is more reality (meaning?) in the questions asked of the subject. Our access, however, is still only in the question. We wish to know what the relationship of the actions referring to the future events (as a class) is to the focus actions. We have, however, developed an important point. Essentially, we are asking the subject questions from which we will make inferences about *generalized attitudes. It is not a difficult transition from this to the assessment of personality characteristics of the individual.*

The simple logical approach to the information sought is to set up the conditions in which the questions (representing a class of future events, conditions not well identified) are presented to the subject, and then, *create* conditions of the relevant class. The last five words are ones that identify the difficult task. Some attempts have been made in this line, but there is a noticeable void in the data. The problem of defining future events, conditions not well identified, in experimental situations in a sense leads us to observing present events, conditions well identified. *But,* the social interaction we observe is not a sample of decisions or choices of the definitive and specific type of the attitude questions; rather it is some approximation to "ordinary" types of behavioral situations. While pressures and artificiali-

ties may be introduced in the experimental situation, the crises implied by ". . . Assume that . . ." are not immediately present.

One of the problems which is immediately evident is that the types of predictions we wish to make imply the *classification of actions and references to these into the same set of categories.* Essentially, we are interested in finding if one set of our observations is *directly* (in the face validity sense) representative of another set. For the moment at least, we are not interested in the fact that liking for the poetry of the Indian writers is associated with owning prize winning dogs, should this be the case. We would be interested in the fact that expressed liking for reading the poetry of the Indian writers is associated with the reading of their poetry. Similarly, in terms of personality characteristics, we would be interested, for example, in examining the relationship of the characteristics as assessed in one set of situations and another. Given the two sets of situations, one indicator we have that we are measuring the same characteristics is by using *equivalent categories.* This, essentially, completes our identification of the problem area.

Implications.

In the first part of this presentation we dealt with the general sources of information available to (or created by) the psychotherapist as diagnostician and it is apparent that this point of reference is close to that of the social psychologist. In the second section we have been concerned with the development of one particular source of information—the observation of the behavior of the person—as a general problem area. Of course, recognition that this is a problem area appears in phenomena like observer bias, both in selection and perception, reliability of recording and other common sources of error on which we have offered no comment here, but it is a problem area in a much wider sense. It exists in the direct and indirect identification of what the person does. For any observer, no matter what his training and opportunities for observation, access to all the determinants of action and all the actions of the person is strictly limited, so that he must depend on other sources of information which will help in inference of the action. The validity of the predictions from these sources to action is the real problem area. Investigation of special problems in the area must be made systematically and diligently, with careful definition of the situation, not haphazardly and intuitively, for even the most direct type of prediction from report to action is suspect of gross inaccuracy. Far too often all types of prediction of action from report are regarded as being equally

reliable and valid, even if lip service is given to the need for discrimination. In a sense, therefore, investigaton of this problem area will be concerned with *current and future action* as much as with verbal behavior in the past or present and this action may either be "real" or constructed in the laboratory. Quantification is essential if the objectives discussed earlier in this paper are to be realized, if there is to be an increasing probability of accurate prediction based upon fewer and more precisely defined set of variables and if the same predictions are to be made by all trained people and not merely by the sensitive few.

Quantification demands controlled observation since only by controlled observation may verifiable data be obtained and tested. To work with the reverse time sequence is almost impossible, leading too often to *post hoc* hypotheses and worse, to finding in the data only those things relevant to a particular theory. In this sense, analysis of case histories, though often essential is a scientifically questionable procedure unless used to generate hypotheses about future or present action which can be tested by the more rigorous methods suggested here. Particular actions or relationships may be discerned in most case histories, but quantification and generalization is not as easily established. To try to relate reported crisis situations of the person, particularly those concerning relationships, to the manifest actions in the present is a completely ambitious task, complicated still further by the difficulty of determining the social situation in which the past behavior took place. On the other hand, defining the problem area as essentially one of a forward time sequence reveals enormous gaps in our research methods and the data we have about prediction.[1]

It may be argued that much of what we have had to say is self-evident and that much of the research in this area has been concerned with the establishment of what appear to be self-evident truths. Experience is that this is not the case: many of the basic assumptions made about the prediction of future behavior from present verbal statements have been shown to be false. There is great need for research in this area, but to ignore it because of this is to reject the possibility of quantification and precise prediction in the psychotherapeutic sphere.

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[1] The senior author is particularly interested in research focused on *type d*, and an investigation of this is at present being made.

THE "BEHIND YOUR BACK" TECHNIQUE IN GROUP PSYCHOTHERAPY AND PSYCHODRAMA

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Chicago

"O wad some Pow'r the giftie gie us
To see oursels as ithrs see us."
—BURNS

Perhaps the most important need in group psychotherapy at the present period of its growth is understanding of the mechanics of its effectiveness; theoretical comprehension to enable us to instruct others in the use of this expanding method of treatment. Coupled to every article dealing with techniques, cases or uses in group psychotherapy, there should be an explanation for the reasons of the results. Only with understanding can true progress occur.

The present paper deals with a simple but powerful technique of group therapy, a description of its use, examples of cases treated by this method, and an attempt at a theoretical explanation for its effectiveness.

BACKGROUND

It is the writer's bias that group psychotherapy should be natural in its form. That is to say, any particular method should mirror the world of reality, and should draw on natural forces. It must flow; it cannot be forced, or be artificial or unreal. The classic example is Psychodrama which reproduces real life in the round; dynamical in action; spontaneous. We observe, for example, children instinctively use Psychodrama in their make-believe games.

But the most common arrangement of group therapy, the lecture-discussion, is not natural. This arrangement occurs in schools, not in real life. It has general value for the economical imparting of knowledge, not for release of feeling. In this technique it is easy to discuss cases but not a single case; problems but not a single problem, groups but not an individual. In short, group therapy using this method tends to be more educational than therapeutic; it strikes on the surface; it does not penetrate deeply.*

But which is the natural way for a group of people to discuss the unique

* R. J. Corsini, Education and Therapy. *J. Correct. Educ.* 1952, 4, 24-26.

individual? It is, of course, the gossip group, wherein a number of people talk "behind a person's back". The ubiquity of the gossip group at the sewing circle, the locker room, the club car, the water cooler, is well known. The eternal tendency of people to "cut each other up", to spread gossip, indicates that this form of behavior has deep roots. It does not take a perceptive mind to realize that the opinions most of us have about ourselves are quite different from the opinions that others have. It often seems that certain people whose pomposity, stupidity, inadequacy, meanness, stinginess, cruelty and so forth are so obvious must be truly blind not to be able to see themselves as they really are. It is undeniably true that if all of us could know what others really think of us that most of us would be profoundly shocked.

