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THE SIGNIFICANCE OF THE THERAPEUTIC FORMAT AND THE PLACE OF ACTING OUT IN PSYCHOTHERAPY

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Moreno Sanitarium, Beacon N. Y.

Third Lecture

INTRODUCTION

I have described the development of therapeutic concept, from animal magnetism and suggestibility to transference and tele. Then I dealt with the inherent inability of the individual methods to treat interpersonal and group problems. Now I am going to explore the *formats* of the therapeutic situation,[1] in which it is said that analysis, treatment and cure take place. A therapeutic format consist of two parts, one the *vehicle*, as the "couch", the "chair", the "table" in the round, the "stage" of the therapeutic theatre, the open field, etc.; and two, the *instructions* as to how to behave in reference to the vehicle. Broadly speaking, there are two tendencies, to work within a specific format or to work without it—being indifferent to or even negating it.

I

Let us examine the *format* of the psychoanalytic situation first; not only because it continues to dominate the psychiatric scene, but because it should be easier to reach an understanding with other schools of psychotherapy once the status and the needs of psychoanalytic therapy have been made clear.

The format of Freudian psychoanalysis is distinguished by specific instructions and a conspicuous vehicle, the couch. The greater cohesion of the Freudian school was greatly facilitated by the common use of such a vehicle and by sticking to a prescribed behavior during treatment. But, the couch is not something which Freud had introduced as a vehicle of "choice". It is a prop which he had inherited from the hypnotists without accounting too much to himself for the reason, and unaware of the consequences involved in their function for the therapeutic effects. He probably thought that keeping the patient uninvolved, apart from any complicated interpersonal disturbances, as reclining on a couch, would make the process of analysis more objective and scientific. It was the

[1] Therapeutic formats are analogous to "rituals" in religion.

observer's bias. The model of the psychological laboratory of Fechner may have been on his mind, even more perhaps, Ernst Brücke's physiological laboratory. Freud's picture of the objective scientist was associated with being *outside* of the experimental situation, that is, *outside* of the patient. If one looks at the prescientific models of psychotherapy in the great religions, they made full and complete use of vehicles, as the Buddhist temples and the Christian churches show in an exemplary fashion. One may suspect that the comparative form and artlessness of our modern psychotherapies are a symptom of the decline in cohesion of the culture in which they developed. The counter-revolution came with psychodrama. The most conscious and emphatic use of "vehicle" in our time is the therapeutic theatre.

Hypothesis I: the very format of the psychoanalytic situation induces the development of transference and resistance neurosis, a) the physical conditioning, the couch and a doctor sitting behind, b) the unreal relation between therapist and patient; the patient shares the same room with a persistently non-interacting observer, c) the set relation of a superior versus a subordinate, d) the horizontal position on the couch, not being able to get up, is associated in the mind of the patient with sleep, dream and sex, with subordination, withdrawal from reality, and lovemaking. Instead of the customary saying that "the fact of transference . . . is the most irrefragable proof that the source of the propelling forces of neurosis lies in the sexual life,"[2] why not *reverse* it and say that the physical and psychological set up of psychoanalysis is so structured as to *invite* the patient to produce transference and to fall in love with the therapist. When this happens in the course of treatment, it may be because it was the unconscious intention of the method to reinforce its theory. "The patient remains under the influence of the analytic situation even though he is not directing his mental activities on to a particular subject. We shall be justified in assuming that nothing will occur to him that has not some reference to that situation".[3]

II

The cathartic method (1880-82) has been described as "making the (hypnotized) patient revert to the psychic state in which the symptom had appeared for the first time".[4] *The free association method of psy-*

[2] "History of Psychoanalytic Movement", Collected Papers, Vol. I, 1914, p. 293.
[3] S. Freud, "An Autobiographical Study", W. W. Norton, New York, 1935, p. 76.
[4] Sigmund Freud, *Collected Papers*, Vol. I, p. 274.

choanalysis (1895) went one step further and gave up hypnosis as well.[5] The "patients recline in a comfortable position on a couch while he (the doctor himself) is seated on a chair behind him outside their field of vision." ". . . Freud now found an entirely adequate substitute in the "associations" of the patients; that is, in the involuntary thoughts most frequently regarded as disturbing elements and therefore ordinarily pushed aside whenever they cross an intention of following a definite train of thought."[6] Psychoanalysis tried to overcome its first crisis by renouncing hypnosis and Freud gives some good logical argument for this change. Free association makes a more universal application of analysis possible and it is an easier skill to learn, but, close inspection of the history of psychoanalysis may show that the change was precipitated if not caused by a crisis which took place in the "personal" field, the relationship between Doctor Breuer, Frau Breuer and one of his patients, Miss Anna O., and between Doctor Breuer and Doctor Freud. It was *the acting out* of the patient towards Breuer, of Breuer towards the patient, of Breuer's wife towards Breuer, of Breuer towards Freud and finally, of Freud towards himself in a number of scenes which a psychodramatic session could have easily objectified; it was more than the usual transference in an office. It was "carried over" beyond the therapeutic situation into life itself, producing the vicious chain which involved the four persons. The patient lost her analyst (Breuer), Freud lost his friend and psychoanalysis lost its first leader. The only one who may have gained something from it was Frau Breuer: she gave birth to a baby.

Hypothesis II: the motive for the change from the hypnotic technique to the free association technique was its inferiority as a research method and Freud's dread of acting out.[7] He dreaded the implications of the sexual and homicidal acting out inherent in the situation. It is amusing to think that he who discovered the importance of sex in the development of the neuroses should be eventually halted by the fear of its consequences. It is evident that Freud felt that the hypnotic technique was unpleasant. The acting out of the patient during and after the session was more difficult to control and besides, he did not like himself in the role of an hypnotizing actor. "One of my most acquiescent patients, with whom hypnotism had enabled me to bring about the most marvelous results, and whom I was engaged in relieving of her suffering by tracing back her attacks of pain to

[5] Op. cit., pp. 275, Vol. I.

[6] Op. cit., p. 266, Vol. I.

[7] S. Freud, "An Autobiographical Study", p. 48.

their origins, as she woke up on one occasion, threw her arms around my neck. In order to exclude (such transference) or at all events to isolate it, it was necessary to abandon hypnotism." His ideal was analysis, purely and simply, not only for scientific but particularly for *personal* reasons. The format of the psychoanalytic situation as he aspired and devised it, suited his personality best. "I must, however, expressly state that this technique has proved to be the only method suited to my individuality. I do not venture to deny that a physician quite differently constituted might feel impelled to adopt a different attitude to his patients and to the task before him."[8] Indeed, it has proved to be the only method suited to his personality—the discoveries he made thanks to it attest to this—*but the question remains whether it was the best method for his patients.* It certainly conditioned him to becoming a persistent opponent of the spontaneous acting out and acting out techniques in all its forms. He was conscious of some of the aspects of this problem, as he disclosed in his paper on Transference Love many years later (1914), but of some of its aspects he was unconscious to the end. He was sufficiently moved by this crisis to regard it of such great importance that he blamed it for having "retarded the development of the psychoanalytic therapy for ten years."[9]

Hypothesis III: There are groups of therapists who are best suited for the analytic type of behavior; there are other therapists who are best suited for the histrionic type of behavior; a third category of therapists best suited for the entirely informal, unstructured type of behavior; finally, there is the flexible type, a fourth category, able to combine all the skills. It may be that the patients also tend to fall into similar groups, prone to one technique more than to another.

III

The next crisis, although comparatively minor compared with the above, occurred when Freud (1897) discovered that the early traumatic episodes related by patients in the course of analysis are not real but fantasy products. It did not discourage him sufficiently to give up the free association method itself. However, when the early traumatic situation as a focus began to be void of any degree of objective, tangible reality, he looked for another, more tangible and direct focus without giving up the earlier one. He gave up exclusive attention to the past *unwillingly* because

[8] *Collected Papers,* Vol. II, p. 323.

[9] See "Observations of Transference Love", *Collected Papers,* Vol. II, p. 378; see also "Passing of the Psychoanalytic Movement", *Who Shall Survive?* 1953, p. lv.

by moving towards the present, the transference dread became far more real and imminent.

Hypothesis IV: The dynamics of the *present* situation induce the therapist and patient to perceive each other more realistically; acting out becomes increasingly the logical method of communication. Tele tends to rise, transference to decline or turn neurotic.

IV

The next and yet unresolved crisis in the psychoanalytic movement took place between 1919 and 1923. It was accompanied perhaps precipitated by "the recurrence of a malignant disease; but surgical skill saved me in 1923 and I was able to continue my life and my work, though no longer in freedom from pain." "I have made no further decisive contributions to psychoanalysis: what I have written on the subject since then (1923) has been either unessential or would soon have been supplied by someone else."[10] Freud's worst fears had come to pass, he knew that it was a crisis but *this* time he did not find a way out, with the result that the psychoanalytic technique stopped growing, at least, the psychoanalytic technique which he has devised. The trouble came with "the transference syndrome"[11] which had two phases, the transference love of the patient and "transference dread" of the physician. Freud had cried out "The physician should be impenetrable to the patient and, like a mirror reflect nothing but what is shown to him".[12] But increasingly he found the psychoanalytic practitioner enmeshed in "transference love" which, once established, was difficult to remove from existence by working through an analysis. The question was, therefore, how to deal with this problem. Freud displayed all the theoretical insight his genius could muster but he was unhappy because he had no technique to overcome it and, as far as I can see from current psychoanalytic literature, this situation has remained unchanged.

It is more than mere coincidence that in these very years (1919-1923) some of the techniques emerged[13] which could have helped Freud to solve

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[10] Op. cit., p. 136-37.

[11] Because of the different emphasis which Freud has given to Transference Neuroses in contrast to Narcissistic neuroses, it may be less confusing when dealing with the psychoanalytic situation per se to call *this* variation Transference syndrome and differentiate its two aspects—Tranference Love and Tranference Dread.

[12] S. Freud, Collected Papers, 1912, Vol. II, p. 331.

[13] J. L. Moreno, "DieGottheit als Komodiant", Daimon, Vienna, 1919 and "Das Stegreiftheater", G. Kiepenheuer, publisher, Berlin, 1923.

the transference conflict but from a different quarter, the psychodrama of the therapeutic theatre. The psychodramatic method has a technique which might have furthered the cause of psychoanalysis, the *technique of the auxiliary ego or auxiliary therapist.* In the psychodramatic situation the chief therapist or analyst, if you wish, has associate therapists, so called auxiliary egos, on hand, who are permitted to enter into closer, more intimate relation with the patient. The immediate target of transference then switches from the therapist himself to the auxiliary egos. He is now far less involved in the potential interactions. The auxiliary therapists, moreover, are not just other analysts or observers like himself, but represent intimate roles and figures in the world of the patient, past and present. They are not artificially introduced, bystanders or onlookers interfering with the customary secrecy of therapeutic procedure—in *this* variation of the technique there is *no* group or audience present. The auxiliary egos are like assistants in a surgical operation, an integral function in helping the patient to present and solve his problem. They are, therefore, not only on the side of the chief therapist but even more on the side of the patient; the danger of transference "love" is towards him, to an extent, at least, milder or transformed because it is a part of psychodramatic technique to permit the feelings of love and hate *overtly* to be expressed by the protagonist as well as by the auxiliary therapists. As in scenes between husband and wife, father and son, etc., he is not only *not* fearfully frustrated in both, but encouraged to bring them out as would happen in a living context. The atmosphere of abstinence and of asceticism, of scientific and analytic objectivity from the side of the chief therapist as required by the psychoanalystic rule is still maintained because the chief therapist or analyst does not have to enter into the production itself except for certain indications. He just watches and evaluates material coming forth. The emotions between auxiliary egos and patients are not transference-produced, they approximate real love and real hate. They are accepted by the patients as natural parts of their world. These additional therapists are not only *not* intruders but dramatis personae of their private universe; once and for all they protect the analyst from the dilemma of too intensive transference involvement and give him a chance to be more truly the analyst, the observer and overall conductor. The psychoanalytic rule that "the situation of analysis involves a superior and a subordinate"[14] is replaced by the psychodramatic rule that every participant is superior or subordinate according to the role which he plays in the psychodramatic production. The status of the

[14] Op. cit., p. 337, Vol. II.

auxiliary ego depends, therefore, upon the role he is to portray. If he is to portray a quasi subordinate role in the life of the patient, for instance, a son or a daughter, then the patient, as the father, may have the status of superiority towards him; the auxiliary therapist gives the patient an opportunity to breathe more easily and not to be continuously aware of the chief therapist's authority as the last word and final arbiter. Since the introduction of auxiliary ego therapists by psychodrama, the idea of using "multiple therapists" has become widely accepted and been found effective in group as well as in individual methods. I have often wondered why none of the psychoanalytic revisionists have introduced auxiliary therapists into psychoanalysis. It would facilitate a rapprochement between psychoanalysis and psychodrama.

Hypothesis V: The interpolation of auxiliary therapists tends to decrease transference tension between chief therapist and patient and to increase the tele communications between them.

V

We have just heard of the difficulties which arise from the development of transference neurosis, but the difficulties which arise from what might be called "resistance neurosis" are no less serious; the patient often refuses to budge, wanders away from the theme or stops with his associations altogether.

All the forces which oppose the work of cure are called in psychoanalysis resistance. "Acting out" is considered by psychoanalysis as a form of resistance of the patient. But strategic moments for the use of acting out techniques occur frequently during the psychoanalytic situation itself; the patient may lie on the couch and free associate about his wife. He may desire to get up and openly accuse her of being unfaithful to him, or it may be on his mind to start a fight with his father because of the way he treats his mother. By taking advantage of the aggressive feelings to which the patient is warmed up at the moment, a negative and resistant patient may be turned into a productive and clarifying agent. Acting out outbursts, such as unsuccessful suicide attempts or overnight decisions to run away from father without the consent and knowledge of the analyst are then brought to the analytic situation post festum, so to speak. They may come to his attention too late, at times after the harm is done. It is advisable, therefore, to differentiate between *controllable forms of acting out* taking place within the framework of the therapeutic situation which have a constructive aim, and *uncontrollable, irrational acting out* outside

of it. By making acting out techniques *official* and *legitimate* parts of therapy the patient will expect to act out in front of the therapist the various fantasies and plans which urge him at the moment, instead of frustrating them and turning them into resistance against cure. The aim of the therapeutic methods must be to provide the patients with a variety of flexible settings able to portray the "multi-dimensional" character of life.

Hypothesis VI: The "act hunger"[15] of an individual is continuously looking for situational opportunities for expression. Hypothesis VII: The forces of resistance of the patient against cure are weakened or pacified by making acting out techniques official and legitimate parts of the therapeutic procedure. Hypothesis VIII: Acting out of a situation in a controlled environment can be a preventive measure against irrational acting out in life itself. Hypothesis IX: "Multi-dimensional" psychotherapy requires multi-dimensional vehicles. Hypothesis X: Multi-dimensional space vehicles, for instance an open field or a stage, permit the patient more freedom of movement and action than the couch. Couch and chair continue to be props on the stage whenever indicated. The patient should also be permitted and instructed to create, with the aid of auxiliary egos, situations which he feels are significant and which he perceives and feels intensively. The roles which are played by him and the auxiliary egos remove his attention from the chief therapist who then has a better chance of watching the behavior of the patient objectively. The technique offers the analyst other advantages; he does not only hear the words spoken by the patient but he can see the actions and study his behavior directly. The more the patient becomes involved, the less conscious is he of his actions; it is like seeing the acting out of the unconscious itself. The objective indication of this is that the patient hardly remembers afterwards what he did. In the effort to develop psychoanalysis as a science of the unconscious, Freud relied heavily upon dreams. Well, it is in the area of dreams in which psychodrama has been able to advance the science beyond the "Interpretation of Dreams". It is by acting out and role playing techniques. The verbal telling of a dream is a poor duplication of the experience which the dreamer actually goes through in situ, that is, when he sleeps. Psychodrama is the essence of the dream.[16] The latent dream constellations in the Ucs are livelier than those which reach the dream

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[15] See "Spontaneity Theory of Child Development", *Sociometry*, Vol. 7, 1944.

[16] See Lewis Mumford, "The Conduct of Life", Harcourt Brace & Co., 1952.

level of the sleeper. By letting the dreams be acted out via psychodramatic techniques, those deeper parts of the unconscious can be brought to view for the analyst and observer even if they cannot be made conscious to the actor. But, the actor may, after the act is over, with the aid of his observers, reconstruct his own experience. Carefully conducted experimental sessions may disclose that the contribution of the actor in the process of reconstruction is far greater than yet anticipated.

If there is any cogency to the argument that to be, to act, and to behave is closer to the deeper levels of the unconscious than language and words, then the direct contact with the behavior of the patient in all its fullness should bring the hidden dynamics better to view than if he is only engaged in free word associations. The "psychodramatic view of the unconscious" is more complete and potentially superior to the psychoanalytic view of the Ucs. The free associations are not lost, they are included, in a sort of free floating of words and fragments of phrases, the degree of dissociation depending upon the intensity of the bond between word, symbol, behavior and action.

The various personality figures of the patient's past (father figure, mother figure, male and female figures, devil and God figures, object representations) are embodied in the psychodrama by the patient and the auxiliary egos in the essential form in which they are experienced and perceived by the patient. They disclose their representation in the form of roles (the roles of father, mother, animal or object, etc.). The roles are not necessarily identical with the social roles of our culture but infused with the many psychodramatic characteristics with which the patient has provided them. This again opens up a new era of research of the symbol systems of the unconscious. Whereas up to now the real things came to the fore by inference only through the word symbol, by means of the psychodramatic method the behavior and action symbols themselves come to the fore.