Now, if we could arrange a gossip group to discuss an individual, and permit the individual to overhear the group, we would be attempting to use a natural means of human interaction for therapeutic purposes. But how can we get spontaneity and honesty if the subject is present? To have a subject eavesdrop is unthinkable. To have the subject right there in the group, and have people speak right up to his face is unnatural and unrealistic. We are schooled, trained and conditioned to be kind, tactful and polite to others. We are generally so sensitive to be unable to accept any criticism to our faces with good grace. Attempts to discuss a person critically when the subject is present are rarely successful for these reasons.

Our task then is to remove the subject from the arena of discussion and yet to have him there. This paradox is resolvable by letting him stay in the room physically but taking him out psychologically.** This can be done by having the subject turn his back to the group, or by hiding him behind a screen. That this simple device works can be proven to anybody's satisfaction whenever a group of three or more people meet, if with the consent of all, one member turns his back so that he cannot be seen while the others talk about him "behind his back".

The Method

A subject is permitted to volunteer in advance. The therapist asks the subject to discuss any problem that he may have. The subject speaks for ten to thirty minutes, either prompted or not by the therapist and other subjects. Questions may be asked. Following this phase, the therapist says,

** This technique appears like a variety of the "Mirror-technique" frequently used in psychodramatic therapy (Ed. J. L. M.).

ritualistically, "Mr. X, we wish to discuss your problems frankly, fearlessly and truthfully. We cannot permit you to remain in the room while we discuss you because your presence would inhibit us. We must ask you to leave the room." The subject assents, then the therapist continues, "But it will only be necessary for you to go out of the room psychologically, not physically. You must turn your back to the group, and you'll be out of the room." After the subject does so, the therapist goes in front of the subject and says, "Now, you are no longer in the room. You can have no knowledge of what is said."

The therapist rejoins the circle and says, "Mr. X is no longer with us. We can talk frankly about him. We must strike at the heart of his problem. I now want each and every one of you to make one short statement about Mr. X and his problem. Just one sentence—anything—but let us hurry up. We don't have much time. The more personal your remark, the better. You, start, please."

Each of the subjects makes one statement. No one is exempted. If anyone should balk, the therapist forces him to make a remark by statements of this type:

"You *must* say something. This is for X's benefit. If you want to help him, say something—anything."

"It is absolutely necessary for you to speak about X. You are just as smart as anyone else here and your opinions are just as valuable. If you should not speak, why should anyone else? It isn't fair!"

And finally, "I demand that you speak! If you do not, I will immediately disband this group. You have a solemn obligation to say something. I don't care how foolish it is—anything, please!"

As can be seen, the therapist is very active, and must work quickly and incisively to create and maintain a mood. All these props help to create the illusion that Mr. X is no longer in the room. After the short, round-robin statements, a discussion starts which lasts typically twenty to thirty minutes and ends once more with a round-robin final statement from each member. The therapist now says, "Let's call in Mr. X." And, he goes to Mr. X and ceremoniously asks him to return to the group and informs him there has been some discussion about him and would he like to participate in further discussion? Or, the session may end at this point, at least for the subject, and he may be sent out of the room for the rest of the session to meditate by himself on the comments made about him. If he stays, further discussion is held, which generally tends to be quite lively.

CASES

Philip was the only Negro member of our therapy group at the state prison at Wisconsin. He was tall, slim, and quite light. He was a very cold, distant and proper sort of person. An individual of very superior intelligence, he gave the impression of being very sensitive. During the period he had been in our group he was located in the so-called "Idle Company" which was composed of inmates who would not work. When it came his turn to come on the stage, Philip told a story somewhat as follows:

"I am now in the Idle Company. I don't like it there. I could get out. All I would have to do is tell the old man that I want to get out. But I don't want to do it. It is solely a matter of principle. This is my story. I was working in the school. Somebody thought I did something wrong. I was tried by the deputy and was found guilty. I was not guilty. They were wrong. I was punished. All that was all right. But then my old job in the prison school was taken away. I didn't think that was right. Double jeopardy, that's what it was. So I said, if I didn't get my old job back, I wouldn't work anywhere else. As I say, it's all a matter of principle, nothing else. And so, three months have gone by. I don't care how long I am in Idle Company, I'll never change my mind, I'll never ask to get out."

Philip was asked to "go out of the room" and once "out" we began our discussion. Sample comments:

"He reminds me of what they call in the South—a smart nigger."

"He is more concerned that the other Negroes think well of him than anything else."

"He probably thinks the old man is treating him bad because he's colored."

"He figures that if he stands up to the old man, the other colored guys will think he has nerve."

"Philip gives me the impression he's always daring white guys to call him names."

"I think Philip hates the whites, and he can't take no abuse. A white man would accept this, but not him. Everything is prejudice with him."

"Philip is really scared. He doesn't like to stay in Idle Company but his false pride won't let him back down."

Following these comments, a lively discussion followed, mostly on the theme that what was the matter with Philip was that he carried a prejudice chip on his shoulder. The fact that he was very light in color received con-

siderable attention. In short, the discussion was very frank, and at an oblique direction from that which Philip tried to go.

When Philip was called "into" the room, further discussion, still at a very polite level, was maintained. In a very emphatic manner, Philip denied extra sensitivity about his color. He insisted the sole issue was one of principle, not anything else. It was natural, he told us in his most reasonable manner for us to be misled. Of course, most Negroes were very sensitive about their inferior status; of course he, too, was concerned about prejudice. But in this case color had nothing to do with the issue. It was simply a matter of principle.

Two days later Philip asked the Associate Warden to go to work, and the prison official stated that this change of attitude was the most remarkable turnabout that he had ever seen. He informed the writer he had talked to Philip weekly for several months but had found him adamant and not susceptible to reason.

The following session, Philip stated that "after the discussion I could see I was sort of silly, so I asked to go to work."

He further stated, "I heard some things during the therapy that I never thought I would allow anybody to say and get away with them".

This case is given for several reasons: first, it is a rather uncomplicated case which showed immediate good results in terms of institutional adjustment; secondly, it points out the very personal type of remark that the group would probably not make if he were "present", and perhaps even if he were truly out of the group, but which is freely made when it is made "behind his back."

We shall present a second case to illustrate a most unusual reaction.

Lorenzo was the subject on the fourth session that he had attended. This group met at San Quentin. He "went out" of the room, and the members attacked him in a very vicious manner. No one had a good word to say for him, including the therapist who stated that he had not liked Lorenzo's appearance, did not like his attitude and believed that Lorenzo was insincere.

After a very lively session wherein we talked behind Lorenzo's back, he was called "back into the room". Lorenzo stood up and faced us and said something like this: "Well, I have heard what you people think of me—now let me tell you what I think of you!"

He then proceeded, in the most abusive and vulgar manner to dress down the group, the method, the individuals in the group and the therapist. He ended up by telling us all what we could do with the method, and he

went out with a vow never to return. It looked as though all therapeutic contact was severed and that this would be the last we would hear of Lorenzo. This was not so. Nor was it so that the session had been wasted. It had a surprisingly strong therapeutic effect.

About two months after this incident of "talking behind Lorenzo's back" I received a request for an interview which I honored after keeping him waiting several weeks. The change in his appearance and in his manner was remarkable. Formerly he had been fat, arrogant, and loud. He now had lost weight, seemed humble and unsure and talked in a low voice. His remarkable story went to the effect that after he had left the group he had attempted to laugh off the opinions he had been forced to listen to. But he was unable to shake off the memory of that session. He found himself continuously preoccupied by why these people had attacked him so. He noticed that he really didn't have friends. He began to wonder, finally, if there was something wrong in his attitude and in his behavior. The more he tried to throw off these introspections, the more he found himself enmeshed in them. The one thing that puzzled him most was why we had spoken so ill of him, why we were all united against him when he knew we were not his enemies. He couldn't really get mad at us because we bore him no personal ill-will. Maybe there was something wrong with him; could I help him straighten himself out?

I need not go into the details of what happened from then on, since all I am interested in at this point is to point out how an apparently unsuccessful session had been really tremendously effective. Enough to say that Lorenzo did not receive further formal psychotherapy, but was merely asked to test himself by taking a menial job as a ward attendant, taking care of deteriorated older patients. This individual became one of the most devoted attendants and showed a very strong desire to be of service. In short, the change in his attitude and behavior was so very marked and appeared to have been caused entirely by the one session of group psychotherapy cited, to constitute another sample of "Immediate Therapy".*

Theoretical Discussion

In our preliminary remarks we have indicated our philosophical bias that effective group therapy is natural in its form. We have argued that the circle, which forms the structure of the gossip group is superior to any other arrangement. We have also argued that it is possible to resolve the paradox

* R. J. Corsini. Immediate Therapy. Group Psychotherapy, 1952, 4, 43-46.

of having a person in and out of the room simultaneously by having him behind a screen, or with his back turned to the rest of the group.

We wish now to give some further reasons for the usefulness and the effectiveness of this method, which we believe can be used to advantage from time to time.

Man is a rational animal only on the surface. Underneath he is a complex of strong emotions. These emotions are generally held in check by the individual's higher center, but a reciprocal relation exists. Rationality is affected by emotions just as emotions are affected by reason. For this reason people cannot stand criticism. The criticism which is accepted sometimes in good spirit on the surface often wounds the subject's *amour propre* and causes a strong negative emotional reaction towards the criticizer. To get along with people we must never criticize them. The stronger the personality, the less criticism it gets. And yet criticism is the most important brake of social relations. Without it, society could not exist. The individual who needs criticism and does not get it suffers ostracism. He begins to operate in a more and more select circle of people like himself who can accept him. He and his clique, whenever they discuss those out of the group, criticize them, but the criticism does not reach them.

Also, people who do not like others tend to avoid them, if they can, rather than criticize them. Criticism is done mostly in the spirit of hurt love rather than hatred, but it arouses feelings of deep anger. The slogan, "Not even your best friend will tell you" exactly expresses the fundamental idea.

But, criticism is rampant! We all do it and it is universal. But over 99 per cent of such criticism is behind a person's back where it does him no good. Why it is done in such a manner has just been stated: we can neither give nor accept criticism without getting hurt, without hating our criticizer. So we criticize in secret.

In literature, the dramatic effect of overhearing criticism has been cited many times. We need think only of "Hamlet", "The School for Scandal", "Cyrano de Bergerac" and "Claudia" for examples. The individual who overhears conversation about himself of a highly critical nature suffers a terrible blow, more terrible because he cannot reveal his knowledge nor show its effect.

But the basic essence of the reason for the value of this method was expressed by Lorenzo, in the case cited above. He found himself unable to hate the people who had made those unpleasant remarks. He was emo-

tionally upset but there was no one he could vent his anger on. He could not laugh off the criticism, because he knew it was true. He could not hate us who had said these things because he could not see us and he knew we were not his enemies. He was forced to listen. We injected something into his system which he had to absorb. So long as it was a foreign matter it caused irritation. As soon as he accepted it, he became a changed person.

In other words, as far as the subject is concerned, because he does not see his critics, they are impersonal. After a while, on the basis of introspection we have received, these criticisms appear to be self-generated. They are more or less accepted by the individual as being his own. They are no longer felt to have come from the group nor from the individual.

From the point of view of the subjects who are able to easily criticize an individual who is still physically in the room, the answer is that simple conditioning is the answer. If we cannot see a man's face, he is not in our phenomenological field. An element of suggestion probably occurs through the therapist's manipulation and his statements. But the fact is that people in this situation discuss an individual with unbelievable frankness to his back when they cannot do so to his face.

SUMMARY

The "Behind your Back" technique calls for a circle of people who meet for formal group psychotherapy. One subject discusses himself and his problems, and he may or may not be questioned. He then "goes out of the room" psychologically but not physically by retreating behind a screen, or by simply turning his back to the group. Each of the members of the group is forced by the therapist to make a comment about the "absent" member, and a discussion develops. Unusual frankness of criticism often results. The subject may be sent out of the room or may "come back in" for further discussion.