Hypothesis XI: Symbolic behavior can be more effectively studied by actional and operational methods than by verbal methods.

VI

"Breuer's communication of the famous case of Fr. Anno O. was one of the starting points that led to psychoanalysis,"[17] to the free association method and the transference technique which in turn brought about the

[17] E. Jones, *Biography of Freud,* p. 222.

chronic crisis of psychoanalysis. Therefore, it might be interesting to consider how the Breuer anecdote could have been handled, had the psychodramatic technique been applied to it. It is unfair to call it the "case" of Miss O. In psychodramatic terms it was just as well the case of Dr. Breuer and Frau Breuer and eventually also the case of Dr. Freud. If Dr. Breuer would have come to a psychodramatist with his problem, Dr Breuer would have sat with the psychodramatist in the audience. The protagonist, Miss O., would have been provided with two auxiliary egos, the one to portray Dr. Breuer, the other to portray Frau Breuer. The treatment might have begun with a session in which the professional relationship between Miss O. and Dr. Breuer is re-enacted, Dr. Breuer watching himself like in a mirror, at times prompting his auxiliary ego as to details, reporting also to the psychodramatist upon questions. In a second session we see the auxiliary ego of Dr. Breuer facing the auxiliary ego of Frau Breuer. The two protagonists are now sitting in the audience and watching this scene. In a third session the patient, Miss O., confronts Frau Breuer. In a fourth session we see the *real* Dr. Breuer changing place with his auxiliary ego and confronting the patient as it would be in his own office. By means of such an approach to the problem Dr. Breuer might have been cured of his counter-transference love for the patient; Frau Breuer might have buried her jealousy of Miss O., realizing that she is a sick woman, also a good patient for the doctor, and letting the matter go without nagging him further. The patient, on the other hand, being, notwithstanding her sickness a smart woman, might have accepted Dr. Breuer as he is, in the objective light which psychodrama threw upon him, and would have given some of her transference love to the auxiliary ego who represented Dr. Breuer on the stage and who may be a good surrogate for him, if not better than the real. Frau Breuer might have had her baby just the same and the storm might have blown over nicely. But what about psychoanalysis? Well, Freud would have heard of the famous case of Miss O. a few years later when Breuer confided in him about it. But, now, it would be a story of a triumphant victory over transference love instead of failure. It is known that Frau Freud identified herself with Frau Breuer when she heard of the incident and it is now quite clear that also Freud must have identified himself with Breuer. In the end, he, just like Breuer, failed on transference love, not literally as it was in the case of Breuer, but symbolically as the representative of psychoanalysis in a long battle lasting 50 years. Had the case of Breuer ended victoriously, then also Freud would have been more open in the critical years between 1919 and 1923

to techniques which might have meant a new advancement for psychoanalysis. The case of Breuer retarded psychoanalysis by ten years. The case of Freud appears to have retarded it by over thirty years as this case is not yet resolved.

VII

With change of technique go parallel changes in theory. The problem of acting out is closely linked to the problem of the Unconscious. The dynamics of acting out suggests a remodeling of the system of the Ucs if its vitality should be maintained. However important verbal behavior is, *the act is prior to the word* and "includes" it. The act residua in the Ucs are topographically prior to the word residua. The inclusion of the motor end of the psychic apparatus into the system of the Ucs becomes a foregone conclusion. Freud divided the unconscious into two kinds of processes, Pcs and Ucs; a third may have to be added, the dimension of the act or motor events in the unconscious, the Acs. He gave to the irrational aspects of actional phenomena[18] considerable attention. His analysis of "symptomatic and chance actions", "erroneously carried out actions" and "faulty acts" was superb, but, he failed to give them a proper niche in the system of Ucs. It is not like him, he always worked on two levels, the empirical and the theoretical. As soon as he made some significant observation he tried to find a niche for it in his theoretical system. It may be that because he dreaded the acting-out angle, he failed to perceive its implications on the treatment level and left the metapsychology of action incomplete. A dimension of the act and motor events in any psychogenetic system is indicated by the following observations: a) the infant prefers acting to language, it resists logically organized syntaxed language. b) In reverse, the adult protagonist in psychodrama prefers talking to acting. c) Dreamers, in the course of acting out a dream, stop to produce, they don't remember. But when free association has failed, some incidental motoric activity, as walking upstairs, falling on the floor, hitting his head on the wall, an embrace or kiss, is able to resurrect blocked fragments of a dream. d) The phenomena of retroactive amnesia[19] of every individual for the first 2-3 years of life; they are probably due to the "act hunger syn-

[18] "The Psychopathology of Everyday Life," *The Basic Writings of Sigmund Freud,* The Modern Library, Random House, New York.

[19] J. L. Moreno, "The Spontaneity Theory of Child Development", *Psychodrama,* Vol. I, Beacon House, Beacon, N. Y., 1945.

[20] Op. cit.

drome", the prevalence of psychomotoric involvement[20] during infancy. e) There is a marked difference noticeable in the psychomotoric capacities of groups of mental patients versus groups of normal individuals; these differences can be measured and we become able "to diagnose the present status of the patient's mental condition, predict changes in his conduct *without* verbal communication.[21]

Freud has defined psychoanalysis as "the science of unconscious mental processes". But is the unconscious a substance, an entity, a noun, "*the* Unconscious"? Or is it not better to consider it as an attribute, "unconscious", a condition which accompanies psychological and social events in varying quantity and intensity? He concurred with Lipps that it is *the* problem of psychology. It loomed of overall concern and more basic when contrasted with conscious phenomena: "unconscious is a larger circle which includes a smaller circle of the conscious; everything conscious has a preliminary unconscious stage. . . ."[22] But how would it fare when compared with phenomena as spontaneity and creativity? The verdict may be different.

In *conclusion,* 1) the formats of psychotherapy and the techniques used within it are closely linked; the couch is linked to free association and transference technique, multi-dimensional space vehicles as the stage to movement, physical contact, acting out techniques and roleplaying.

2) Freud's theoretical system of the unconscious shows a vast deficiency in its failure to take care of psychomotor and action events.

3) Freud may be blamed for having tried to make unconscious events of the past conscious in excess of what was beneficial to the patient. In order to advance the science of the unconscious he took at times a calculated risk with patients.

4) It appears that Freud did not make clear, either to himself or to his patients, the full significance of the couch technique in the psychoanalytic situation. *He has left things unconscious which he might better have made conscious, and tried to make such things conscious which may have better remained unconscious.*

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[21] "Normal and Abnormal Characteristics of Performance Patterns", Joseph Sargent, Anita Uhl and J. L. Moreno, *Sociometry,* Vol. II, 1939, No. 4, p. 40.

[22] "The Interpretation of Dreams", *The Basic Writings of Sigmund Freud.*

Postscript

The format of the therapeutic situation in Adlerian or Jungian psychology is apparently of little importance to its authors, although they must have had some operational procedure in the way they consulted their patients. I did not find any record to speak of, of their preferences. In the foreground of their contribution is theory and interpretation, the format of treatment is secondary. They were both keen observers, they tried to analyze their patient's behavior under all circumstances and implied that the dynamics of their behavior will always be the same. They preferred to be alone with their patients, usually sitting on chairs facing them, although the "chair" is not a postulated requisite, the relationship of a superior versus a subordinate being maintained. But the therapists of the format-free type fall into some pattern, whether intended or not. It may vary from case to case, it may be highly individualized fitting either the patient or the therapist in question. This may be, by itself, a virtue. The psychodramatist in situ, for instance, *purposely* leaves open the form which the therapeutic situation takes, to work itself out spontaneously. But the greater mobility and flexibility of the format-free therapies has some disadvantages. Considering that it is difficult to apply to clinical psychotherapy rigorous experimental methods, a standardized format of treatment is the nearest to an experimental setup, giving all clinical workers an identical pattern of procedure as a frame of reference. Working without a a format or leaving the format unstructured makes more demands upon the art of the therapist than upon his science. The tendency to be intuitive and interpretative makes it difficult to communicate with other therapists and to compare with them what happens in a session. The often undeserved decline of influence of Adler, Jung and other revisionists of orthodox psychoanalysis can be ascribed to their exclusive emphasis upon exploratory interpretation and their neglect of format and technique. The comparative weakness in the cohesion of the Adlerian and Jungian schools, as well as of similar enterprises, is in some measure linked to their lack of a specific vehicle and of a prescribed behavior in the therapeutic situation.

PSYCHODRAMA AT VETERANS ADMINISTRATION HOSPITAL DOWNEY, ILLINOIS

*Adeline Starr and **Irving Chelnek

Since we are all aware of the many organizational and personnel problems which arise whenever a group plan is introduced into any of our large mental hospitals, I think there is some value in briefly describing how the Psychodrama Program functions at our hospital.

Our hospital is concerned, not only with the treatment of "mentally ill" patients, but with the training of medical personnel. There are training programs for aides, student nurses, psychiatric residents, psychology trainees and others. This report will show how we are using psychodrama in both of these areas: as a treatment for a patient group and as one of the methods of training the hospital staff.

Initially, the psychiatric staff selected six men and six women who they thought able to profit from Group Psychodrama. The patients ran the gamut of diagnostic categories seen in a psychiatric hospital, with the exception of those too prone to act out their aggressive tendencies. We have not, in this group of patients limited ourselves to any diagnostic category. However, it is our feeling that lobotomy patients and deteriorated patients require a special group. When the problem of replacements came up, the psychodrama staff decided against trying to keep the patient-group in its original balance. The decision to keep the group open as to number, sex and length of attendance has worked out satisfactorily both to individual and hospital needs. New members were easily assimilated into the group without significant loss of group cohesion. The open group serves to provide a continuous therapeutic source for additional patients. Focus of therapy continues about the original members or those longer in the group with new members gradually integrated into action.

Replacements, at times, have been sociometrically assigned: each patient refers another patient from the ward whom he would like included in the group. Most of the patients are referred to the group by individual therapists. A patient is accepted into this group when his therapist feels he is ready for a group experience and when the patient shows an interest and

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readiness to attend the sessions. Many of the patients are receiving other forms of treatment as well as attendance in this group. A second group is composed of all closed ward female patients, actively psychotic and regressed.

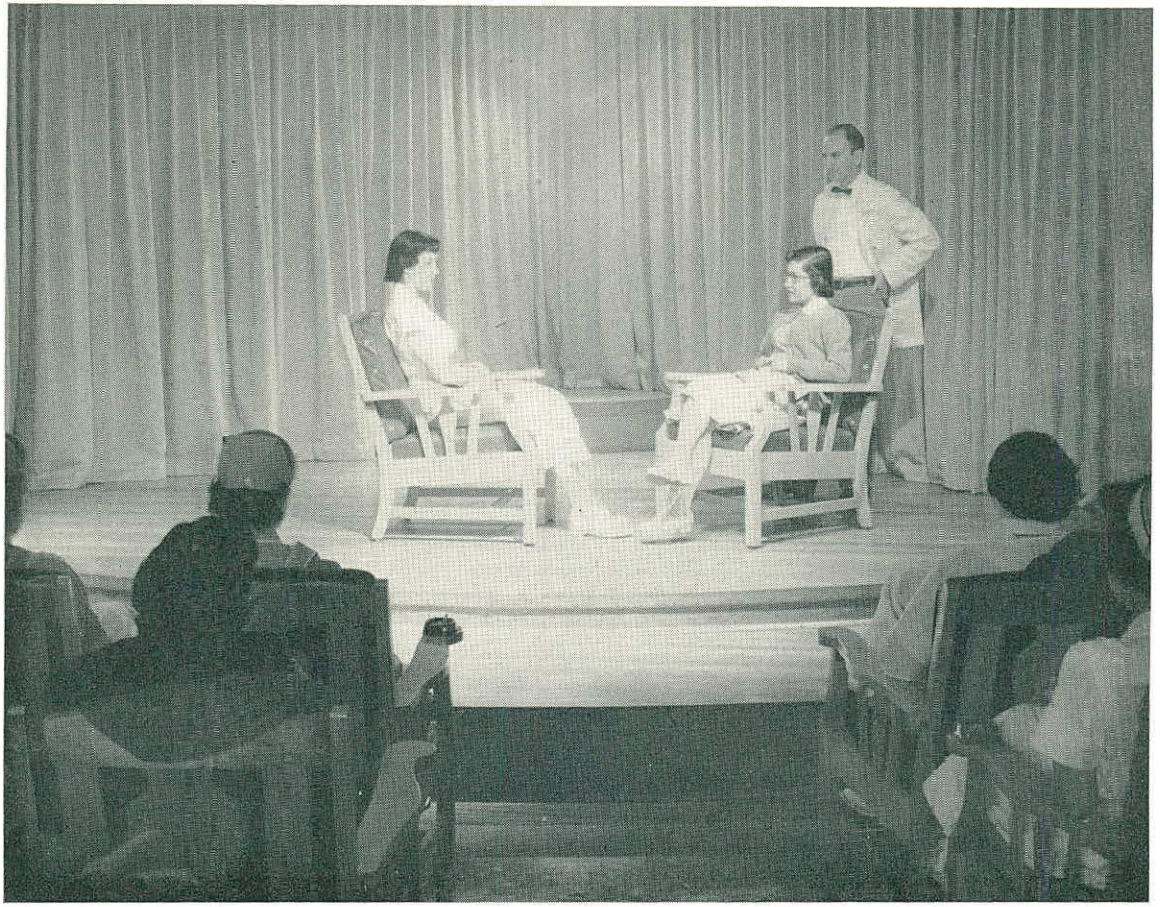
At present, the open group comprises fifteen men and women who meet once a week in a room especially selected because of its availability to other buildings. To meet our physical problems, a stage was built in a corner of the room. The stage-plan attempts to follow Dr. Moreno's stage at Beacon, New York. For a period, until our stage was completed, we used flat available areas with satisfactory results. While a stage is not essential, there appear to be both tangible and intangible advantages. The emphasis of the psychodrama is not on a "staged" effect, but rather on a structured area designated for action.

Psychodrama is a therapeutic method of enacting the emotional problems of the patients in front of a group in order to help rehabilitate them. The process of treatment offers an opportunity for clinical observation and acquaints the staff with the techniques and potentialities of psychodrama. With the training program in mind, we invited six to eight student nurses and an available member of each branch of the services of a building (Women's Psychiatric Unit) to attend the sessions.

During the psychodrama session, the professional staff provides the director with resource people who act as auxiliary egos. Through their familiarity with actual ward situations, they can help re-create a realistic problem situation in which the patient can act out or test his reactions, thereby changing his attitude and making a better social adjustment.

The staff consists of a consultant in psychodrama who is responsible for training the other staff members in the dynamics of this methodology: reverse role, mirror technique, double ego, dream enactment and other processes. At the session, the consultant acts as a participant observer and over-all director. There are two directors from the regular hospital staff, one in charge of the actual session, the other in training as a director, a psychiatrist and a clinical psychologist, respectively.

The psychodrama group meets for a two-hour period. During the first hour, the director encourages the patients to a spontaneous enactment of a problem of a member of the group. Scenes to be enacted are usually derived from the patient-group; they include things like: relationship to ward associates, anxiety about family, trial visits, job hunting, dissatisfaction with personnel. If the work area is a major problem of the patient, then one of the immediate goals would be to define the problem through psychodramatic



Both pictures were taken during the "after-session" in which psychodrama is used to work through problems with patients brought forth by the student nurses.

Picture No. 1 shows two student nurses and Dr. I. Chelnek, Director, on the stage and the student-nurse audience in the foreground.

Picture No. 2 shows Dr. R. Coopersmith entering the scene where Dr. C. Reed, Assistant Director, is in the role of auxiliary ego along with a student nurse who as auxiliary ego is in a patient's role. In the background is Dr. I. Chelnek, Director. Student nurse group is seen in the foreground.

action, followed by an exploration of his adaptational capacity using spontaneous or structured solutions.

The patients leave at the end of the hour; the staff remains. The consultant in alternate roles of discussion leader and director of psychodrama, uses the psychodramatic action of the previous hour for teaching. An evaluation of the patient's gains and the director's skill is made. Each member of the training group becomes at once a teacher and a student in this learning process. We find this procedure of greater value to the staff than a pre-planning session. Another advantage of this after-session meeting in a training program is that the psychodramatic action tends to define the interpersonal "role" of the patient. The participating audience is aware of the behavioral patterns as they occur on the ward and as they are met in this therapeutic setting.

Some of the difficulties in arriving at a smooth functioning Psychodrama Program, such as we now have in operation, are the usual ones typical to introducing a new group program:

1. Selecting a period most convenient to the staff.
2. Working through the resistance of the staff to the new program.
3. Finding a suitable place.
4. Coordination of differing therapeutic philosophies of attending therapists.

Treatment results have been difficult to assess objectively because of the multiple factors involved and the concurrent use of other therapies. However, some tentative conclusions can be drawn. Over 100 patients have attended. Varying degrees of improvement have been observed, from improved hospital adjustment of markedly withdrawn isolated patients to discharge from the hospital of patients with more adaptational potential. It is our belief that psychodrama can be successfully used in a wide range of psychiatric disorders, providing appropriate adjustments of technique and selections are made. For example, patients who are prone to act out their aggressivity require the presence of auxiliary egos who are capable of dealing with emergency situations that can arise. Patients with organic brain damage would require more structured, simple situations to make up for their impaired spontaneity and intelligence. Similarly, the markedly autistic, regressed schizophrenic, with impaired schizophrenic language, requires special techniques. We are still in the process of studying the latter group. We have little experience with the first two groups.

In conclusion, it is our feeling that psychodrama serves as a unique modality for psychotherapy and is a useful addition to the armamentaria of the hospital treatment and training program.

A THERAPEUTIC GROUP WITH HUSBANDS AND WIVES OF POLIOMYELITIC PATIENTS*

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Introduction. A psychotherapeutic group for husbands and wives of bulbospinal poliomyelitic patients was organized under the assumption that while considerable individual work was done with patients by various staff members to help the patient accept his physical disability and to make a good physiological adjustment to that disability, relatively little was being done to help the husbands and wives of these patients to make a similar adjustment. A letter was sent to all husbands and wives of patients at the Ranch Los Amigos Respiratory Center for Poliomyelitis, Hondo, California, stating that there were psychological problems which were common to all patients having respiratory poliomyelitis, and that the eventual success of the patient's rehabilitation was directly or indirectly affected by the influence of the immediate family, especially that person's husband or wife. The letter further stated that husbands and wives of the patients are likewise faced with some problems which have specific implications for the patient's total recovery. Enclosed in this letter was a self-addressed card on which the individual was instructed to indicate whether or not he was interested in participating in such a group. If so, it was to be returned to the hospital as soon as possible. Approximately fifty letters were sent out in the initial survey and about thirty persons returned the cards. As new married patients were admitted to the hospital, a similar letter was sent to the husband or wife, giving information regarding the time and place of this meeting. The first meeting was held on a Thursday night for approximately one hour and the basic structure for this group was established.

Structuring. The clinical psychologist is the male therapist and the supervisor of medical social workers is the female co-therapist. The therapist has played the role of the leader of the group while the co-therapist has played the role of recorder. The group, at its first meeting, discussed the desirability of having a running account of the meetings made by the co-

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** The Respiratory Center is aided by an annual grant from the National Foundation for Infantile Paralysis, Inc.

therapist and all seemed to be in agreement that it was desirable. Some members suggested that they would like to see the meetings recorded verbatim and then transcribed. This suggestion was not followed since the value of such recordings did not seem to merit the work involved. It was also felt that supplementary notes concerning the dynamics of interaction would need to be made, whether or not there was verbatim recording.

The individuals who came to the group were invited on the basis that this would have specific relationship to the total rehabilitation program of the patient, and in this sense they, themselves, did not come under the assumption that they were to be the benefactors directly in the group situation. In other words, they were coming because they were interested in information and attempting to understand more adequately the psychological problems which the patients were facing. Thus, the members of the group did not come as patients but rather as interested relatives of patients in the hospital. It would seem that structuring of this sort with members of the group was necessary in that it was designated as a supportive type of group, similar to the type of work that is done with mothers who have children under therapy. It was believed that to structure the group in a more traditional group psychotherapeutic way would be so threatening that many of them would not return after the initial conference session. This group has not been referred to as a psychotherapy group but rather as a group conference which has, as was intended, developed into a therapeutic group. Only in more recent sessions has any attempt been made to interpret the material presented in the sessions.

This group is a self-perpetuating one since the members tend to drop out as the patient is returned home. New members come to the group as a husband or wife is brought to the hospital as a respiratory patient. Some of the members of the group at the present time have been in regular attendance since its inception. The group tends to be a rather homogeneous one in the sense that all members have patients at the hospital, all of whom have had bulbospinal poliomyelitis, and all are or have been in respiratory equipment, with varying degrees of orthopedic involvement. The average attendance of the group has been thirteen with both sexes being represented at each meeting.

To bring the members that were present at the first meeting into the thinking and the structuring of the group, they were asked to state some of the problems which were of specific interest to them at the moment. It is interesting to note that most of these problems mentioned had a patient reference and that none of the stated problems dealt with the feelings and

the adjustment problems of a husband or wife of a patient. Some of the common psychological problems which all patients appeared to experience, and some of the adjustment problems which the husband or wife of a patient appeared to have, were also briefly summarized. The group decided at the first meeting that the therapist should begin the meetings with a short discussion of some topic related to the psychological adjustment of a husband and wife of a poliomyelitic patient. This procedure has been followed since its inception but an attempt has been made during the past months to gradually wean the group away from from this type of thinking and to guide it into more of a group therapy situation.

Areas of Group Concern. The initial interest of the group revolved around concern for the welfare and rehabilitation of the patient about whom they were specifically concerned. Some of the first evidences of this interest related around the fact that the illness tends to bring out many of the narcissistic behavior patterns of the patient. Members of the group discussed various means of dealing with the patient's narcissistic drives. The members likewise demonstrated the need for reassurance that when the patient was finally discharged to the home it would be possible for him to return to the hospital in the event of complications, such as an upper respiratory infection. It was assumed that indirectly this also represented a need for reassurance on the part of the husband or wife that if the adjustment problem was too great, the patient could be returned to the hospital. The members of the group were likewise considerably concerned about the various psychological reactions of the patients, such as the anxiety which is so typical during the intial stages of the disease, the regression which is so frequently seen during the early course of a completely paralyzed bulbospinal poliomyelitic patient, the depression which is almost universally observed in the patients, and the hostility of a patient.

The whole problem of self-acceptance and the acceptance of others tended to take up considerable time in a number of sessions. This problem revolved around the drastic changes which inevitably take place during the course of bulbospinal poliomyelitis in the body structure of the patient. This means that the patient's body image is probably severely jeopardized. While the patient is given some assistance in attempting to accept his disability, this group appeared to be the avenue through which the husbands and wives sought to face the problem of their own feelings about the changed body status of the husband or wife and their ability to accept that person with his drastically changed body structure.

Another problem which seemed to be important in the experience of

many of the husbands and wives, especially when the patient was able to leave the hospital on a day or a week-end pass, was the degree to which the physical condition of the patient should determine the total life experience of the rest of the family. For instance, if the husband and wife prior to the illness both enjoyed water skiing or swimming or hunting, does this mean that the husband or wife of the patient must curtail these interests because the marital partner can no longer patricipate, or does one continue to live one's own life within certain logical limitations imposed by the patient's condition. Indirectly, this seemed to be an expression of hostility on the part of the husband or wife toward the patient's condition in that it might mean that they felt they must give up the things which they enjoy because continued participation would produce guilt feelings which would be difficult for them to handle.

Another significant area which tended to be expressed fairly early in the course of the group sessions were feelings of hostility. These expressions of hostility were usually initially directed toward other hospitals or toward nurses, therapists and physicians who had treated the patient in these other facilities. After several weeks of expressions of this sort the members were able to express their hostility toward the present facility and staff. This hostility was usually couched in such a way that it implied that they were displeased with the care the patient was receiving, believing that the hospital was not as efficient as it should be or that the medical staff did not treat them or the patients as adults, capable of knowing the real medical facts. It is interesting to note that few of these members made use of the privilege of having conferences with the various staff members, but inferred in their hostility that nobody seemed to be able to give them the information they wanted. It would appear that this is a reflection of the person's own inability to face the information which might have been available through such a staff person.

The members of the group tended to insist that the patient be told more about his or her condition by the staff, or that they be brought into a conference where they might hear the comments made by the various department heads. In various ways it would appear that the members had sought to avoid their responsibility of becoming familiar with the patient's condition for such knowledge would then place on them the responsibility of relating such information to their patient. Not knowing such information would consequently excuse the husband or wife from the responsibility of discussing the physical rehabilitation program with the patient and would also, of course, relieve the individual of the necessity to face those medical facts themselves.

Reasons for the individual's inability to discuss such material with the patient would of course be partly their own refusal to accept the patient's prognosis. It is also possible that the relatives, having talked to one of the staff, may not be psychologically ready to hear what the individual has to say and thus either misinterpret what was said or simply say that the doctor didn't have anything specific to say. Thus, avoiding acquisition of medical information would relieve the relative of responsibility of sharing it with the patient, who is bound to ask questions and to express feelings related to his or her condition. As the sessions progressed, hostility toward the staff and the hospital gradually gave way to a more specific hostility toward the illness itself. Some of the wives of patients expressed hostility toward the husbands, who, when they were brought home on week-end passes, had failed to note the conscientious way in which the wives were handling the home problems. In general, it was felt by a number of the wives that their husband patients did not fully appreciate the tremendous work load which they necessarily needed to carry during their stay at the hospital.

Many of these wives had not been working outside the home prior to the illness, but the expense of the illness necessitated their finding work in order to support the family.

Considerable hostility was expressed toward the necessity to work which indirectly seemed to be an expression of hostility toward the fact that their husbands had become ill and were no longer in a capacity to support them and their families. The hostility that was expressed by men toward their wives and wives toward their husbands who were patients, began to be felt within the group itself as male members of the group began to have hostile exchanges with female members of the group and vice versa. There was also an expression of hostility by women feeling that their situation is more difficult, in that when a husband is the patient the woman may go to work but still must assume the responsibility of coming back home in the evening to take care of many of the details of the home. Frequently the women members of the group expressed their need for sympathy and reassurance by making statements to the effect that they were all tired out, or that they did not know how long they could continue carrying on a dual role of breadwinner and home-maker at the same time.

The problem of taking the patient home and re-establishing the home was one which frequently came into the discussion. In certain cases the feeling was expressed by both male and female members that it was impossible to take the patient home. The reasons varied considerably. To a certain extent feelings were verbalized to the fact that it was the difficulty of accepting the condition of the patient which made this problem so diffi-

cult. When the question of divorce of the patient was brought up, inasmuch as this has occurred and usually is publicized to some degree, the group by and large agreed on the intellectual level that they could not accept anyone who refused to take the patient home and preferred divorce instead. One member stated rather pointedly that society would look with considerable disfavor and disapproval upon anyone who would abandon a husband or wife who was a patient. It would appear that the thought had occurred to many of the individuals that this would be an easy way out of the situation if it were not for the disapproval of society. To some extent it would appear that there was hostility toward those individuals who did solve their problem by divorce, but perhaps the hostile feelings were more specifically directed toward their own selves for having had similar feelings. In general there was a feeling that they were caught in a situation for which there was no solution.

Early in the course of the sessions one member stated that death might be preferable to a long term invalidism, feeling that while it might be very painful and difficult if the patient did die, it would then be over; that when a patient is paralyzed and lives on and on it is a constant reminder of the tragedy which has occurred because of the illness.

The anxiety of the members of the group seemed to revolve around several areas, one being imminent discharge of the patient which then tended to crystallize many of their fears and problems related to re-establishing a home or re-integrating the patient back into the home. The second major area in which the member needed support, as well as clarification of feeling, tended to revolve around the problem of sexual adjustment. This seemed be be especially true where the husband was the patient and if he was severely involved, necessitating a reversal of sex roles in terms of the wife becoming the aggressive sex partner whereas the invalid husband is the passive partner. Another sex concern seemed to revolve around the preoccupation with sex relations on the part of the male patients while on passes and after discharge. It would appear that this hyperactive sex need is symptomatic of the need of the individual to prove his masculinity to himself. This seems to be especially true where the patient is very severely involved orthopedically. It would seem to follow that when the male individual has lost much or most of what to him symbolically stands for masculinity and masculine behavior, that individual will attempt to reassure himself by over-using that which he has left. The fear of pregnancy seemed to be an important problem especially with women members of the group, for they more or less felt that they needed to work and that pregnancy would consequently be a complicating factor. Perhaps this is also an expres-

sion of male-protest in that these women now have a socially acceptable reason not to bear children. Some of the male members of the group likewise feared that their patient wives might become pregnant and wondered concerning the consequences of such pregnancy. It was recognized by members of the group that male patients might have the need to father a child in that it might be a way of reassuring themselves of their masculinity and their capacity as fathers. The same thing seemed to follow in reference to the male members of the group who felt that their wives who were the patients might have a need to bear a child in an attempt to reassure themselves of their own femininity and ability to bear a child.

Role playing has been a very effective method for bringing the reality aspects of the various areas of concern into focus. Talking about problems is often less threatening in the group situation than in individual therapy; that is, the group tends to provide a security function, making it easier to talk about difficult feelings. However, it may also be true that at times it is possible to talk about rather anxiety provoking material in the group without the anxiety feelings being evoked, discussing the material in a rather intellectualized fashion. It is important to bring the feelings of the members into the group situation, and it is at this point that role playing performs an important function.

To illustrate this function of role playing the following instance is cited. The group discussion had revolved around the dependency needs which are often activated in the patient after a long illness. The discussion in the group had pointed out that patients sometimes see the hospital and tank respirator as a "mother-figure" and find it difficult to go too far from it. The importance of the husband or wife taking his or her patient on early day or week-end passes from the hospital, with respect to the developing dependency upon the hospital, had been stressed. One woman said that her husband had not mentioned wanting a pass even though he was on a ward where other patients had been frequently going on passes. The woman pointed out that she had not approached the ward physician concerning the feasibility of the pass either. However, she anticipated that her husband would have all sorts of excuses why he would not want a pass as yet, such as the changes for upper respiratory infections, the children would make him nervous, and others. The therapist suggested that he would play the role of the husband and would raise excuses for not wanting a pass, and together we would discuss the problem in this way. Through role playing the question of passes and their meaning was dealt with on the emotional rather than the purely academic level. An interesting consequence of this particular discussion was that, as is true with other group members, the

respective patients ask them at the following visiting hour what was discussed at the group meeting. This practice is not encouraged or discouraged. This woman told the husband about the discussion concerning dependency on the hospital and the fear of going too far from the respirator. She also told him that the therapist had played his role and of the reasons which were given why it was felt that he, as the patient, would not want to go on a pass. As a result of this the patient's thinking about passes was clarified and steps have been taken by the patient and wife to have a pass in the near future.

Some Problems Confronted. Because of the nature of the structuring of the group, and also due to the fact that the sessions are held during the hour following the visiting hour, certain problems have been encountered. The major problem has been that the members on several occasions have brought with them relatives or friends who had accompanied them to the hospital for the purpose of visiting the patient. It has been obvious that the presence of an in-law, or in one instance the presence of a priest, has definitely curtailed the therapeutic process. While meeting after the visiting hour does have the above objection it may have at least one advantage. The advantage would seem to be that the members, having just spent an hour with their patient, were emotionally ready for the meeting, and at times positive and negative emotionally loaded materials were expressed at the onset of the session. Thus while an hour might seem to be undesirably short for good therapy, the fact that the members were emotionally ready made the time spent in the session often unusually productive.

In one instance two female members of the group brought their husband patients with them to the group. Such a problem had not been anticipated inasmuch as patients are to be in their wards at the end of the visiting hours. When the persons involved were reminded of this fact they eliminated this objection by getting the approval of the nurse to remain. They were thus permitted to remain for the session but it was felt that their presence hampered the spontaneity of the group.

Conclusion. This is a report of a form of group therapy with the husbands and wives of bulbospinal poliomyelitic patients at the Rancho Los Amigos Respiratory Center for Poliomyelitis. It is the feeling of the therapist and co-therapist that this is an effective way of dealing with some of the psychological problems of the patient and of his or her spouse. What the long term effect of this program will be is of course unknown, but it is felt that it should continue to be a part of the rehabilitation program of the poliomyelitic patient.

CLINICAL SOCIOMETRY, ITS APPLICATION TO COLLEGE RESIDENCE HALLS*

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J. L. Moreno, the founder of sociometry, first expressed the basic idea during World War I.[1] Though his concept was somewhat utopian in that he saw it as the answer to the world's problems, a worldwide political sociometry being his idea of the major experiment—the culmination, still many significant contributions have been made through its use to an understanding of social interaction.[2]

Designed to give graphic presentation to the measurement of interpersonal relations, the sociogram is conventionally based on certain responses of a confidential nature to questions calling for statements of various types of attraction and repulsion among people.

Moreno's basic concepts have received growing attention in the practical application of sociometric techniques. Among them are the "tele factor" which refers to that influence which brings about greater than chance attraction and/or repulsion; the "status nascendi" or developing pattern of interpersonal relations; the "locus" or point of action in social space; the "matrix" or originating circumstance; the "social atom" or pattern of attraction and/or repulsion both inward and outward centering about the individual; and the "psycho-social network" or configuration of dynamic emotional relation among interacting social atoms.[3]

Sociometric techniques as generally used were worked out in their basic form by Moreno and Jennings[4] and further refined by a number of theorists and investigators, Bronfenbrenner being among the more prominent contributors.[5]

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* Because of the increasing application of sociometric methods to group psychotherapy this study is worthy of careful consideration. (Ed.).

[1] J. L. Moreno, *Foundations of Sociometry* (Sociometry Monographs, No. 4. New York: Beacon House, 1941), p. 17.

[2] *Ibid.*, pp. 19-20.

[3] *Ibid.*

[4] J. L. Moreno and Helen Hall Jennings, "Statistics of Social Configurations," *Sociometry*, 6:342-78, 1943.

[5] Urie Bronfenbrenner, *The Measurement of Sociometric Status, Structure and Development* (Sociometry Monographs, No. 6, New York: Beacon House, 1945).