Two cases of its use are cited and a theoretical explanation for its effectiveness is given.

THE DEVELOPMENT OF A PSYCHODRAMA DEPARTMENT IN A MENTAL HOSPITAL*

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This report seeks to describe briefly how a new Psychodrama Department was established at the Mental Health Institute of Independence, Iowa, (one of the four State mental hospitals).

The physical plant of the Hospital is, in general, adequate, and the grounds are lovely and open. The atmosphere is permissive and pleasant, and many of the 1400 patients have freedom of the grounds. Most restraints have been abolished, except the minimum for the patient's own safety. There is a "Screening Center" for voluntary patients who can sign themselves in and out for a few weeks at a time and for whom the Hospital may be a place of counsel, reorientation, psychotherapy and freely chosen psychiatric treatments. These patients usually go home on weekends and are of the type who might go to counselors, analysts, etc. on the outside if more of such were available in Iowa. They range from simple maladjustment to the more complicated psychoneurotic conditions, usually without psychosis. Some people come in for a "rest", calming their "nerves", "re-evaluating their life" and for a new sort of re-education in personal relationships. In these cases the Hospital may be acting as a *preventive medicine* focus.

Besides the standard medical treatments such as Electro-Convulsive-Therapy, sub-coma insulin and brain-surgery (trans-orbital lobotomy), the Independence Mental Health Institute uses varied types of *therapies*. It has Art Therapy, Music Therapy and Occupational Therapy departments. From ten to thirty employees are selected (by Dr. Witte) to practice "individual therapy." Such employees are required to have a College degree, or equivalent, and must have displayed a particular ability and interest in dealing with patients. Groups meet regularly (on at least half a dozen wards) for the purpose of simple group discussion, or in an attempt

* We are greatly indebted to Dr. Max E. Witte, Superintendent of the Mental Health Institute in Independence, Iowa, whose inspiring leadership since 1948 has transformed this Hospital into a modern and well known therapeutic center. We are grateful to Dr. Witte for his material assistance in making the Psychodrama Department a reality, and to Dr. J. L. Moreno for his counsel and suggestions. The senior author came to this Hospital in March, 1952, and this report covers the sixteen months following.

to perform a more intensive kind of group psychotherapy, according to the experience of the leader. The Psychology Department handles as many individual therapy cases as their regular testing program allows. Other individual therapy methods are also used whenever competent personnel are present.

The year before the senior author reached the Hospital, a brief experiment in "acting out" had been conducted by an untrained worker. Otherwise no serious psychodramatic treatment of patients had ever been undertaken in Iowa. In order to become acquainted with the Hospital, patients, employees, the senior author went on the wards with the group psychotherapists and participated in their work. It was observed at the time that groups (whether male or female) were particularly responsive when a man and a woman came together as therapist-figures in the group, especially on the closed male wards.

Beginning Psychodrama work on the wards, however, proved difficult. Response was gained when a couple of male patients were asked to assist on the corresponding female ward and vice versa. After a couple of months of experience on the wards, groups were established in an office (size, 17′ x 21′) and have been held there since. Patients reacted favorably to the office setting and were much more spontaneous than in the wards. Two simple light reflectors with red or blue cellophane slides have been used. Notes were taken each session and finally a tape recording machine was obtained which was of particular value.

In the meantime, another phase of work was opened in a classroom when a group of about a dozen employees (ministers in clinical training, attendants, etc.) met and an open class was established to study and apply psychodramatic methods. Sessions were held once a week at night, and were open to all. Attendance varied each time; some came steadily for weeks, others a few times. There were newcomers almost every time, as well as outside visitors. This led to the consideration of *training* methods and activities in the public relations field.

A Brief Summary of Activities in the Psychodrama Department

(1) Public Relations

Open Group Sessions, April through October, 1952: outside visitors, various employees, patients. Attendance began with twelve, grew to thirty to fifty at each session. Six to fourteen patients participated each time. Patients, in most cases, were from the voluntary screening center, or psychotics who had been put on the best of open wards as a result of their improvement and behavior.

This experiment proved of great value in bringing to the participants the experience of how a "democratic" group functions. Patients and employees met in a therapeutic environment largely as equals sharing problems and ideals, as "human beings" relatively unconcerned with classifications or status. Each could be a therapeutic agent for the other. This was the first time that employees and patients mixed and worked together in a therapy group, after regular working hours. It promoted much good feeling between therapists and patients, as roles were often reversed and each discovered the "human side" of the other. When the group did not supply its own material, the director would set up situations dealing particularly with re-education and training, or demonstrating psychodramatic techniques. Various "spontaneity" tests and "fantasy" methods proved satisfactory. The Open Group at night was resumed July, 1953, primarily as a Training Class. Only those patients who were interested in learning how to use psychodramatic techniqes in their own lives or professions were invited. This cut down patient attendance. During the first two months, the group averaged twenty to thirty, meeting once a week.

Lecture-demonstrations are often given in the Hospital for various visiting groups: clubs, professional groups (doctors, nurses, etc.), groups from Colleges, etc. Special arrangements are made through this department. When advisable, patients are invited to participate as "auxiliary egos" in such demonstrations; also, people from the audience are usually called upon to take part in action and discussion.

Many lecture-demonstrations have been given on the outside throughout the State of Iowa. Colleges, Universities, clubs, etc., organize meeting and usually participate actively in the Psychodrama demonstration. Rural Women's Day programs have shown particularly the women's willingness to learn. At these gatherings 300 to 400 have usually been present. During one year, this department gave thirteen large lecture-demonstrations on the outside and several lectures to small community groups.

(2) Individual Interviews (individual therapy)

At least eight to ten members of the regular groups receive individual therapy. A dual method of interview technique is employed, that of using both the dirtecor (a woman) and the assistant director (a man) for these private sessions, thus achieving a more complete field to which the patient may relate. Various psychodramatic interview and action techniques are employed depending upon the particular patient's needs. A wide range of possible relationships are introduced which are predicated upon the expressed or implied requirements of the patient.