A noteworthy example of classroom application of sociometry is Cook's oft-cited work[6] while a general view of sociometric theory and practice is supplied through the American Council on Education in the work of Jennings and Taba.[7]

These methods have been used with some frequency in the analyses of relationships between friendship patterns and various other factors. Mick's work with college women is an example of this type of study.[8]

Zeleny, in the Encyclopedia of Educational Research, reviews the extensive application of sociometric techniques to the discovery, analysis and utilization of leadership status.[9]

It appears that at least the foregoing references are necessary for a basic insight into the methodology and possible applications of this technique to the measurement of social interaction.

School personnel administration. The possibilities of utilizing sociometry in school personnel administration have been generally neglected as far as the literature reveals. Cooper has given some consideration to the topic and he is generally optimistic regarding it.[10]

Cooper sees three ways in which sociometry may contribute to personnel administration: 1) that it is one way of viewing and understanding social groups; 2) that it is a method of formally plotting, diagramming and tabulating—literally according to its name, a method of measuring—the social structures of groups with which the administrator must work; and 3) that it is a research tool for the investigation of certain problems of school administration.[11]

Cooper points out that the sociometric terms "star" and "cluster" and "chain" have taken on standardized meanings and are useful designations of certain interpersonal relations.[12]

Among the more specific uses which Cooper envisions for sociometric

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[6] Lloyd Allen Cook, "An Experimental Sociographic Study of a Stratified 10th Grade Class," *American Sociological Review,* 10:250-61, 1945.

[7] Helen Hall Jennings and Hilda Taba, *Intergroup Education in Cooperating Schools* (Washington: American Council on Education, 1948).

[8] Lucille Kennedy Mick, "A Sociometric Study of Dormitory Friendships" (unpublished Master's thesis, Michigan State College, East Lansing, 1948).

[9] Leslie Day Zeleney, "Leadership," in Walter S. Monroe, ed., *Encyclopedia of Educational Research* (New York: Macmillan Company, Revised Edition).

[10] Dan H. Cooper, "The Potentialities of Sociometry for School Administration," *Sociometry,* 10:111-21, 1947.

[11] *Ibid.,* p. 111.

[12] *Ibid.,* p. 112.

techniques are: 1) the detection of operational leaders who may or may not coincide with nominal or official leaders; 2) the consideration of individual problems involving frustration, insecurity and lack of recognition; and 3) as an aid in self analysis by the administrator.[13]

Cooper wisely points out the danger in a hasty application of this technique at the administrative level. The administrator's relation to his personnel can hardly be thought of as exactly parallel to the teacher's relation to her pupils. It seems that the imposition of this technique through administrative decree might easily lead the personnel group to accuse the administrator of snooping, secretive fact-gathering and an invasion of private opinions which they consider none of his business.[14]

In the opinion of this writer, there are essentially two precautions which, if adequately observed, should make the application of sociometric techniques in school personnel administration not only feasible but desirable. They are: 1) a democratic, educational approach which produces group acceptance and preferably desire for its use; and 2) considerable care in utilizing and interpreting the results along with a highly confidential treatment.

It seems indefensible that an administrator would foist this experience upon a personnel group without a clear understanding of its potential value to all concerned and the whole-hearted cooperation of that group.

It seems equally indefensible that an administrator should ignore all other factors in his planning once the results were known and proceed to design all activities in exclusive relation to the leadership and friendship patterns revealed.

These results should be treated as highly significant facts, giving at best a momentary picture of a spontaneous reaction which is undergoing constant change at least in intensity and probably accompanied by occasional modifications of direction. The known interests, abilities, attitudes, and experiences of the persons under the administrator's jurisdiction should continue to occupy a prominent place in over-all planning.

An application of sociometry. Each of six residence halls for men at Michigan State College houses approximately 600 students. Directly responsible for student personnel, morals and discipline are a member of the teaching staff and his wife, known as Resident Adviser and Hostess, one or two such couples residing in each hall. Living in each section of the hall

[13] *Ibid.*, pp. 114-16.

[14] *Ibid.*, p. 118.

and in charge of 50-75 students are one or two specially selected and trained students known as Resident Assistants. The Resident Assistant is thus both a student and an administrative hireling and, being the most intimately associated with the students of all the administrative personnel, is a vital cog in the administrative machinery.

While certain criteria have usually been applied in the selection of this type personnel including an above-average academic record, an acceptable behavior record, prior residence in the hall being desirable, and the judgment of various persons as to his probable success in the role, occasional poor choices have been made as evidenced by the ensuing low morale, criticisms, and generally unsatisfactory and unhappy conditions in their respective sections.

In an attempt to eliminate the possibility of such poor choices being made, the sociometric technique was applied to one of the halls experimentally and is now a standard practice as a result of the extremely favorable preliminary evidence.

Through the medium of a confidential questionnaire, the residents of the hall were asked to name, among other things, the persons they would most and least prefer as Resident Assistant in their respective sections.[15]

Thus each resident was assigned a score equal to the number of times he was chosen minus the number of times he was rejected in this capacity by his fellow students.

At that time the nine Resident Assistants in the experimental hall had been selected without such complete evidence of their state with their fellow students. Numerous complaints had been received about one of them, and it was felt that he had not been particularly successful in the position. This was verified by the questionnaire responses, 94 per cent of which were returned. Whereas the other eight had an average of 20 more positive than negative citations, this one was rated negatively as often as positively. This undesirable situation was relieved as he left the hall at the end of that term due exclusively to other reasons.

To replace him, a student was chosen who, otherwise acceptable, stood high on ratings by his fellow students as a desirable Resident Assistant. The conversion of that section from a disorderly, unhappy, critical group to a cooperative, spirited, orderly group was seemingly miraculous.

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[15] John W. Kidd, "An Analysis of Social Rejection in a College Men's Residence Hall" (unpublished Doctor's dissertation, Michigan State College, East Lansing, 1951), App. A.

On the basis of that experience, when five other Resident Assistants had to be replaced due to graduation, the new ones were chosen as far as possible from those rated high by their fellow students on both leadership (desirability as a Resident Assistant) and friendship (from questions included in the questionnaire).[16] The criteria formerly applied were still used, but other things being equal the sociometric status was used as the critical factor in selection.

Their success the ensuing year drew widespread attention, and the entire hall took on a new spirit of cooperativeness rather unique in residence halls.

During its brief existence, this system has been accepted by all concerned. The Resident Assistants themselves realize that their success depends to a great extent upon their being accepted as real leaders, not merely nominal ones, by the men under their jurisdiction. The students realize that they have a voice in the selection of Resident Assistants. During the ensuing year a similar questionnaire revealed that all nine Resident Assistants continued to be highly acceptable to the residents.

Extreme care has been exerted to preserve the anonymity of the raters, and, in addition to providing critical evidence in the selection process, this sociometric technique has served to reveal isolates and rejected students as well as the nature and structure of friendship groups and cliques, all of which is invaluable in the advisory program.

This program of leadership selection is now in its sixth year and is being extended this year to all men's halls housing some 3500 men.

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[16] Kidd, *loc. cit.*

PSYCHODRAMATIC METHODS AND GROUP PROCEDURES

As part of editorial policy every issue of GROUP PSYCHOTHERAPY *will contain this section on Notes on Psychodramatic Methods and Group Procedures. Readers are invited to contribute notes on new or old procedures which they have found useful in practice.*

A comprehensive statement is not necessary. The editorial committee will accept brief accounts of psychodramatic practices, which, in its judgment, could be effectively applied by other workers in the field. Critical comments or questions with reference to published notes are also welcome..

It is hoped that this section on Notes will be helpful in disseminating information about methods and procedures to a wider audience of practitioners in the field of group psychotherapy.

PREPARING PAROLEES FOR ESSENTIAL SOCIAL ROLES

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Psychodrama can be useful as a method of training for life roles which are *necessary* for an individual as requisites for his participation in community life. One particular area, where it has been found useful, is in preparing parolees and recently released mental patients to participate in necessary roles and life situations. The parolee from a correctional institution must find and maintain a job as a necessary condition of his release, whether he finds it unpleasant or not. The mental patient on release if he is to function must be equipped in some minimal way to operate in everyday situations.

Although their fear and anxiety may be rooted in more complex psychological dynamics, it is still absolutely necessary that these people be prepared to act effectively in key areas of social life. Psychodrama and role playing can often cut through the complexity of the personality problem and help prepare individuals for these situations. Although it is recogognized that the subject requires further therapeutic attention, "getting by" vital situations is an important wedge to keep him interacting on the "normal" social scene, where a favorable sociometric position may produce therapeutic results.

Summary of Procedure

1. With the cooperation of the subject select key situations and roles.
2. Project subject into the situations with the aid of auxiliary egos, role reversal, double and other psychodramatic techniques which seem indicated.
3. Follow up with subject on his performance in actual situations.
4. Use psychodramatic procedures to have the subject further explore situations and reinforce his positive actions.

Case Summarized

The subject is a 50-year-old parolee recently released from a state prison whom we will call Bill. He has spent more time in correctional institutions than in the open community. His offenses include narcotics addiction, assault and robbery. He came to my attention as a member of a group with whom I was meeting weekly in an effort to help them become better integrated into their jobs and the community. With Bill and the group it was determined that two basic key roles and situations necessary for Bill to maintain were his job and reporting to his parole officer.

Bill role-played a number of situations on his job with members of the group playing auxiliary roles. The major problem in this area for Bill was the big gap between his conception of what was adequate performance on the job and that of his employer. Slowly, Bill began to accept the fact that perhaps many of the gripes he had were not valid. Although he still felt he was right, he agreed that he would have to accept his employer's view of his performance, as the job was a necessary condition for his remaining in the commmunity.

His second major role, that of reporting to his parole officer, was also acted out. After a number of sessions Bill accepted more fully the fact that he had to report or he would be returned to prison.

Role reversal was most effective in this situation. Bill, while playing the role of his parole officer, soliloquized, "This guy needs to report somewhere at least once a week so that he can be reminded that he is on parole and that if he fouls up one more time we're going to lock him up and throw away the key. Maybe I don't really do him any good with his problems, mainly because I'm so busy with other guys, but he has to come in regularly or else." The group at first sided with Bill and his attitude of "why report, it doesn't do me any good"; however, after considerable psychodramatic exploration they reinforced Bill's conclusion that it was essential for him to report to his parole officer.

Athough the sessions didn't greatly reorganize Bill's basic personality structure they did help him to accept two essential conditions necessary for his remaining on the job. This enabled him to remain in relationship with a group whose understanding of him and his problems put them in a position to be therapeutic agents. The sessions were instrumental in placing Bill in a favorable sociometric position where it would be possible for day to day *in situ* interaction to produce successful therapeutic results.*

Summary and Conclusions

1. There are certain cultural key roles and situations which are difficult. This is especially true of individuals who have been institutionalized.
2. Although it is recognized that preparation for these roles through psychodrama may not significantly shift personality structure and dynamics, its application can enable the individual to remain in the open community.
3. Functioning in these roles gives the subject an opportunity to receive therapeutic benefits from "normal" interaction conditions.
4. This type of role training has usefulness not only with people who have been institutionalized. It offers a possibility for "cutting through" into new spheres of social relations which had been closed to the individual because of his inability to function adequately in the "key" roles and situations.

THE BEHIND-YOUR-BACK TECHNIQUE IN MARRIAGE COUNSELING

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The Behind-Your-Back technique is essentially a simple procedure. As described by Corsini,** one member of a therapeutic group after discussing his problem, "leaves" the room by turning his back to the group, who in turn act as though he were really out of the room and begin to discuss him "behind his back." The effectiveness of this method is based on the absence

* J. L. Moreno: *Group Method and Group Psychotherapy,* 1931. A report prepared for the *National Committee on Prisons and Prison Labor* as a result of a conference held under the auspices of the American Psychiatric Association Annual Convention, Toronto, 1931.

** Raymond J. Corsini. The Behind-Your-Back Technique in Group Psychotherapy. GROUP PSYCHOTHERAPY, 1953, 4, 55-58.

of visual stimulation: the person "out of the room" is able to accept criticisms without hurt and the others are able to talk about the "missing member" with great frankness.

Because of its relative simplicity and the logic of its dynamics, it seemed that this method might be used to advantage in marriage counseling. The following is a report of its use in such a group.

Theoretical Discussion

The writer's orientation is Adlerian, which means a straight-forward and common-sense approach keeping close to reality. The basic mechanism of life is believed to be teleology—the pursuit of goals, which often are unknown to the individual. The intellect, the emotions and the body are not regarded as three systems but rather as one: these aspects being only parts of the complete and indivisible individual. For this reason, Adler's method and theory is known as Individual Psychology.

It is recognized that each person has a private logic which determines his behavior, but this logic is often not available to the individual, and it is the function of counselling and psychotherapy to make the individual become aware of his own premises so that he may be able to adjust his own logic to the logic of the world outside. In short, the Adlerian viewpoint, as interpreted by the writer, is that psychotherapy is essentially a learning process, engaged in by the individual but accelerated by the therapist.

Learning can take place in many ways. However, there is often a real resistance to learning, especially when the learning is really a re-learning. There is a kind of inertia to either the acceptance of new ideas or the performance of new actions. Subjects in counselling will use an unbelievable variety of techniques to sabotage the treatment that they desire so much. They will argue and confound the counselor; they will forget and misinterpret what he says; and will even dislike the therapist for threatening him with new knowledge.

In psychotherapeutic groups, resistance and hostility are lessened considerably due to the effect of common participation. There is a kind of compulsion exerted which forces people to move along with the group. People anxious to move on are held back by the others, and conversely those with great resistance are pushed ahead. While in group psychotherapy, the ultimate unit of treatment is the individual, it is really the group that is being treated since, psychologically speaking, they advance as a body.

However, in a group consisting of couples, due to the fact that the

problems consisted mainly of already well structured and defined attitudes, progress is rather slow, and often it appeared that the two protagonists in the marriage were unable to move forward because of their prior strongly entrenched positions. It was felt that the Behind-Your-Back Technique might have value in breaking through these emotional impasses.

Description of the Group

The group to be reported on consists of six couples. In every case the husband and wife had been seen by the writer in individual therapy. After it appeared that the problem of the individual might best be met by group counselling, the couple was invited to join a couple's group with the counsellor.

The groups are closed, and meet once weekly for two hour periods.

The essential idea of the sessions is to provide a warm accepting atmosphere in which all members feel comfortable and thus able to discuss intimate problems. The counsellor, who knows each of the members well, through having worked with each of them, contributes to the advancement of the group mainly by interpreting behavior and feeling in terms of appropriate dynamics.

The counsellor, at one of the sessions of this particular group, described the Behind-Your-Back technique in detail and obtained unanimous consent to try it out. A couple volunteered to participate. In a variation of Corsini's technique *both* of the couple were "sent out of the room." That is to say that after this couple had the opportunity to recapitulate their various positions, they were asked to sit in such a manner that each of them was out of visual communication with the other and with the rest of the group. They were thus put into the position of being able to hear what the rest of the group thought of them and their problems.

The Couple

May and John had been married for 20 years, and have a twelve-year-old daughter. Each had psychiatric therapy about 15 years ago. At the time of the use of the Behind-Your-Back Technique, May had had about 70 counselling sessions with the writer and had been a member of a mother's therapy group for two years. At the time she began with the writer she was extremely disturbed and on the verge of divorcing her husband.

John had a short period of individual counselling and had been a member of a men's psychotherapeutic group for several months.

THE EXPERIMENT

May summarized her position as follows: The main difficulty of her family was that she and her husband did not get together on major issues. There is a gap between their goals and their performance. John sabotages the goals. In turn, John states, "I am not able to make decisions, nor to follow them through once I make them. I lack the self-starting mechanism. We work at cross purposes. Since the war (John served for two years in the army in India) things have become worse. Economics are always a bone of contention. There is a lack of communication." May adds, "I don't like being a woman. It also troubles me that I am a mother."

At this point they "went out of the room", and facing in opposite directions, out of sight of each other and of the rest of the group they listen to the following remarks:

MIRIAM: "May impresses me as a kind and warm person, but this is only on the surface. She can be biting, and when angry is sharp-tongued. She is very verbal, and it must be difficult for her to live with John who never reveals what he feels. You never know if he loves you or if he is angry with you. This could cause the bad part of May to erupt."

SIDNEY (Miriam's husband): "I picture John as a typical emasculated American male. He seems to be overwhelmed by women. His relationship to May is that of a son to his mother and he resents it. He does nothing about his problem. He should be more assertive."

HERMAN: "John and May seem to travel different paths. There is no unity; no give and take relations. John seems to have a strong desire for heroics. The home is uninteresting to him. He is living the role of a preacher's son, but he never really left home. May, however, is a warm and understanding person. She understands John more than he understands her."

RUTH (Herman's wife): "Their marriage seems cold and matter-of-fact. I like May's sense of humor which is repressed by John's education. One is going one way and the other is going the other way."

LUCY: "May and John have opposite roles in the marriage. May has not enough warmth to understand John and to help him. John is like an old lady, prissy and precise."

MAC (Lucy's husband): "Neither can let down their bars. Both seem cold to me. There is always something left unsaid. The feeling of coldness toward each other seems to be their main problem."

ESTHER: "May wants to overpower John. She resents him. John in-

furiates May in the same way that a child does. She probably would like a good fight with him at times."

BILL (Esther's husband): "May is a discouraged person. John has his private logic. He has done many things of which he should be proud but he is a bit smug."

The sixth couple was not present this evening due to illness in the family.

After further discussion by the group, which lasted about a half hour, the counsellor invited the couple back into the group and summarized for them the opinions of the various members, adding, of course, her own opinions. May appears to be a warm person who has no chance to give warmth to John, who withdraws. May is the more dominant person and swallows John. They are not really together. John is still mainly a preacher's son. Although they each, individually, have good traits, they do not work together. John plays the role of the woman and May the role of the man in the marriage. They have little understanding of each other and their relationship is cold and unaccepting. John has a rather smug attitude.

At this point, May and John are asked to comment on the summary of the therapist's remarks, the fiction being maintained that they did not hear the remarks made by the group originally.

JOHN: "I am amazed at how close these remarks are about me. I am the strong silent type. We really don't get together. I guess I am a castrated American man. I am not realistic and I am impractical, that is true. So what! I am puzzled by the observation that May is my mother. My mother and May are real opposites."

John begins to talk about his jobs, etc., but is interrupted by Mac. "You are running away from the real issue now." John counters that this and his insecurity is based on his various difficulties with his jobs. Lucy denies this. "No, that is not true. I am sure it goes back much farther than that." Ruth states: "John always finds an excuse." Mac remarks: "John always wanted to be a preacher like his father. He has a holier-than-thou attitude." Sidney comments that John has a wonderful structure of rationalization. John comments: "It is true that I am proper, prim and cold." Mac: "That might just be a weapon for you." John begins to relate an incident: May got up one night from bed and went into the living room. She smoked one cigarette after another. He followed her, got angry and slapped the cigarette out of her hand. He seems to be proud of this act. Lucy comments: "In the middle of the night you could have done something

else to get her back to bed." The group laughs. Sidney asks: "Why do you always look to where you still have to go, instead of looking how far you have already gone?" May: "I guess Lucy is right about my warmth. It is superficial. I think I can love, but I haven't. I agree I am not sympathetic to John's problems."

JOHN: "I think May can understand my problems better than I can understand her."

COMMENTS

At this point the following appears to be true. The nature of the remarks made were different in that they were more personal and more penetrating than the usual kind of discussion. Many of the members showed remarkable insights into May and John. Both of the protagonists seemed to be able to accept the rather devastating remarks with considerable comfort. Each was able to react to only a small part of the material discussed.

FOLLOW UP

At the following session, both John and May were asked to introspect in terms of their thinking over the past week. Each of them stated that they "had carried the meeting with them" thinking about what had been said.

MAY: "We still haven't talked much about it. I think we had it a little too soon after the group was formed. An odd thing resulted from the Behind-Your-Back technique: We kept away from the house. We went somewhere else every night and we had a good time. In talking, we skirted around the edges and we agreed it was hard to talk about. We talked about other things. We got the house cleaner than usual for grandfather's birthday party."

"I felt very much like a man. I also felt very angry at the group because they were picking on John."

JOHN: "I felt different from May. First, I acted like a cold fish. I usually take things as they come. I was sort of calm about it during the session. It didn't bother me. But the reaction hit me next morning. I was all stirred up and emotional. I thought of things I didn't think of for years and I thought of what was wrong with me. I felt depressed and puzzled. My disposition has not been so sweet. And yet I don't feel hostility to the group nor to May. I think I do not have enough self-assurance. We do not have much to say to each other. The Behind-Your-Back business was like a hot foot. It stimulated a dream. I was walking and ran into a group of young hoodlums. Some of them looked like some of my students. They

were armed. I began to disarm them and I began slashing through the group with a knife. I was slitting their throats. I felt quite indifferent about this, but I felt I had to do it. I felt it might be difficult to explain to others why I had to do it."

A discussion followed these introspections during which John recalled another dream in which he brought a cat to be castrated. He then recalled that his father used to say that he walked like a girl and that if he had redder cheeks that he would look just like a girl.

Although it might have been advisable to continue further with this case, it was felt since this was the first use of this particular technique and since the depth of therapy had suddenly become much deeper for the group as a whole, that it might be better not to pursue the problem any further.

The group was queried about the method and the general opinion was that it should not be used regularly nor too soon. It appeared that the technique was threatening. Later, May remarked to the writer that she really didn't mind it, and that it was quite an experience.

Discussion

The Behind-Your-Back techniques, as can be seen, by the simple expedient of asking people to make out that they are out of the room, creates a new situation in a group in which the members discuss "missing" members with unwonted and almost unbelievable frankness. It changed a group which was still in its early period of formation from a rather superficial, polite group into one that operated at a deeper level.

It appeared that the method had the first effect of inhibiting communication between the partners. We note that they "skirted about the edges" of conversations and that apparently they avoided being alone in their home by going out every night. John had a violently aggressive dream in which he symbolically cut the throats of all of the members of the group with great unconcern. May also was quite disturbed by the group, but only because they had picked on John. She went out of her way to emphasize its lack of effect on her to the therapist in a private conversation.

The group wanted to avoid the use of the method, at least until they were better integrated. This might well be considered to be a testimonial for its potential effectiveness. That this is probably true is evident from the writer's use of the Behind-Your-Back technique with another group which had been in longer existence. In this second group the method was accepted well, and has been used several times on the basis of demand.

It would appear that Corsini's basic observation that the simple expe-

dient of preventing visual interaction manages to separate people physically present in a room to such an extent that the discussants are able to bring up material which they ordinarily would suppress. The effect of the discussion appears to have a long lasting and deep reaction which takes time to integrate.

SUMMARY

The Behind-Your-Back technique has been used experimentally in a counselling group, consisting of married couples. It appears that this method caused the emergence of sets of attitudes and of impressions which would ordinarily not have appeared for some time. The method made a strong impression on the individuals, but appeared too threatening for use in a group that had not yet formed strong relationships. However, it did enable the group to proceed to a deeper level of understanding and helped to discuss what would have ordinarily been forbidden material.

THE USE OF VIDEO METHODS IN GROUP PSYCHOTHERAPY*

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The right selection of patients constitutes the principal problem in group psychotherapy. In the particular series of sessions here described all patients change; they participate in a group only as long as they are under therapy and then make room for new arrivals. They are mostly patients with endogeneous or reactive depressions, neurotics, people involved in "problem marriages," etc. The women are between the 20th and 55th years, and most of them are working. They come from the middle classes, but are by no means "intellectuals," with the exception of a physician, who presently is under analysis and is learning group psychotherapy.

I do not wish to enter here into any details of group psychotherapy. Rather do I wish to report on my experience with a method, which I would like to call the "Method of Still-Pictures," a method which was examined previously by Desoille, Federking, Happich, Kretschmer, Jr., and Mauz.

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* Published under the title "Ruhebilder in der Gruppen-Psychotherapie" in *Der Psychologe,* Vol. 9, pp. 347-352, 1953. Translated from the German and abridged by Hans A. Illing, Los Angeles, Calif.

1) So far I have not succeeded in my private practice in collecting male groups. However, this failure is not due—as is usually assumed—to psychological factors but to the fact that men's working days end at different times.

We know from the experiments of Langen, Kretschmer W., June., and from the work of the American pioneers, Moreno, Haas and Enneis, that the group experience enhances the suggestibility of the patient to an extraordinary degree. The mutual exchange of experiences is quite effective and constitutes an important training technique for the therapist, since the elements of the suggestion do not originate from him but from the patients. A record will be played (usually Bach or Haendel) in order to get the patients "harmonized" as much as possible. I employ the following two methods.

Method I. Before playing the record, I pass around a picture. From my experience I can say that a picture like Boecklin's "Herbstgedanken" (Musings in the Fall) will communicate a mood. This picture shows a figure clad in a toga at the edge of a brook which is surrounded by willows and planetrees. The picture has many mediatory aspects.[1]

The patients are asked to remember the picture as much as possible, especially if they are in a state of complete relaxation. After the completion of the depth experience, the picture will again be introduced, verbally. For example, I say to the patients: "Here is the slowly flowing brook at whose edge we sit relaxed and rested. We are very quiet and listen to our unconscious. The quietness is very much in evidence and is very intensive. The quietness, therefore, becomes a part and parcel of us." How important the right selection of a picture is can be seen from the following unsuccessful experiment:

For example, those patients who are forced to wash themselves are not instructed to fight their own impulses.[2] If they fancy they have dirty hands, Frankl recommends that he has them say to themselves: "I want my hands to get still dirtier." The patient is not to fight his own psychic disturbances; rather he should outgrow it and be able to feel: "The neurosis is not anymore above, but below me." This technique, which I learned from Jung, inspired me to present the following word-picture to two patients (it derives from a series by the Japanese painter Hokusai, entitled: "The

[1] Intentionally I did not choose a symbol. For the structure of the group made me assume that a picture with emotional undertones could be better understood *than a symbol which can* become effective only in analysis.

[2] Frankl called this "paradox intention" during therapy.

Highway of Kyoto"): "We are standing on a high mountain peak. We feel as if we are above all difficulties and problems, which are deep down below us. Down in the canyon it is grey, foggy, and misty. But here the air is clear, cold, and pure."—Subsequently I found that both patients started to get cold, to have dizzy spells, etc., as soon as they imagined they were standing on a high mountain peak.

Here are the notes of a 56 year old teacher on the aforementioned session (my diagnosis: manic depression):

> "The quite intense imagination of myself standing on a sunbathed peak and of a mass of clouds below me produced a unique effect on me. Physically I felt nothing; but I had, so to speak, a psychic anxiety, bordering almost on fear. I was in a sort of no-man's-land: the link with my old environment was broken and with the other, perhaps more beautiful one, I did not yet have a link. I lacked the key to the new world. I was freezing and I appeared to be helpless."

Method II. Aside from using a picture that really exists, we can also lead the patient to produce a picture emotionally propelled from his unconscious. I first attempt in individual sessions to get the patients to tell me of a situation which they recall with special vividness. I thus obtained two frequently remembered scenes: lying on a lawn at the foot of a mountain or lying on the shore of a lake.

One of these pictures is painted verbally somewhat like this: "We are lying on a mountain plain; the soil is good and warm, and the sun is shining hot on us. Our bodies are wonderfully relaxed; our blood circulation is healthy. We are looking up at a clear sky in which clouds are slowly wandering." Or: "We are lying beside a lake in dry sand. The warmth of the sand permeates the whole body; very distinctly we can feel the sand between our fingers. The body is like a heavy, warm mass. The shadow of a tree strikes our forehead; the head is comfortably cool."

Here are some case recordings in the patients' own words:

A 36 year old female business employee with sexual complexes wrote:

> "My hands are again very heavy, like masses, and the sun's rays seem to spread over my whole back. I thought of the picture which you described to us in the group yesterday and tried to reproduce it: I stood on a mountain ledge in my *Dirndlkostuem,* breathed deeply with spread-out arms and exclaimed: 'What a happy human being I am!' The blue of the sky was incandescent."

A 46 year old female accountant with migraine headaches of a psychopathological origin wrote:

"The picture of the lake which you described so vividly to us impressed me deeply. However, I think I'm going to choose a different picture which has left a deep impression on me. I was in Abbazzia and often used to sit at the harbor. The most relaxing thing in the world was to hear the waves breaking on the shore. Whenever I imagine this noise and simultaneously breathe in keeping with the rhythm, I experience a relaxation such as I never before in my life knew."

And a 39 year old domestic employee with sudden attacks of heart palpitation wrote:

"Since you described the good picture to me [the breast cavity as a large and dark room; a red, not fully inflated, rubber ball being thrown at the wall], the impact on my 'heart' is genuine, whenever I observe my own breathing. Since then I try more often to think of pictures. The lawn with the cacti seems to me especially attractive [a small drawing at the margin of the recording]. For the first time I noticed that I dreamt in colors."

Present-day Methods of Psychotherapy. It cannot be stressed enough that the "Method of Still-pictures" is not to be confused with the old magic of hypnosis. We train during daylight and do not employ any tricks.

This method is not something opposed to analysis. We also have to be aware that only a fraction of the patients can be considered for analytical therapy. There will always be people who not only are desirous of inner experiences, but who also experience dreams and are not afraid of discussions verbalizing their experiences.

THE AUXILIARY CHAIR TECHNIQUE—A CASE STUDY

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Don Wright was something of a "holy terror" in his third grade class. He was not liked by his classmates for he could be an aggressive bully. A special program of role playing seemed to help Don make progress toward improving his behavior during the summer school session. At the end of the summer, the teacher reported that Don was "more positive, less bossy, now more a part of the group, and the children probably like him better."

This project was supported by a grant from the National Institute of Mental Health of the U. S. Public Health Service. The research was conducted by Ronald Lippitt, Sidney Rosen and George Lesinger. The experimental helping sessions were supervised by Rosemary Lippitt.

This was one of the cases in a study conducted by the Research Center for Group Dynamics of the University of Michigan. During this study a systematic approach was developed, for short term role playing, guidance, to help change the behavior of rejected or "left out" children. This procedure of giving help can be illustrated by describing the sequential development of the work with Don. Near sociometric and observational data were gathered by the research staff on the entire class. These data, plus [about 15 or 20 minutes of limited] observation of classroom behavior by the helper or "change agent," served as the basis for planning the first one hour session with the child. A second observation by the research staff, plus the case history of the first session of role playing, served as the basis for planning the second session. Near sociometric measurements and observations were taken at the close of the six weeks summer session to measure the change. There were only two hours spent in actual role playing with the child. Planning for each hour of role playing usually occupied two hours.

The change agent planned the session with the help of the consulting psychotherapist, trained in the techniques of role playing.

Initial Research Data:

The research data on Don Wright showed that he was the least liked among all of the boys in his class and was rated by the other boys as having the least social influence. He gave and received the lowest amount of positive affect and spent the least time with other boys. He made only an average number of influence attempts, usually of a bossy nature, and was consequently not very successful. The data also showed that Don did not have an accurate self perception of how the other children felt about him and his behavior.

From the data and observations, the psychotherapist and the change agent felt that Don was not a seriously maladjusted child and that his difficulties stemmed from a lack of social behavior skills and lack of insight into how the other children felt about his behavior.

Plan for Giving Help: From these research data and observations, the following aims were developed: (1) It was hoped that Don could be given some insight into the cause and effect of behavior (in children's groups). It was hoped that he could be sensitized to not only his own aggressive behavior but also to the behavior of the shy child. (2) Once the insight into the cause of the behavior (on the feeling level) was reached, it was hoped that Don might be helped to try out more appropriate behavior

and practice it until it became part of his own pattern. It was felt that he might not know how to make friends or how to give praise or be helpful. It was unclear whether he had a basic need to be aggressive. It was hoped that he could become more cooperative, more sensitive to others and thus be less forceful and less selfish.

The Chair Game: A procedure was worked out which filled the following needs:

1. It was fun for the children and could be introduced to the classroom before the sessions began. In this way the stigma of special help was avoided for the children because all knew that the "chair game" involved a charade-like activity. They understood that the helpers were interested in finding new ways for children to have fun, and they all wanted to be in on the game.
2. It provided a quick medium for giving insights into behavior and feedback of the near sociometric data without direct reference to the child himself. It thus prevented shock and allowed the child to identify with as much of the insight as he was ready to absorb.
3. It provided an efficient method for supplying other imaginary members in the session without the need for actual people. They were represented by folding chairs with arms.
4. It encouraged projection and identification, for the chair could be helped to mirror the child's teacher's, or any one's behavior.
5. It provided a setting for skill practice of social behavior.
6. It permitted different levels of learning and allowed the child to return to the first charade-like level if the material became too threatening.

Specifications for the technique will be brought out in the two sessions that follow:

The First Helping Session: Don had been introduced to the "chair game" in his class. At that time the helper had entered the room, lined up 5 chairs and challenged the children to guess who each might be. He then spoke and acted with or for each chair. The group had been working on hand puppets so the helper started off by saying, "Here is a child sitting making something. Yes, he is holding it up like this. It is moving on his hand. What is the child doing?" Of course they guessed it correctly. Then the helper took one chair and turned it over in the position of an animal. Now he said, "Look, this chair is walking on four feet. It is following me. It has a nice long tail and long fur. It likes bones to eat." Thus the game continued. With the older ages it involved characters of literature and history.

Step I—Introducing the game and discovering safe areas.

A few days after Don had played the game in class he was asked to go with the helper to play the chair game again. On the way to the experimental room the helper asked Don what he was interested in and what games he liked to play. This was to improve rapport and to discover possible episodes for the first role playing situations. In the warm up of the chair game the helper sought a few situations that were especially enjoyable to each child. These situations were replayed with minor variations whenever the insights became too threatening or the child tried to change the subject. With Don it was baseball and celebrating his birthday that he really enjoyed. The chairs provided the other members of the team and the friends bringing him gifts. As soon as these two situations were discovered the helper moved into the next step.

Step II—The feeling behind behavior.

Gradually the game shifted from "who am I," and "what am I." or the birthday to "How am I feeling?" or "How is he feeling?" The change agent acted sad, mad, happy, and Don was asked to guess how the helper was feeling. Don was then encouraged to act out a way of feeling and he acted being sleepy. Then Don was shown a chair coming into the group and acting shy and reticent. (A type of behavior different from his own, but one he needed to understand.) He had some difficulty in detecting the feelings of being shy or afraid to enter the group. He was then shown a chair behaving in an active rather rude manner, typical of Don's own behavior. Don was a little shy, but responded that he was pushing to see the books like the other children. (Don was small for his size.) The helper then moved into the next step.

Step III—Cause of behavior.

"Why was the boy acting this way?" Don responded that "he got up on the wrong side of bed" and then "His mother scolded him this morning and a boy hit him." It was much harder for Don to figure out why the child might be feeling shy than why he might be feeling aggressive. As soon as Don was able to accept the idea that behavior had a cause, the helper moved into the next step.