The fact that two therapists are employed, a man and a woman trained in the same discipline, make possible a more objective operation. As the therapists can observe each other in action and as well in their mutual interactions, a higher standard of critical evaluation may be met. Thus by complementing each other, they can provide the patient to a much greater extent with the following:

a. a cathartic environment.
b. more available areas of interpersonal relationships.
c. goals for self-fulfillment.
d. techniques for achieving these goals.

(3) Individual Interviews (group therapy)

This is given daily in regard to joining groups and as a follow-up technique for any patient who becomes intensely involved in a group session and thus requires a private and cathartic recapitulation.

Correspondence and follow-up interviews with patients are kept up, as well as interviews and correspondence with relatives when the time allows.

(4) Marital Counseling (private)

Prior to their joining a group, we begin with interviews of either a husband or wife, or both. Both partners ars usually present at first, so that their personal interactions, behavior blocks, etc., may be better observed. Interviewers endeavor to produce as much as possible a natural mood of being "at home", and to induce the couple to act spontaneously and overcome the artificial behavior due to the Hospital environment. Separate interviews are held with husband and wife, and work with auxiliaries filling the role of the absent partner in order to obtain more information, to bring emotional release and to effect re-training. Group work is done with both partners present. If one partner is a patient at the hospital, the other may be asked to come once or twice a week; or both may come as Out-Patients. From five to ten couples at a time are usually undergoing Psychodrama work.

(5) Psychodrama Groups

This department is directly under the supervision of the Superintendent and most patients are referred to this department by him. However, patients on the open wards often come to investigate on their own, having heard about the work from fellow-patients. Being free to make such an independent choice, these patients frequently turn out to be the most amenable to psychodramatic treatment. Other doctors, therapists, etc. may rec-

ommend patients. Almost all patients undergo various kinds of treatments (Electro-Convulsive-Therapy, sub-coma insulin, etc.) while attending Psychodrama. They are interviewed, assigned to the most suitable group. Suitability is judged in terms of their responses after several trial visits to the groups and in terms of the director's knowledge of the needs of the group and the individual. Reports are kept of each session, and individual summaries typed for the Hospital records.

At present (August 1953) there are six group sessions a week, each session lasting about two hours. The *general therapy* group meets twice a week. Ten to twenty patients attend and the cases vary from simple maladjustment to psychosis of long duration. Relatives are at times permitted to come, if they can actively participate in the therapeutic process. Six to eight patients are carefully selected for specific, intensive work of mutual benefit and meet once a week in a *closed depth therapy* group. Twice a week, a group concentrates on problems of *marriage, home,* and *community*. Gradually there has developed a group on Saturday mornings (so working people can more easily come) and the marriage relationship is primarily explored. Discharged patients as well as Out-Patient couples attend. When possible, whole families come. For the discharged patient, this group serves as a follow-up therapy and helps greatly in observing how well they adapt back at home and at work and if they need additional attention to surmount new difficulties. For the unmarried members who attend, this group is used as a pre-marital counseling service.

Conclusions:

It is interesting to note that in Iowa there is, on the part of the general public, a growing readiness to come voluntarily to the Mental Health Institute. Relatives who come to visit a patient find that they can play a part at the Hospital in the therapy process which is thus made to deal with the family *situation as a whole*. Often the husbands or wives on the outside discover they need attention as much as the partner who is at the Hospital, and they begin to come regularly to some of the Psychodrama groups. Parents bring in their troublesome adolescent children and the children bring in their equally troublesome parents.

There are indications that mental Hospitals such as this one may eventually become *re-education centers* in their communities. Oriented around group psychotherapy and psychodrama, such centers could offer the widest range possible for the experiencing and understanding of interpersonal relations and group living.

AN INITIAL VENTURE IN THE USE OF TELEVISION AS A MEDIUM FOR PSYCHODRAMA

VERNA MINEAR, PH.D.

Public Health Service, Washington, D. C.

A Psychodrama session was televised for the first time on Station WTOP in Washington, D. C. on the 19th of April 1953. It was one of a series of thirteen programs produced by the Committee on Education of the Alcoholic Rehabilitation Program of the District of Columbia. Public Law 347, which established this Program on February 16, 1950 requires, among other things, that the organization, ". . . shall prepare and publish materials, data and information to be used in a program of public education . . . ." Psychodrama has been used effectively by the clinic as a technique of group psychotherapy since its establishment.

The apparent difficulty of reconciling the necessary spontaneity of Psychodrama to the rigid medium of television seemed insurmountable but it was decided to make the attempt. Many modifications and compromises had to be worked through by Mr. Robert Quinn, the Television Director and the writer as Psychodrama Director. The purpose of this paper is to present some of the problems involved and the measures taken to overcome them.

Original Program. There was no precedent for such a program, consequently it was necessary to proceed on a trial and error basis. The original plan called for the preparation of a script by the Psychology Department, to run for a period of fifteen minutes. The cast and Psychodrama direction were to be provided by the clinic. Mr. Robert Quinn, with the aid of the technical staff of WTOP were responsible for the mechanics of the production. It soon became apparent that while the general idea seemed completely feasible, some of the minor details were complicated in the extreme.

Difficulties Encountered. The requirements of Television broadcasting are, of necessity extremely rigid. The program must begin and end exactly at the scheduled time. Nothing may be said or done which might offend the most puritanical of listeners, nor can the station permit anything to be said or done which could possibly give rise to damage claims on the part of the participants in the production. Hence, the suggestion of trained actors for the star roles, the insistence on the use of approved scripts, repeated rehearsals, censorship, etc. Lighting, so that all participants would

be seen only in silhouette, that they might remain anonymous was a major problem which combined with the limited space, tended to restrict action to a minimum.

These requirements were in direct conflict with the demand of Psychodrama for complete emotional and physical spontaneity. Flexibility in timing and almost unrestricted space are vital in successful Psychodrama. Any attempt to follow a written script or re-enact a rehearsed scene would negate the purpose of the drama method. It is doubted that even the best of professional actors can simulate the deep emotions that the skilled director can draw from the participants in a well conducted Psychodrama session. Nevertheless, the use of a prepared script and rehearsals were mandatory.