Step IV—How do others feel about the behavior?

Don was asked how the others felt about the shy and retiring chairs and then finally the more aggressive ones. Each time the helper used a chair to represent a child and followed through the steps of "How is he feeling,"

"Why the behavior" and then "How do others feel about the behavior?" each behavior was treated in a matter-of-fact way as having cause and effect. Aggressive behavior was not condemned or criticized, but it was shown to have a negative effect upon some of the others.

Step V—Helping others change behavior.

The next step involved showing how the other chairs might act to make the shy or aggressive child feel more at ease and more at home in the group. At one time Don talked back to the aggressive chair and told him to be more patient, "The other kids don't like it." At this opening the helper moved into the next phase.

Step VI—Changing own behavior.

Don enthusiastically showed the shy chair how to enter the group and how to take his place among the group. He proudly acted the role of the shy one and showed how he should be less fearful. He seemed to gain some insight into the feelings of this role. He was then confronted with active behavior similar to his own. However no comment was made to suggest that the helper thought the behavior was typical of Don's social relationships. Don was free to reject the behavior, accept it and keep it to himself or share the acceptance with the helper. He was fascinated watching the helper approach the "chair group" aggressively, kicking the chairs, pulling the girl's hair and then grab the imaginary bat from the batter. He watched intently and seemed to get insight into how others may see and feel about his own behavior. Don was hesitant to show the aggressor how to act so the helper showed him and guided him in different ways of behaving. This type of active behavior was put into several settings. Finally the helper mirrored Don's behavior in the extreme, by setting up a line of children (chairs) waiting for a drink at a fountain and Don was at the end of the line. The change agent, acting like the aggressive child, pushed his way into the front of the line, a behavior that Don had been known to exhibit. Don was asked what he thought of such actions and how he should act to handle this situation. Again the helper made no suggestion of it being Don's behavior. Both he and the change agent role played what they should do to handle this situation. Don was then asked how this boy (the bully) should act, even though he was thirsty, and Don was helped to role play out the new behavior. He did this in several different situations to gain social behavior skills.

Throughout the hour session, there were periods in which Don needed

ego support. The change agent gave him this when it was needed (when Don seemed threatened, attempted to "leave the field," or had just received some close insight). At such times the change agent and Don role played baseball games where Don hit almost endless home runs and birthday parties with Don receiving gifts from all the children—which he enjoyed greatly. Don became so immersed in role playing that it was easy for the helper to do almost anything with the setting.

Step VII—Intention Setting.

At the close of the session Don walked back to his classroom with the helper. On their way back the helper suggested that Don might like to try some of these different ways of behaving in the classroom. He agreed, but offered no more suggestions. Some children mentioned the things they would like to try first and which they felt the most important or hardest to carry out.

Following the first session, Don walked slowly back to his classmates who were playing baseball. Two children hit him in the course of the playing but Don didn't hit back! He actually gave the baseball to another child and later he was seen helping another child to get a drink.

Second Helping Session

The observations and the research data taken during the intervening two weeks indicated that the first session had influenced Don and that the second session should support the aims of the first session, by repeating many of the things that were done in the first session. In addition, it was hoped that Don could be helped more from the level of "talking about other children" and their problems and actions to the level of "talking about his own" problems and actions.

In the second session many of the problems were re-role played in different settings. Don's actions in a re-role play of such scenes as the drinking fountain line indicated that Don had at least partially internalized the learning for he was now more thoughtful of the others and was able to act this way almost unhesitatingly. Don was able to speak more freely about himself and when the helper asked Don if there were any problems that he would like to work on, Don answered "making friends." Don and the change agent thought out ways that a boy might make friends. When these ideas were role played Don soon saw which ones were not effective and which ones he should try to use with the children.

Results

At the end of the summer (3 weeks after the second session), remeasurements were taken by the research staff. Don's score on being liked by the others changed from twelfth (lowest in the class) to sixth and the judgments by the others in the class showed that he had jumped from twelfth (lowest) to seventh in personal influence. From observations made by the research team, the teacher, and the change agent, Don became more friendly, less bossy, less forceful, much better liked, and changed from twelfth (lowest) to first (highest) in the number of friendly acts (approval, friendly gestures, etc.) that he gave other children. It was felt that the role playing made a definite contribution to this change. In a single case study such as this it is, of course, impossible to judge how much of the movement was contributed by this special helping procedure.

Concluding Remarks

It seemed to the change agent that unless the deviancy is the result of deep psychological problems, deviant children seem to lack at least three things. First many children do not understand that there are reasons why children act as they do. For example, they do not know that often the boy who teases a girl may be trying to make friends or that the boy who doesn't join the group may feel that others don't like him or that he is new and unsure about what he should do. Secondly, many of these children do not know some of the simple things of good social relations, such as how to make friends, through sharing things, talking with others about things of common interest, smiling, and giving recognition to other's achievements when they merit comment.

Thirdly, many of these children need ego support in order to try out new behaviors.

It seems one can help children like Don Wright, who have social relation problems, on the behavioral level through intensive, carefully planned, and goal directed role playing. Even a few sessions may help them be happier and better developed individuals as well as better group members. The rewards they receive from others for their changed behavior helps support and stabilize the change.

COMMENTS

Plan of Discussion

The second session is starting. The group consists of nine psychiatrists, Drs. Nathan W. Ackerman, Cornelius Beukenkamp, Walter Bromberg, Louis S. Cholden, Earl A. Loomis, Jules H. Masserman, J. L. Moreno, John W. Turner, Joseph B. Wheelwright; four psychologists, Drs. Raymond J. Corsini, Robert James, W. Lynn Smith and Stanley Standal; one sociologist, Dr. Wellman J. Warner. Besides the actual participants a number of symbolic characters have entered the sociogram; their influence upon its structure is profound and therefore they will be treated as if they were present, Freud, Adler, Jung, Meyer, Sullivan and Rank.

I am herewith opening the second session, and want first of all, to thank those who took part in the first session for their participation, and to welcome the newcomers among us. I will try to be the advocate of every position taken by any of the participants, going beyond my own bias, representing, for instance, Freudian psychoanalysis, exploring the system of the unconscious, trying to show its good and bad features. This should not imply, however, that I accept it. Similarly, I will defend the Jungian position or the non-directive counseling approach, the sociological approach, etc., without, however, being identical with them. This I will do in the hope that by bringing the pros and cons out into the open, a better understanding of the various views will be reached, even where agreement is not attainable. In other words, I will apply here the principles of group psychotherapy, respect of the *spontaneity* of group members, *permissiveness, interacting out,* etc. I say "therapy" because it is hoped that some catharsis and integration will take place in the participants themselves, for whom the ideas which they advocate are not free from their emotional involvement. As already visible in the first comments, I will frequently be the center of attack as well as of approval. Therefore, I will support my attackers in their criticism of my views, even going to the point of attacking myself. But, in order to strike the proper balance, I will clarify and extend the statements of those who appear to be in my favor.

The old conflicts between the Freudian, Alderian, Jungian and Meyerian schools will find their proper echo, but, we will find that the newer schools are developing new conflicts amongst themselves, in part, just as irrational as the ones which existed between Freud, Adler and Jung. Although this session is principally didactic, dealing with ideas and methods, we won't be able to leave problems of priority and feelings of rivalry entirely undiscussed. Let

us look at the sociogram. Here is the figure of Freud. He suffered all his life from a "paternity syndrome".[1] You all remember, among many others, the incident on November 24th, 1912, in Münich. After finishing luncheon he reproached Jung for writing articles on psychoanalysis without mentioning his name. During the discussion with Jung he fell on the floor and collapsed.[2] This incident is symbolic for Freud's relationship to his pupils, whether Jung, Adler or any other who left the ranks. He suspiciously looked over quotations, footnotes or tables of references, frequently with good reasons for being annoyed. Let us look at the other figures in the sociogram, Jung, Adler, Rank, who have been referred to up to now in our group session. They, too, suffered in relationship to Freud but from what I would like to call "creator envy".[3] But let us look at the "father", Freud, from the point of view of the "sons", Jung, Adler, and so forth. Freud saw clearly what they took from him, but he was blind to what they added. Adler tried to get out of the unconscious as fast as possible and to move into the social reality of human events; he was an incipient sociometrist in his analysis of family constellations. Jung, on the other hand, tried to go into the unconscious as deeply as possible and almost lost contact with the reality of the individual. On the side we see the figure of Adolf Meyer, whose networks of influence are deep and far-reaching, but he has not produced as many cold wars as his European colleagues. The dynamic relation between these and other key figures and their relationship to all of us who are taking part in these group sessions will come into focus from time to time.

In order to avoid misunderstanding and dispell false rumors I will add here a few autobiographical notes. I have never been a pupil of Freud. My

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[1] See *Who Shall Survive?* p. lxxxvi, Preludes.

[2] See *The Life and Work of Sigmund Freud,* Ernest Jones, Basic Books, 1953, p. 317. The interpersonal dynamics involved in "paternity syndrome" and "creator envy" is a better explanation of the incident in Münich than Jones' reference to that esoteric meaning which death was supposed to have for Freud. The first words which he spoke as he was coming to from the faint "How sweet it must be to die" are like the manifest abreactions after a dream. What Freud might have meant is "how wonderful it was when I was free from priority worries, working all by myself, without any followers, without sons who might try to rob me and put me to death. When I look back to those lonely years from the perplexities and pressure of the present it seems to me like a beautiful and heroic era. The 'splendid isolation' was not lacking in advantages and in charms, I did not have to read any of the medical literature or listen to any ill-informed opponents. I was subject to no influences, and no pressure was brought to bear on me." (From *The Basic Writings of Sigmund Freud,* "History of the Psychoanalytic Movement", p. 943.)

[3] *Who Shall Survive?* p. 25.

acquaintance with him in 1911 was superficial and coincidental with my working in the psychiatric clinic in the University of Vienna. My position was then in favor of rapprochement between religion, psychiatry and sociology, and therefore opposed to Freud's biological psychology. Contrary to rumors, I have never been psychoanalyzed; I share this fate with Freud and God Himself, but I am perhaps the most analyzed and evaluated psychotherapist living by having stood in front of groups for more than thirty-five years, being questioned, interviewed, ridiculed by thousands of persons as well as by therapists of all schools.

MORENO'S TRANSFERENCE, COUNTERTRANSFERENCE AND TELE: THEIR RELATION TO GROUP RESEARCH AND GROUP PSYCHOTHERAPY

N. W. Ackerman

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Ever since reading Moreno's "Who Shall Survive" in 1938 I have followed his original and crusading efforts in group psychotherapy with interest and admiration. I am personally indebted to him for an awakening to the crucial problems of group interaction and the individual's emotional integration into the group. In this present paper on "Transference and Tele," true to his enterprising character, Moreno presents a broad challenge to psychotherapists of every school and vintage. He says, in effect, "Let's be big about this. We've got to be. We confront nothing less than the problem of mental health of all humanity. It is high time that we gave up our obsessive brooding over small differences and reached out beyond them for a consensus on the essentials of the psychotherapeutic experience. What are the common features of psychotherapy regardless of their varied forms?"

In setting before us this sweeping challenge Moreno shows courage and foresight. He appeals to us with open sincerity to lower the mean barriers of mistrust among us and put aside the trivialities of narrow prejudice. He takes leadership in energizing a more effective communication across the anachronistic barricades which separate the various schools of psychotherapy. We would surely be remiss, if we failed to answer this appeal.

In this paper Moreno describes with admirable clarity and simplicity, and with a minimum of esoteric jargon, some of the basic dynamisms of the psychotherapeutic relationship. He suggests that every such relationship contains the elements of both transference and tele. Transference reflects the one person's unreal perception of the other; tele, by contrast, represents the one person's correct intuitive estimate of the actualities of the other. These two elements may be present in varying proportion. Moreno says further: the process moves both ways. The therapist as well as the patient may engage in irrational projections. The therapist reacts to his patient as one human being to another; he too feels his way into the patient toward an accurate intuitive estimate of his human quality. The therapist as well as the patient invests the relationship with emotional needs of his own. Thus, Moreno depicts an open, free and more democratic view of the therapeutic relationship. Each member of the pair exerts psychological influence upon the other and the therapeutic effects may move in either direction. Here Moreno rejects forthrightly any hierarchical structuring of the patient-therapist relationship in terms of superiority and inferiority.

There is little doubt in my mind that psychoanalysts give increasing recognition to the validity of these basic principles though they may use a different language. In psychotherapeutic practice today, there is increasing concern with the dynamics of interpersonal relations, with the importance of current experience as against the past; the significance of the phenomena of counter-transference and a frank acceptance of the principle that the actualities of behavior in the two-person therapeutic relationship are as significant in determining the outcome as the patterns of irrational unconscious motivation. At least in certain quarters mental health is now viewed as a phenomenon not restricted to what is inside one person but as something to be evaluated within the person, between persons, in the group life of the family, and in the structure of social relations in the entire community. The development of personality is viewed in a broader frame which involves the individual organism, family and society. The adaptational theory of personality places an increasing stress on the study of three phenomenological levels: individual personality, role adaptation and group structure.

Moreno's pioneer leadership in the field of study of group interaction, role behavior, and the mental health of social structure deserves wider recognition.

COMMENTS ON "INTERPERSONAL THERAPY, GROUP PSYCHOTHERAPY AND THE FUNCTION OF THE UNCONSCIOUS"

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The unveiling of Moreno's plan for a group discussion via correspondence, with its basic wish to find the common denominator in group and individual psychotherapy, indicates a truly ingenious experiment. This larger horizon allows a brief review of comments on Lecture I published in the last issue of this journal.

This commentator would sum up his reflections on the tele phenomenon by the assumption that tele refers to a *primary* human interrelationship. As observed in experiences with therapeutic groups, tele is to be considered as a positive bond, an ongoing force, seen in its most simple form, when one group member becomes interested in helping another. In this sense it is a force making for social cooperation through spontaneous solidarity suggesting the essence of Kropotkin's "Mutual Aid". However, if we are not to fall into mystical connotations, tele should be defined in terms of human emotions. By analogy with the transference phenomena one would expect to find irrational factors. An appreciation of the nature of tele would suggest removal of these irrational or unconscious factors, if they be present, from the primary interpersonal relationship through some experimental setting such as suggested by Moreno. Already the alteration of "the unalterable relationship in which the therapist is designated as 'healer' (the fixed role)," has revealed that some of these irrational factors are inherent in the respective roles of patient and physician. The present democratization of psychotherapy with its dethroning of the therapist and dilution of the overtones of his role might well allow clearer perception of the basic primary relationship factor.

From this point of view the "rich implications of unconscious elements in a personality" which are drawn into the transference situation in individual therapy, might prove to be a luxuriant possession which will have less effective meaning in individual psychotherapy than heretofore supposed. If the therapeutic effect in group work operates through the hypothetical tele, the problem of a "common unconscious" within a group of two or three (which the writer takes to be other than the collective unconscious) or a co-unconscious might not be as significant as its understanding in a theoretical system demands.

Another question suggests itself, mainly, is the "feeling into", the "Zweifuhlung" a sign of some deeper level of relationship, a kind of universalism that exists under the surface in all human contacts which is another order of thing than the unconscious mentation that is sought in the psychoanalytic situation. This would be a universalistic feeling which has been expressed in symbolic forms, organized institutions and art forms. Again, is it possible that the effective psychotherapeutic force may simply utilize telic function as a vehicle for exertion of its effects and that that which brings about emotional or conative changes in a "patient" is another influence yet unknown.

These are questions which a group therapist divines from contact with various types of group situations and which cannot be answered without experimental work of a type being developed through Moreno's resourcefulness and ingenuity.

COMMENTS ON MORENO'S "INTERPERSONAL THERAPY, GROUP PSYCHOTHERAPY AND THE FUNCTION OF THE UNCONSCIOUS"

JULES H. MASSERMAN

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My discussion of Moreno's first lecture consisted of less than 300 words —an instance of remarkable restraint. And yet it has already elicited comments several scores of times its own length, some favorable and some perhaps not quite. The latter were mostly to the effect that nowhere in his Autobiography, as I stated, did Freud literally propound a "dictum . . . in which he identifies a transference neurosis as an artifact of poor therapeutic technique." Such strictures typify many of our current dialectic difficulties: a preoccupation with exegetic verbalisms in lieu of scientific principles and operations. However, since it seems necessary to do so, let us examine the case on this level also.

To begin with, therapists that regard "the establishment of a transference neurosis" as the essence of the psychoanalytic procedure cannot mean what Freud meant by the term "transference neurosis", else they would be saying that analytic therapy must result in "hysteria and obsessional neurosis"—the only forms of transference neuroses described by Freud, and distinguished by him from the "narcissistic neurosis or paraphenia.* So also,

* Freud, S.: The Predisposition to Obsessional Neurosis. Collected Papers, II,

those that insist on the "specificity of the cure by working through the stage of transference neurosis" must mean something other than the essential analysis of transference itself as exemplifying the patient's patterns of interpersonal transactions. Upon this Freud commented as follows.**

> "It must not be supposed, however, that transference is created by analysis and does not occur apart from it. Transference is *merely uncovered and isolated* by analysis. It is a universal phenomenon of the human mind, *it decides the success of all medical influence,* and in fact dominates the whole of each person's relations to his human environment. *We can easily recognize it as the same dynamic factor that the hypnotists have named "suggestibility" which is the agent of hypnotic rapport and whose incalculable behavior led to such difficulties with the cathartic method."*

Elsewhere in his Autobiography (p. 48) Freud also comments:*

> "One of my most acquisecent patients, with whom hypnotism had enabled me to bring about the most marvelous results, and whom I was engaged in relieving of her suffering by tracing back her attacks of pain to their origins, as she woke up on one occasion, threw her arms round my neck. . . . In order to exclude [such transference] or at all events to isolate it, it was necessary to abandon hypnotism."

Here, then, Freud clearly states his position on *perversions and misapplications of transference* (i.e., transference neuroses, in the remaining current sense) as being due to errors in therapeutic concept and technique. Though such errors may no longer take the form of crude hypnotic or cathartic procedures, they are still latent in over-long, and sometimes seductively unrealistic and misleading forms of individual therapy. Indeed, the well-intentioned but not frequently adverse complications of such therapies are in a sense comparable to the rationalizations of the medieval surgeon, who proclaimed that no wound could heal deeply unless he produced what he euphemistically called "laudable pus".

With the perhaps over-cryptic statements in my first comments on Moreno's article thus amplified, we may proceed to his second lecture. And here, I must confess that his somewhat indiscriminate broadside against three patriarchs in our field and their current groups of disciples produced a protective counter-reaction in me: I am opposed in principle to genocide.

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p. 124; Neurosis and Psychosis, *Zeitsehr f. Psa.* Pd 10, 1924; Further Recommendations in the Technique of Psychoanalysis. Collected Papers II, p. 344 (footnote); On Narcissism, Collected Papers, Vol. IV, p. 403.

** Freud, S.: An Autobiographical Study. London: Hogarth Press, 1950, p. 76 (Italics mine).

Freud did *not* deal exclusively with the "individual unconscious", any more than a roentgenologist deals only with "individual" shadows; the roentgenologist knows that, though each patient is different, his insides fit a pattern of structure and function common to *homo sapiens*, thus making possible a generalized *science* of roentgenology. I am more in sympathy with Moreno's plea for a continuum from Conscious through Preconscious to Unconscious—a position long maintained by Adolph Meyer in his relativistic concepts of "more or less conscious" motivation and symbolic behavior. Moreno likewise under-estimates the holding power of Jung's "anchor in the . . . collective unconscious", since it is ostensibly embedded in strata deeper than the Old Stone Age. Nor is Adler's "individual psychology" given sufficient credit for recognizing marked individual differences in "life style". Moreno's position is not as different from Sullivan's as might appear from the second lecture, since both are interested not alone in what the patient learns about interpersonal relations in the office or on the stage, but in how the patient applies his newer knowledge and orientations in more important social roles outside. Moreno is on firmer ground when he acknowledges the kinship rather than the difference between these metapsychologies and his own.

The remainder of Moreno's second lecture apparently assumes that everyone is familiar with the rationale of his techniques of role reversal, double, mirror, etc.—a sanguine assumption which must hold if the reader is to go beyond Moreno's words to his essentially dynamic meanings. Parenthetically, as to the "passing of the psychoanalytic system" (defined as a progressive science rather than as a dogma or *brunderbund*)—we may quote Mark Twain's comment on his reported demise: "The rumor has been much exaggerated." However, Moreno is, as usual, synoptic, provocative—and stimulating; for example, this comment is considerably more than 300 words long.

DISCUSSION OF DR. MORENO'S ARTICLE—"TRANSFERENCE, COUNTER-TRANSFERENCE AND TELE"

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In his article "Transference Counter-Transference and Tele," Dr. Moreno has effectively pointed up some areas of confusion in our present psychiatric thinking. This in itself is a noteworthy and important task. How-

ever in clarifying some of these problem areas, Dr. Moreno has instituted new word models that suffer from the same lack of clarity and definition that is characteristic of the subjects he is studying. Consequently we see in this article a sensitive portrayal of areas of deficiency, with the addition of new areas which, however important they may be, also contain inherent defects.

The author asks the hopeful question, "How can the various methods of psychotherapy be brought into agreement, into a single comprehensive system?" This eclectic concept which emphasizes a variegated approach to the therapeutic situation is stimulating to consider. However, the basic question seems to be whether such an effort is philosophically conceivable. Dr. Moreno states "At times there may be an indication for using an authoritarian, and other times a democratic method, at times it may be necessary to be more direct or more passive, but one has to be willing to move gradually from one extreme to the other if the situation requires." This intriguing flexibility presumes that the psychotherapist takes a certain dose of authoritarianism out of his armamentarium and gives that in response to the patient's need, etc. However one has to feel that the authoritarian relationship has some deep implications in psychotherapy as does the democratic method. The therapist must work on some basic, consistent concept of patient-therapist relationship. This reviewer questions whether he can simply serve as the dispenser of one or another type of therapy. Of course, there must be room for movement within each therapeutic conceptual scheme. However it would seem to be a vain hope to believe that all of the extant psychotherapeutic systems are congruent; that contradictions do not exist.

Dr. Moreno points up an important aspect of transference when he emphasizes the fact that transference and counter-transference are of the same genre. That basically it depends on whether one is sitting behind the couch or lying on the couch, that determines whether the name given for the distorted aspects of the relationship are transference or counter-transference. It might be said that in the individual psychotherapeutic situation not two people are present, but rather two bodies; and the many roles that each of these body does and can portray as a sender, and the many roles that each of these bodies perceives as a receiver. It is for this reason that individual psychotherapy can never be reduplicated, a factor that is true both for the psychotherapist and for the patient. Each psychotherapist will react differently to each patient and vice versa. This inevitably simple fact is the greatest stumbling block to the scientific assessment and evaluation of the psychotherapeutic process. Most of our basic scientific methods require

comparison studies, and the comparison is the one thing that has little relevance in the study of psychotherapy.

When Dr. Moreno first presented the concept of tele in this paper I felt that he was describing the awareness of the patient whether by intuition, subliminal clues, or clear evidence of the therapist in reality, that tele would be undistorted by the transference aspect of the relationship. However, as I read on and attempted to get a clearer concept of tele I became somewhat unsure, for it would seem that tele is another way of describing transference. I came to this conclusion inasmuch as the patient tele awareness seems to change as a result of closer association. While this may result from increasing amount of "reality" data, it also makes the concept of tele seem much more like the concept of transference than the original definition which Dr. Moreno offered. If the tele is an intuitive and integrative awareness of reality based on cues that are below our limen of awareness, this is a very important formulation and really requires much further study. However, it must be more clearly delineated and conceptualized.

The author's excellent discussion of the concept of transference to a role is seldom so clearly seen in our literature. We speak of our patients' attitude toward the father figure or authority figure or mother surrogate or nourishing institution, but do we realize these as transference factors in which the individual reacts to the role-figure. These role-figures and the many sub-roles that Dr. Moreno discusses have important valence in our understanding of the whole psychotherapeutic relationship. What the patient's specific set of behavioral manifestations and expectations toward a person entitled doctor is, is certainly an important consideration in the study of the therapeutic dyad. The doctors' specific reaction characteristic towards different types of patient roles also must be seriously evaluated in this dyad.

I wonder about the validity of studying the psychotherapeutic situation by the "role playing" method. For no matter how much psychotherapists and subject are attempting to imitate the therapy situation, it seems quite impossible that the situation can be successfully acted out. For by definition the major drive in the psychotherapeutic situation would be lacking, namely, the motivation to achieve a therapeutic goal. How anyone can act as though he were in a therapeutic situation without the motivation for a change and this to be studied as though it were a therapeutic situation, eludes me. One must be a Heisenbergian in thinking of the study of the evaluation of psychotherapy. However as Parloff points out, this must not paralyze our thinking.

This stimulating paper raises a number of important points and ends on a note of hope. For the prospect that such things as transference, counter-transference, tele, etc., can be studied by sociometric methods in the group situation is very important. While it is difficult to shift the gears in transposing concepts derived from the group of 2, to a group of 6 or 8, it may be easier to study the large group and derive meaningful laws of behavior from them. These studies, if successful, should be anticipated with joy, for they will be milestones in our science.

COMMENTS, APPRECIATION, AND CRITIQUE OF J. L. MORENO'S

Interpersonal Therapy, Group Psychotherapy, and the Function of the Unconscious

(in *Group Psychotherapy*, Vol. 7, December 1954, No. 3/4)

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Having got my feet wet in discussing Dr. Moreno's "First European Lecture" (1954), I am tempted to plunge in a little deeper and discuss his "Second." Certainly examination of the varied, yet convergent comments on the first round suggests the probable fruitfulness of facing seriously some of these hitherto frequently unclarified and neglected aspects of our work.

The topic of the *therapeutic triad* (two patients and a therapist) is probably familiar to those who have done marital and family counseling, including many in child guidance work who have seen parents jointly, and sometimes a parent and a child. For many others this has been a "hot seat" scrupulously avoided, either because of honest recognition of potential discomfort for the therapist or because of rationalizations in terms of possible violation of "therapeutic purity." That individual handling in certain cases is not only justified but imperative is undeniable. That it is necessary to develop new techniques for the therapist's survival and effectiveness if he is going to work in novel settings involving more than one patient in the room with him at once is also self-evident. Despite these two obstacles or challenges, I believe more and more of us are discovering the worth of these new approaches in selected instances. That diagnostic information is gained by such techniques has been understood for a long time. That therapeutic advantages might lie in the joint interview has been largely neglected. And

that a special kind of tie, relationship, or now TELE, inheres in such a process seems now to be effectively publicized and acknowledged.

Moreno's recognition of the dissimilarities of his concept of the *unconscious* to Jung's *collective unconscious* is astute and points up the need for new theory to account for collective relatedness that includes concreteness and interpersonal relations, in contrast with a body of ideas, symbols, or images. Powerful as the latter may be, they are not on the basic "*tele* exchange" unless activated by personal meaningfulness and interaction, at least as thus far formulated. (The late Charles Williams has given them a kind of spiritual flesh and blood and animation that might well make meaningful their category of being—but this is not the way in which Jungians generally have employed them.) The concept of co-unconscious (dyadic or triadic unconscious), however, has implications for symbiotic states.

In directing himself to the problem of the whole and the parts, the individual and the collective, and the relevance of the foregoing for pairs in treatment, Moreno touches on a topic of keen interest to those studying the symbiosis-autism axis in schizophrenic or atypical children. For some time mother has been seen as an external ego for the child, who provides for him whatever undeveloped ego functions he requires until he is able to exercise them for himself. Moreno approaches the *interpersonal neurosis* by offering himself as the external ego for the relationship between the members of the pair. It seems he has the joint task of both increasing communication, on the one hand, and increasing individuation, on the other. He lists ten techniques in approaching his therapeutic goals; especially exciting is the ninth, the consciously executed *folie á double*; the tenth, the mirror approach, also has implications for the concept of *optimal distance* (here, from one's own image).

Interpersonal syndromes and *interpersonal therapy* are terms which deserve examination and application. The possibility of linkage of the associations of one patient with the unconscious of another has implications for therapy, interpersonal relations, communication theory, extrasensory perception, and the earliest kinds of communication between mother and child. Whether there is a common unconscious or not, the synchronicity of two persons in a close relationship is strikingly evident: the mother who knows when her children are hungry, and the husband who knows when his wife is sad. The implications of these ties for therapy deserve exploration. The sharing of fantasy between patient and doctor was recognized by Freud in both his recognition of a common language of the unconscious and the suggestion that the analyst employ an evenly hovering attention. Rosen and Whitaker have

extended this to the therapist's voicing *his own* fantasies to the patient. That the boundaries of the unconscious and preconscious are probably not sharp is testified to by the *shifting ego states* (Ekstein) of most of us throughout the day and night and is most dramatically evidenced in borderline psychotic states of children.

I look forward with keen interest to the development of the remaining lectures in Dr. Moreno's European series and to the comments on this and the subsequent lectures.

MORENO'S "INTERPERSONAL THERAPY, GROUP THERAPY AND THE FUNCTION OF THE UNCONSCIOUS"— A DISCUSSION

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Approximately a half-century has passed since Freud arrived at the construct "unconscious" to better explain behavioral phenomena. Through the years his clinical observations have endured; however, the unconscious as an entity, a storage place for all repressed material, has all but disappeared as an explanatory concept. Dr. Moreno is entirely justified in leveling criticism at the constructs of conscious, pre-conscious and unconscious, and is quite correct in his appeal for "clarification of terms, concepts, operations and common aims". Yet I cannot help but have the vague impression that Dr. Moreno is inadvertently throwing out the baby with the bath. The system of insights should not disappear with the entity. This, I am certain, is not the intention so I would like to start my discussion with the entity down the drain and the babe safely in arm. If you will be considerate enough to permit another point in extension of this analogy, I would like to add that this baby has been buffeted from pillar to post in various home-placements. Especially traumatic were those of Freud, Adler and Jung, where different languages were spoken and inconsistencies glaring. Resultingly, this baby is in need of an "Esperanto", a common language to reduce some of its tension and enable it to communicate—perhaps it would have been better understood if the masters of the house had applied operationism and theory construction, and taught it how to live within a continuum of awareness.

Moreno stresses the need in this area for ". . . logically constructed

theory and clinical methods . . . to bridge over from the individual to the treatment of interpersonal ensembles; . . .". The central issue in Moreno's interpersonal therapy as I see it, involves communication both from the standpoint of pragmatics, that is, signs and users of signs, and communication science *per se*. It appears reasonable that much of the elaborations of unconscious phenomena could be explained on the basis of avoidant behavior, sign learning, associative conditioning, problem solving patterns, etc. and be discussed in the language of learning theory. Or even better than learning terminology, which often helps clarify the process but provides a somewhat garbled language, would be semiotic. With semiotic, the science of signs, one could talk about, describe or apply signs for varied purposes. Perhaps the answer to the problems of the co-unconscious, or communication between and among the individuals' unconscious, is in the province of semiosis, or sign-process, a process in which something is a sign to some organism.

Each patient, in communication terms, is capable of sending, receiving, channelizing and evaluating. All these aspects of communication can occur at various points along the continuum of awareness. Freud was interested primarily in intrapsychic functions; Moreno, however, is in quest of an extension and more comprehensive understanding of the intra *and* interpsychic phenomena as aspects of interpersonal communication, the latter, a relatively unexplored area. The interpersonal region contains tremendous potential but it also creates more problems than it solves. Although the quantity of problems in itself is not necessarily a deterrant, the quality and dimensions of interaction take on unfamiliar characteristics and pushes us into areas in which theory and research methods are almost non-existent. Those less adventurous, who prefer plenty of spade-work to be done before being called on for critical evaluation of an original contribution, will undoubtedly shy away from this pioneering region. Ruesch and Bateson, somewhat more inquisitive, remind us that the observer, participant or otherwise, can focus on or change the various levels of communication although the characteristics and limitations of the observer's perceptual apparatus remain the same. That is, the therapeutic eye-glass can be placed close to the individual (Freud, Jung), lifted slightly to include two persons (Sullivan, Adler?), or lifted more to include many (Moreno). By definition, however, the focus of observation necessitates the loss of certain information. What, then, is the locus of observation to be? Space does not permit argument involving the merits and demerits of each, but in passing one point can be made and that is regarding the levels or dimensions the group

offers which the individual patient alone does not. Also, in favor of the interpersonal events the Gestaltists would lend support: they stress the necessity of molar units; for the world, they emphasize, is organized in molar fashion. Since man is a social being, the descriptive unit must be large enough to study him meaningfully in proper perspective—in interactional process. The meaningful or appropriate units should be defined only in relation to the problem which initiates investigation. If we are interested in the process of interpersonal pathology and its treatment, the unit must be sufficiently large to involve the relationships we seek to understand. Although the group method increases the field of observations, greater and smaller detail is made possible with the therapist's magnifying glass. A frequent change of level provides a variety of foci to enable a more complete sample.

Moreno, it appears to me, has posed a very insightful and provocative issue of which the basis is not only a molar-molecular argument regarding content, but also one involving methodology as well.

COMMENTS ON MORENO'S "TRANSFERENCE, COUNTER-TRANSFERENCE, AND TELE"

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In spite of being in accord with Dr. Moreno's attempt to dispel the artificial distinctions between client (or patient) and therapist, I could not help but feel that he oversimplifies their mutual relationship. Presumably, the therapist is better adjusted than the client; his over-all level of need-satisfaction is higher, he is more comfortable in his interpersonal relationships, he is less likely to misperceive his own feelings and attitudes or those of others, he is less dependent upon the client, and above all he is more accepting of himself and others. There is also his role as helper, which, although it may have some degree of unreality to it, is nevertheless firmly rooted in the fact that he is in better psychological condition, as well as the reality of the situation, i.e., he faces a troubled person who is asking for help. The potential actualities which any two persons may share are innumerable, and the actualities into which each feels his way are delimited by their mutual roles. The therapist is especially delimited by the therapeutic situation. This is not to say that the therapist hides behind a mask, or is not

"himself", but that the nature of the situation naturally precludes certain activities which under other circumstances would constitute "being himself". Therapy involves two-way *tele* transactions, but this does not necessarily mean that the same thing flows in both directions. From a current client-centered viewpoint, the task of the therapist is to learn to appreciate or value in as unconditional manner as possible the emerging actualities of the client and to communicate this appreciation. This capability of understanding and acceptance is the actuality of the therapist which the client feels into and through which he learns to appreciate and "own" the many unacceptable actualities of himself. Rather than saying, "If the therapist is attracted to the patient or rejects him he is to give his secret away—instead of hiding it behind an analytic mask . . . ," I should say that he might attempt to clear up his own difficulties so that he could discard his mask and begin to feel a deep and unconditional positive regard for the person.