Procedure. Several scripts were prepared before one was produced which was acceptable to all concerned. It was essential that this be rehearsed in the studio in order to familiarize the participants with studio technique, timing, lighting and the limited space for action. The "problem", however, was varied in the televised scenes so that the action and expression were quite spontaneous. The emotionalism was not feigned. The "oneness" of the group, the sympathetic interpretation of the problem and the "accepting" of the "star" were all completely sincere.

The employment of professional actors for the starring roles was considered. The station was fearful of possible damage suits from unpaid participants. This risk would be avoided by hiring professionals to play a part. This proposal was not acceptable inasmuch as it would tend to defeat the purpose, i.e., the demonstration of Psychodrama as a therapeutic technique as used in The Alcoholic Rehabilitation Clinic. It was feared that an unpracticed patient cast might get out of control. Nevertheless this course was finally agreed upon.

The Players. Much credit is due the group of patients from the clinic for their wholehearted cooperation and for the freedom with which they were able to participate, as a group and in starring roles. The director was familiar with the case histories, the basic dynamics and the capacity for expression of those selected as protaganist and auxiliary.

The Scenes Relived Were: Bess, a young widow in her thirties had maintained sobriety for some time through the help of AA and the Clinic. She is well on her way toward complete rehabilitation. She has a nine year old daughter, reared for most part by her maternal grandmother. Bess now feels she wants to be a mother and have some part in the life of the

child. The grandmother still regards her daughter as irresponsible and bad. Hostility between the two women is evident from the beginning of the first scene. Two scenes were relived. The first was current. Bess suggests taking her daughter to see "Peter Pan", the picture at a neighborhood theatre. Mother objects and a quarrel ensues with Bess losing to the mother but bitter, resentful and hysterical. The director then carried the action further back. Bess remembered an experience from her adolescence. She came in late from a dance. The scene was violent and hostile, ending in complete defeat and shame for Bess. Support in the form of sympathetic affection, understanding and interpretation was given Bess by the group and the director during the final discussion. The success of the experiment was due in great measure to the capacity for expression of the two patients playing the starring roles.

The entire production of thirteen programs was worked out by a committee on Education from the Clinic staff headed by Dr. Eleanor Short, aided by Robert Quinn, Director of the staff of WTOP television station and Truman Keesey acting as aid in Public Relations. Whatever success obtained by this or any of the other programs was in great measure due to the unceasing work and interest of this group. Dr. Leopold E. Wexberg and Dr. Anthony Zappala, Director and Assistant Director of the Alcoholic Rehabilitation program gave constructive criticism and encouragement. The presence of Dr. J. L. Moreno, Father of Psychodrama, meant very much to all concerned in giving singificance to the venture.

A film was made and will be made available through WTOP television station.

BOOK REVIEW

Who Shall Survive? J. L. Moreno. Beacon House, Inc., Beacon, N. Y., 1953, 889 pages.

Twenty years ago the relatively tranquil world of the Wissenshaften was disturbed by the appearance of a book with the curious title "Who Shall Survive?" These social scientists whose main occupation up to that time has been said to have been the re-writing of each other's books, must have felt that an individual who thought for himself would soon be forgotten and had best be ignored, for we find little evidence of interest, in the critical reviews of that period. That their judgment was wrong appears from the fact that as a direct result of this early volume, at least two new disciplines, Sociometry and Group Dynamics started, and more than one thousand articles, theses and books owe their subject, in part or *in toto* to "Who Shall Survive?"

The appearance of a new edition of this epochal book, enlarged to contain the mature thinkings of the author, must be accounted a publishing event. This is a book that no person in sociology, social psychology, anthropology or psychiatry can afford to do without, since it represents the mainspring of all current action research and practice in these fields.

The reader will be happy to learn that the fantastic style and irresponsible editing of the previous edition have disappeared and the present volume presents an eminently solid and respectable appearance.

This huge volume, like its writer, will become a controversial subject, in which readers, depending on their motivations, will find much to criticize or admire. Perhaps the most signficant factor that stands out is the author's spontaneity, in that he appears to speak out what he thinks in an unguarded manner. This is found almost only in Moreno's long fore-word (which he calls "preludes") which offers us, in the manner of a projective technique, rare insights into one of the world's most unusual men, a person secure in his ability, willing and able to meet his friends and enemies, completely uncontaminated by modesty, eager to live and to love and to fight, embued with an *élan vital* that makes modern man, stereotyped and fearful, appear like a pale copy of what man should be like. Whatever the author's purpose for the inclusion of this semi-autobiographical segment in this heavy and serious book, it serves several purposes: in the manner of Shakespeare's tragedies, it becomes a palatable appetizer for the main meal within; it gives the spirit and the mood of the volume; and prepares us for what is to come.

The contents proper consist of an introduction, which is concerned mainly with a clarification of basic concepts, historical aspects of sociometry, and semantic issues, giving the reader a preparation for the main chapters.

Books I and II are concerned with expositions of theoretical issues in Moreno's conceptions of sociology, and with the mechanisms of exploration into the jungle of society. We learn, perhaps with some surprise, that the writer is occupied with the most difficult of all possible human tasks, the analysis of dynamics of societies as a whole, and find that he has provided tools for the purpose.

Book III will be considered a classic in science in that we find a closely reasoned, intricate, complex and almost impossibly detailed analysis of the dynamics of a community. In books IV and V the author now faces into the future and begins the task of planning for small communities and large societies. In the final book, the writer gathers, in an amazing *tour de force,* the many, many lines he has cast out, welding his many ideas into a concrete system of thought, ending with a large number of hypotheses calculated to keep another generation of social scientists busy.

It is much easier in a review to criticize than to compliment, and while in "Who Shall Survive?" there is much that can be questioned or deprecated, in proportion to the total, this is relatively small. One point that Moreno has not sufficiently clarified is the relation of group psychotherapy to sociatry. Although the fact is that he introduced both of these terms and a hundred others, it is evident that the former term is currently accepted as meaning *small* group therapies in which individuals are the main focus, into which category Psychodrama fits, and that the latter term is the more appropriate in talking about the reconstruction and reorganization of social groupings. In terms of references to other writers, while Moreno presents the most complete bibliography so far published in the areas of group psychotherapy, societry and group dynamics, listing over 1400 titles, he refers to relatively few people in his volume, half of whom are mentioned in the preludes, and the rest of them, mentioned in the body of the book proper, are almost equally divided between contemporaries and non-contemporaries. The criticism is not that he left out what he should have put in, but rather that it would have been interesting to have, in addition to what he presented, a more complete evaluation of current trends in this field. Perhaps this will be a project for the future!

"Who Shall Survive?" is definitely not a volume for light reading: it needs to be studied carefully and requires at least a month of undivided

attention from the serious student, who must give as much as he will receive. It will take its place with the volumes of Darwin, Marx and Freud, to mention the three authors that Moreno himself refers to most frequently, as a book which handled sensitive human problems in a trenchant manner.

RAYMOND J. CORSINI
Chicago, Ill.

The American Society of Group Psychotherapy and Psychodrama

announces an

A W A R D

to be granted in the year 1953-1954 for the best paper dealing with research, theory, or experience in or pertinent to Group Psychotherapy and Psychodrama. The award shall be $150.00, and shall be made only if the committee of judges feels that a worthy report has been prepared during the year. The committee of judges shall consist of a psychiatrist, a psychologist, and a sociologist as follows:

JULES S. MASSERMAN
ROBERT W. WHITE
ERNEST W. BURGESS

Directions:

Papers should be submitted in form suitable for publication. They should be typed double spaced, and the *original* and *two copies* should be sent. Long monographs should be avoided, and such materials should be abstracted into article form. All papers must be original and *never before published.* Papers submitted for the award will be considered for publication in the official journal of the Society, GROUP PSYCHOTHERAPY. The award winning paper will in all cases be published in the official journal of the Society. Papers must be submitted before March 15, 1954, and the award winning paper, if any, will be announced at the annual meetings of the Society in May.

Papers should be submitted to:

Dr. Edgar F. Borgatta,
Laboratory of Social Relations,
Harvard University,
Cambridge, Massachusetts.

The *ANNUAL CONFERENCE* of the American Society of Group Psychotherapy and Psychodrama will be held in St. Louis, instead of Chicago as previously announced. Probable dates are May 2 and 3, 1954. Reason for this change is that when the earlier date was announced, definite plans had not yet been announced for the First International Congress of Group Psychotherapy (August 1954, Toronto), nor had the policy of workshops in group psychotherapy to be presented in conjunction with American Psychiatric Association meetings been proposed. The meetings as originally scheduled in Chicago would have represented the third major set of meetings on group psychotherapy during the summer.

The American Society of Group Psychotherapy and Psychodrama

The following were elected officers and directors (1953-54) of the MIDWEST SECTION of the American Society of Group Psychotherapy and Psychodrama:

William H. Lundin, *President*

J. W. Klapman, *Treasurer*

Margaret Goldman, *Secretary*

Directors:

Raymond Corsini

Rudolf Dreikurs

Theodore Franks

Esther Gilliland

J. W. Klapman

William H. Lundin

Walter Peterson

Adaline Starr

Herbert Weinstein

Announcements

MORENO INSTITUTE, NEW YORK CITY

IN-SERVICE TRAINING COURSE FOR TEACHERS OF THE NYC BOARD OF EDUCATION, FOR SALARY INCREMENT—A Fifteen-Week Training Course consisting of 14 1½-hour lecture periods and one examination period, entitled "SOCIOMETRY AND SOCIODRAMA IN EDUCATION" to be given by Dr. J. L. Moreno, every Friday, 5:00 to 6:30 p.m. Registrations: October 5th through 16th, from 3:00 to 6:00 p.m. Course Commences: October 16th.

Fee: for teachers only, $15.00; for non-teachers, $30.00.

OPEN COURSE—Every Friday evening, 8:45 to 11:00 p.m. at 101 Park Ave., New York City. A program of demonstration of psychodrama and sociodrama open to the general public.

Fee: $2.00 per session (reduced rates for groups)

Instructors: J. L. Moreno, Zerka T. Moreno, Gerhard Schauer, John Mann, Lewis Yablonsky

BEACON WORKSHOP PROGRAM
MORENO INSTITUTE

Thanksgiving ..... November 26-29, 1953
George Washington's Birthday ..... February 20-22, 1954
Easter ..... April 17-19, 1954
Memorial Day ..... May 29-31, 1954
Independence Day ..... July 3-5, 1954
Labor Day ..... September 4-6, 1954

An accelerated program offering clinical facilities and lecture demonstrations on a seminar basis. Students participate in clinical practice sessions and group discussions.

Each conference takes place at 259 Wolcott Ave., Beacon, New York and begins at 3:00 p.m. on the first day. Room and board are included in the fee.

$50.00 for three day work shop and $60.00 for four day work shop. Enrollments should be completed at least one week in advance of each conference.

BEACON RESIDENT TRAINING PROGRAM

An extended training program in the clinical application of sociodramatic and psychodramatic methods. Especially recommended for teachers, nurses, psychologists and group workers.

July 6, 1954—September 3, 1954

While not a part of the offerings of the Moreno Institute, the following course will be of interest to students. It is offered at the Graduate School of Arts and Sciences, New York University.

SOCIOLOGY 253—Role Playing, the Psychodrama and the Sociodrama—Offered at *New York University, Graduate School of Arts and Sciences, Washington Square, New York City.* Fall Term—Monday, 8:10 to 9:55 p.m. Deals with the theory and practice of Interpersonal Relations with special emphasis on the tecnhiques of the psychodrama and sociodrama.

Instructor: J. L. Moreno

ANNOUNCEMENTS

FIRST INTERNATIONAL CONGRESS ON GROUP PSYCHOTHERAPY, TORONTO, AUGUST, 1954
(SECOND CONGRESS, PARIS, 1957)

INTERNATIONAL COMMITTEE OF GROUP PSYCHOTHERAPY

101 PARK AVENUE -:- NEW YORK 17, N. Y.
ROOM 327

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JOSEPH I. MEIERS, M.D.
New York, N. Y.

The International Committee of Group Psychotherapy was initiated and formed by J. L. Moreno in the spring of 1951 and the First International Congress on Group Psychotherapy announced as an aim of the Committee in *Group Psychotherapy,* Vol. IV, p. 126, 1951 and *The American Journal of Psychiatry,* 1951, and other scientific journals.

All individuals and groups interested in group psychotherapy and desirous of participating in the Congress are invited to write to the above address. The membership of the sponsoring committee is to be enlarged so as to include representatives of all varieties of group psychotherapy without discrimination. The aim is to have a real, all embracing Congress, in order to serve the development and integration of the entire field.

All those interested in participating in the above programs are invited to send an abstract of their paper of fifty words to P.O. Box 311, Beacon, N. Y.

AMERICAN SOCIOMETRIC ASSOCIATION AND THE WORLD FEDERATION FOR MENTAL HEALTH

As a member society in the World Federation for Mental Health, the American Sociometric Association will participate in the Fifth International Congress on Mental Health, to be held at the University of Toronto, August 14-21, 1954. Members of the Association are invited to participate.

American Psychiatric Association Meeting, St. Louis, May 3-6, 1954, St. Louis, Mo.

A symposium "Scientific Foundations of Group Psychotherapy" as well as a "Round Table Conference on Psychodrama" will be held during the meeting.

National Society for the Study of Communication Meeting, Hotel Commodore, New York City, Monday, December 28, 1953

A program, "Towards a Theory of Communication, A Symposium", sponsored by Elwood Murray, will take place; Chairman: Seth Fessenden; Participants: Norbert Wiener, Allen Walker Read, J. L. Moreno and M. Kendig.

PSYCHODRAMA MONOGRAPHS

No. 2. Psychodramatic Treatment of Performance Neurosis—J. L. Moreno (List Price—$2.00)

No. 3. The Theatre of Spontaneity—J. L. Moreno (List Price—$5.00)

No. 4. Spontaneity Test and Spontaneity Training—J. L. Moreno (List Price—$2.00)

No. 5. Psychodramatic Shock Therapy—J. L. Moreno (List Price—$2.00)

No. 6. Mental Catharsis and the Psychodrama—J. L. Moreno (List Price—$2.00)

No. 7. Psychodramatic Treatment of Marriage Problems—J. L. Moreno (List Price—$2.00)

No. 8. Spontaneity Theory of Child Development—J. L. Moreno and Florence B. Moreno (List Price—$2.50)

No. 9. Reality Practice in Education—Alvin Zander, Ronald Lippitt and Charles E. Hendry (List Price $2.00)

No. 11. Psychodrama and Therapeutic Motion Pictures—J. L. Moreno (List Price—$2.00)

No. 12. Role Analysis and Audience Structure—Zerka Toeman (List Price—$1.75)

No. 13. A Case of Paranoia Treated Through Psychodrama—J. L. Moreno (List Price—$2.00)

No. 14. Psychodrama as Expressive and Projective Technique—John del Torto and Paul Cornyetz (List Price—$1.75)

No. 15. Psychodramatic Treatment of Psychoses—J. L. Moreno (List Price—$2.00)

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No. 21. The Future of Man's World—J. L. Moreno (List Price—$2.00)

No. 22. Psychodrama in the Home—Rosemary Lippitt (List Price—$2.00)

No. 23. Open Letter to Group Psychotherapists—J. L. Moreno (List Price—$2.00)

No. 24. Psychodrama Explores a Private World—Margherita A. MacDonald (List Price—$2.00)

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No. 26. Psychodrama in the Counseling of Industrial Personnel—Ernest Fantel (List Price—$1.50)

No. 27. Hypnodrama and Psychodrama—J. L. Moreno and James M. Enneis (List Price—$3.75)

SOCIOMETRY MONOGRAPHS

No. 2. Sociometry and the Cultural Order—J. L. Moreno (List Price—$1.75)

No. 3. Sociometric Masurements of Social Configurations—J. L. Moreno and Helen H. Jennings (List Price—$2.00)

No. 6. The Measurement of Sociometric Status, Structure and Development—Bronfenbrenner (List Price—$2.75)

No. 7. Sociometric Control Studies of Grouping and Regrouping—J. L. Moreno and Helen H. Jennings (List Price—$2.00)

No. 8. Diagnosis of Anti-Semitism—Gustav Ichheiser (List Price—$2.00)

No. 9. Popular and Unpopular Children, A Sociometric Study—Merl E. Bonney (List Price—$2.75)

No. 11. Personality and Sociometric Status—Mary L. Northway, Ester B. Frankel and Reva Potashin (List Price—$2.75)

No. 14. Sociometry and Leadership—Helen Jennings (List Price—$2.00)

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No. 16. Political and Occupational Cleavages in a Hanoverian Village, A Sociometric Study—Charles P. Loomis (List Price—$1.75)

No. 17. The Research Center for Group Dynamics—Kurt Lewin, with a professional biography and bibliography of Kurt Lewin's work by Ronald Lippitt (List Price—$2.00)

No. 18. Interaction Patterns in Changing Neighborhoods: New York and Pittsburgh —Paul Deutschberger (List Price—$2.00)

No. 19. Critique of Class as Related to Social Stratification—C. P. Loomis, J. A. Beegle, and T. W. Longmore (List Price—$2.00)

No. 20. Sociometry, 1937-1947: Theory and Methods—C. P. Loomis and Harold B. Pepinsky (List Price—$2.00)

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No. 22. Sociometry, Experimental Method and the Science of Society—J. L. Moreno (List Price—$6.00)

No. 23. History of the Sociometric Movement in Headlines—Zerka T. Moreno (List Price—$0.40)

No. 24. The Sociometric Approach to Social Casework—J. L. Moreno (List Price—single issue, $0.25; ten or more, $0.15)

No. 25. The Accuracy of Teachers' Judgments Concerning the Sociometric Status of Sixth-Grade Pupils—Norman E. Gronlund (List Price—$2.75)

No. 26. An Analysis of Three Levels of Response: An Approach to Some Relationships Among Dimensions of Personality—Edgar F. Borgatta (List Price—$2.75)

No. 27. Group Characteristics as Revealed in Sociometric Patterns and Personality Ratings—Thomas B. Lemann and Richard L. Solomon (List Price—$3.50)

No. 28. The Sociometric Stability of Personal Relations Among Retarded Children—Hugh Murray (List Price—$2.00)

No. 29. Who Shall Survive?, Foundations of Sociometry Group Psychotherapy and Sociodrama—J. L. Moreno (List Price—$12.50)