But even though I object to Dr. Moreno's seeming oversimplification of the interpersonal aspects of the therapeutic process, his position raises an important question: Is understanding and acceptance enough?

Several considerations come to mind. I feel a certain "artificiality" about a relationship in which I do not give of myself in ways other than being an "understander and accepter". Time and again, especially as a relationship develops, I begin to express myself to the client in ways which do not bear directly upon communicating understanding of him, but amount to expectations of understanding from him. Similarly, other client-centered therapists have told me of expressing more of themselves to their clients and of their satisfaction with doing so. Often, too, the client searches behind understanding and acceptance for a deeper appreciation of the actualities of the therapist, and it seems to me that this search for personal substance should not be denied. Finally, I must admit that I fail to find in the writing of client-centered authors (including my own) so much of the warmth and rough-and-tumble humaness which stands out in Dr. Moreno's discussion of therapy, and I feel dissatisfied that it is not there.

The question has a more formal aspect. The more actualities one perceives in another, the more of a person he becomes. If it is the understanding and acceptance of another (the therapist) which is the crucial factor in psychotherapeutic growth, it would seem to follow that this perceived understanding and acceptance will have more meaning and be of greater value to the client when the therapist is more fully known as a person. And although the client feels into the actualities of the therapist by expressing himself and discovering that the therapist deeply understands him, obviously he cannot

through this process know more of the therapist than he knows of himself. (Except, of course, the therapist's positive reactions to these actualities.) Is this enough—perhaps the optimal psychotherapeutic relationship? Dr. Moreno would seem to think it is not, and I am inclined to agree with him. Carrying this notion to the extreme, perhaps I should view my therapeutic task as working toward communicating to the person a complete understanding and unconditional regard for him, coupled with the eventual expression to him of all my own unique actualities.

My second comment bears on the theoretical status of the distinction between *tele* and *transference*. Dr. Moreno's straightforward explication of transference and countertransference as the same process viewed from different chairs strips the artificiality from the distinction between these terms. But in sharply separating (at least by implication) tele and transference he is introducing the kind of reification which causes transference and countertransference to be viewed as separate entities. Tele and transference perceptions do not appear to be distinct processes but merely two manifestations of the same process—an evaluative conception, based on projection, of some aspect of another in relation to oneself. Tele evaluations are simply more realistic or accurate, i.e., more likely to be maintained throughout a developing relationship.

Distinguishing between tele and transference may be practically expedient so long as it is remembered that thus far the two processes appear to lie on a single continuum—no tele perception being completely accurate and no transference perception being completely inaccurate.

MORENO'S THEORY OF INTERPERSONAL THERAPY

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Buried in the second of Moreno's integrating lectures is a concept to which I shall address myself. That it did not occur as a minor addition is evident since this same point was made by Moreno twenty-four years ago when he condemned the dominant brands of individual psychotherapy for their unsymmetry(4)—that is to say the patient and the therapist did not meet on a level of equality. What Moreno has been doing in his clinical practice and what he has been advocating—as shall be seen along with others—is a kind of democracy in psychotherapy.

Whether this is a more important issue than attempts to diagram lines of relationships, including considerations of such esoteric concepts as UCS and PCS, is not for the writer to say: such matters interest him very little.

* * *

To consider psychotherapy as a treatment of interpersonal relations is an advance over the notion that therapy is the "cure" of the individual. The research of Rogers and Dymond (7) with their collaborators indicate that in successful therapy very little change occurs in basic personality. People are still the same after therapy; they merely see things differently. A man can remain as he was and yet his perceptions can be altered; his behavior can be different; he can deal with others in new, more satisfying and more wholesome ways.

The question Moreno raises is whether it is possible for a person to make real advances in his interpersonal relations with the generalized other if his therapeutic relationship was asymmetrical. He states this as follows: "The therapist must himself become a participant actor, although not formally, 'psychologically' a patient. Then there are two patients, not one: they can give therapy to each other, each in accordance with his ability and needs."

This concept divides all therapies into two real camps: those which are directive, analytic, interpretative or repressive versus those that are non-directive, permissive and accepting. In the first class the therapist assumes that he "knows better", "is wiser" or "more capable" than the patient; in the second class the therapist views the patient as capable of meeting his own problems and patients as capable of helping one another. In the first class, the therapist is a specialist with a knowledge of human nature that transcends the patient, who will follow each resistance and each conflict even back to the womb if necessary. He cuts the patient into parts, concerning himself with his ego, his id, and his superego, listing him as introverted or extraverted, and finally gives him a label such as "Extratensive ambivert with psychopathic syndromes in a pseudo-neurotic near-psychotic circular pathology with organic components."

In contrast the non-directive psychotherapist sees the patient as a living, self-directed, goal-seeking, socially responsible individual for whom reality is his perceptions, who is living here and now and who possesses the potentialities for self improvement. He views himself as providing the climate for growth; he is a catalyzer and not the humus.

Directive therapists are class-bound, retain Aristotelean concepts, and

tend to work in a biological frame of reference. They view the individual as the product of his entire phylogeny with instinct theories; at least they view him as the resultant of his life history. The non-directive therapists, in contrast, take a fluid, Galilean, and environmental point of view. While recognizing the facts of life they nevertheless see improper behavior as a function of improper perceptions which can be readily relearned.

* * *

Group therapy is by its very nature democratic. As Dreikurs and Corsini say, "All group procedures imply the existence of a unique climate which is essentially democratic" (2). Group therapy with its major mechanisms of reality testing, group transference and group interaction, becomes, *per se,* a therapy of interpersonal relations.

In psychodrama, the director takes a patient out of the group, and following the patient's lead, sets up a situation already created by the patient and permits the patient to act out his problems naturally and spontaneously. The patient directs his own therapy, stopping it when he feels the need. It is the very essence of democracy.

* * *

Other therapists have made this point. One of the first psychoanalysts to leave the Freudian fold was Trigant Burrow who was asked one day by a patient: "Why am I on the couch and why am I not analyzing you?" With these words, Burrow permitted his patient to rise and from then on they talked to each other as equals. (1).

Ferenczi, too, regarded the patient as a human being with whom one could interact in a normal fashion. He exchanged gifts with patients, went out to dinner with them, and in general operated in a spirit of loving democracy (3).

However, it is Carl Rogers who must be regarded as the most vigorous of all defenders of true democracy in psychotherapy (6). He states as his credo that every patient has within himself the potentiality for growth and that the therapist can help him realize himself by taking an accepting attitude, trying to understand him. The therapist, out of respect for his client, does not try to analyze him, categorize him, pigeon hole him; nor to advise him, to give him suggestions, to evaluate him or otherwise try to re-direct his growth.

* * *

Non-directive therapists take the patient in situ, as he is, here and now, and follow the patient, having complete respect for him. Directive

therapists take the patient as an unfortunate being who needs their help in re-directing their lives.

I would not agree with Moreno's conclusions that there is no difference of opinion between the individual psychotherapies of the 1920's and the interpersonal therapies which can not be resolved. While these differences of attitudes which have been discussed so far are not time-based, they do represent a very real difference in thinking between two classes of men. And it is a difference which very much does make a difference: one kind of thinking creates a priest class and the other kind of thinking leads forward to a psychiatry for the masses.

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TELE AND TRANSFERENCE FROM THE POINT OF VIEW OF JUNGIAN PSYCHOLOGY

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In a summary of his European lectures on Transference, Countertransference and Tele, etc., Moreno has attempted to spell out the common denominators of psychotherapy. It was a worthwhile task, but handicapped by our limited knowledge of the psyche—its activities and manifestations, a riddle in an enigma. For the most part I find myself agreeing in principle and where not, it may well be due to different presuppositions—the result of Jung's empirical postulations and my own introversional bias. This latter is of note, for it is almost impossible for an introvert to fully comprehend an extravert and Moreno is just that—an intuitive thinking extravert. This difficulty in communication is often overlooked. Then, too, psychological typing

gives meaning and helps in interpretation. Moreno, because he is an extravert, thinks differently to Jung, an introvert. Moreno's psychic energy flows outward, his interest and attention are centered in people; he is anchored in objective relations; his values are collectively developed and oriented. His extraversion explains his strong attraction for children in Vienna's Augarten in 1911. On the other hand the introversion of Jung gives meaning and explains why about the same time (circum 1910) he was so concerned with his inner world which in active imagination he was touring and exploring preparatory to writing his first great opus—The Psychology of the Unconscious. And parenthetically it may be added that a knowledge and understanding of psychological types suggests that it is not improbable that the extraverted attitude is a prerequisite if not a real sine qua non for a most efficient group psychotherapist.

And yet there is a rather amazing "empathy" in Moreno's and Jung's deductions and conclusions. It stems in part from the spiritual components in their transpersonal unconscious. (Note Moreno's Words of the Father and Jung's Psychology and Religion). For example, take Moreno's contention that there is no real psychological difference between transference and countertransference. To this Jung agrees; he puts it this way, that in the dialetic session the therapist is influenced as well as the patient—that both are in analysis. Tele, which Moreno conceives of as a "sociogenetic unit facilitating the transmission of our social heritage" is psychic energy (archetypal) projected and manifesting itself in a positive or negative relationship to other people. It is a part of our own psyche temporarily residing in another person, placed there by projection. In a real sense it is psychic energy appearing at a distance but it is still a part of the projector and has strong emotional ties. And as an unconscious phenomenon it is a manifestation—autonomously and spontaneously, produced. The soul image, the anima of Jung, is a similar concept. As the contra-sexual component of man's psyche, it emigrates to and illuminates as with a halo the beloved woman.

Tele and transference are therefore displacements of psychic energy—projective manifestations appearing in relationship with people. To comprehend this outward flow of psychic energy and its lodgement in remote objects or persons, is difficult for modern man. But for primitive man it is axiomatic; his outside world teems with invisible arbitrary powers, ghosts, spirits and daemons to whom he is subject. He is unpsychological. His psychic processes are thought of as outside himself. Of him Jung says: "the psychic and the objective coalesce in the external world". For him all nature has psychic qualities. His psychic energy flowing to and operat-

ing in animals and trees; causes them to speak and endows the medicine man with "'mana". In our era of enlightment modern man has recalled many of his projections but as he is still so largely unconscious he continues to project. Transference and tele are examples of this phenomenon-psychic reality experienced as at a distance rather than within.

GENERAL REMARKS PERTAINING TO THE FIRST TWO LECTURES (1954) BY J. L. MORENO ON TRANSFERENCE AND THE UNCONSCIOUS

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These days, when the Freudian revolution has reached a status of conservative reactionaryism, Moreno's lectures are refreshing.

After nearly a half century following Freud's tremendous discoveries, his spirit of scientific experimentation appears to have been dissipated. This deficiency can also be noted as one of the cardinal symptoms of the pre-Freudian descriptive psychiatry era.

And this is both frustrating and alarming. In fact, analism can be seen as a vicarious vicissitude in the sneer toward the "appearing" radical departure in psychotherapy.

Can this pregenital defense against the newer techniques be, in essence, the same response which threatens our countertransference communications? Of course, this question cannot be answered. But it is not merely intriguing; instead, it is psychiatry's greatest challenge. Will we face it? Courage, elicited from all quarters, is again needed. This represents my motive in responding to the invitation to comment upon these lectures.

I do not always agree with all of the material. Nor, do I fully understand it. (The latter expressing a lack of experience, no doubt). And yet, I admire the courage. It is regrettable that throughout the history of medicine, and psychiatry representing no exception, conservatism has served as a dredging anchor on the ship of progress. While on the other hand, we must be cautious that our enthusiasm does not overcome our discriminating minds. For perhaps in these areas under discussion, our status is still embryonic.

Embryonic as it may be, formulations do sharpen our thinking. They

weed out our errors and give birth to new growth. However, this state of development precludes real hard and fast conclusions to be formulated. Dogmatism at this point would represent eventual death to all of our worthwhile efforts.

The excellent reviews and critiques already submitted conclude me to circumscribe my own specific comments. Transference, in role playing will thus occupy this area of discussion. What is role playing with respect to transference? The role is merely the conscious manifest and the transference its unconscious content in projected form.

To me, regardless of which technique is employed, the issue of transference remains unaltered. Is this not rather obvious? For does the unconscious really pay attention to the forms of communication or—the nature of its content? This valuable content is the germane issue and therapy's task deals with fulfilling its communication.

Psychodrama, and so many of the other newer techniques have proven themselves in clinical settings. Proven, to be able to directly communicate the content of the unconscsious material.

In contrast with the proponents of the various schools of psychology including the various divergent techniques, personally I see no point of priority. Each has its advantages as well as its limitations. Each has its indications and its contraindications. And, for one to claim complete superiority over the other is folly.

The issue at stake is communication. Its optimum is contingent upon tangible and intangible factors. The personality of the therapist and his ability for empathy stand in the foremost position. This sensitivity of communication perhaps is the unconscious basis for the choice of technique and approach preferred by the given therapist. In other words, the selection is made for us not by us. The unconscious mind like a river attempting to reach the sea knows the most favorable route (but not necessarily the shortest) to its destination. Similarly, the flow of communication on the therapist's part to his patients can be understood as following such a tortuous journey. You see then why it is really folly to criticize one form of communication over another. What may, euphemistically speaking, represent one human to another human's optimum pathway can equally serve as another system's nightmare.

As I look back among my colleagues whose training closely approximates if not duplicates my own, I had often been puzzled why we practiced so differently. Now, I know. We all have different unconscious content and different preferred routes of communicating.

Before you feel that I have neglected to appreciate the academic aspect of this problem, permit me to say that the greatest conflict does not appear to lie in this area. Instead, here we are still in the semi-darkness. And, when a higher degree of tolerance develops toward one another's mode of communication, we may, serve to support ourselves in leaving the semi-darkness of our academic ignorance.

COMMENTS ON MORENO'S TRANSFERENCE AND TELE

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I have read Dr. J. L. Moreno's article on "Transference, Countertransference and Tele" with great interest. He makes several points that it seems to me have needed elucidation for a long time.

The first of these points concerns the usage of the words transference and countertransference and the implication that the projections of the therapist are somehow secondary to those made by the patient. It has been my impression that projections made by the therapist upon the patient are not necessarily a consequence of, or a response to, projections made upon him by the patient. They tend to arise spontaneously, because in some way the patient hits a blind spot in the therapist. As Dr. Moreno points out, the same projection phenomenon occurs in social relationship, sometimes unilaterally, sometimes bilaterally. However, the context in which the therapeutic transaction takes place is so organized that it favors projections by the patient, so that they are more obvious and under closer scrutiny than so-called counterprojections. The therapist is naturally on guard against the possibility of making projections upon the patient. And to a large extent, the fact that he himself has been projected to the analytic process, so that his areas of unconsciousness are diminished, makes him that much less vulnerable. I am here considering transference to consist of a projection or projections from the unconscious. It is clear from my statement about the reduced vulnerability of the trained therapist that I do not share Dr. Moreno's disenchantment with educational analysis. In a large proportion of cases, it seems to me, there has been a significant change in the personality structure and dynamics of the analyzed therapist.

The second point made by the author, which struck me as enormously important, is what he describes as Tele. One of the points of difference

between the Jungian and the Freudian schools has revolved around this. When Jung abandoned the use of the couch in favor of a vis a vis approach, he had in mind the importance of establishing what he referred to as rapport, in the sense in which Janet used the term. My own formulation would be reality-based relationship between therapist and patient. I would submit that such "real" relationship should exist concurrently with the transference relationship. This provides the means for joint exploration, clarification, and resolution of the problems that have brought the patient to therapy.

This brings me to the third point, which seems to be implied in the second section of Dr. Moreno's article. This is the reduction of the authoritarianism and ananimity that was so prominent in the structure of classical psychoanalysis and which, in a modified form, seems still to persist in many quarters. However, one needs to be on guard against the pitfall that lurks in the coequal relationship between therapist and patient, namely, that neither of them should forget that the therapist has been trained to understand and deal with emotional disorders, whereas the patient has not.

SOME COMMENTS ON THE FUNCTION OF THE UNCONSCIOUS FROM THE JUNGIAN POINT OF VIEW

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We were fascinated with the feature of your concept of *co-unconscious* communication. The idea is brilliant—we never once thought of this particular approach and can't recall anyone else discussing precisely this idea. This nascent approach is challenging and serves as a check on much of the genotypical hash presented in the literature on unconscious phenomena. From this framework motivational studies should be made.

We realize you were purposefully making brief your comments on Jung, however, you have short changed him a bit in the process.

One of us, Robert James, studied at the Jungian Institute in Switzerland. We would like to draw your attention to the following quote which provides some helpful suggestions regarding Jung's position on the unconscious. In Vol. 17 of "The Collected Works of C. G. Jung," Page 42, Jung says, "Certainly causes exist, but the psyche is not a mechanism that

reacts of necessity and in a regular way to a specific stimulus. Here as elsewhere in practical psychology we are constantly coming up against the experience that in a family of several children only one of them will react to the unconscious of the parents with a marked degree of identity, while the others show no such reactions. The specific constitution of the individual plays a part here that is practically decisive. For this reason, the biologically trained psychologist seizes upon the fact of organic heredity and is far more inclined to regard the whole mass of genealogical inheritance as the elucidating factor, rather than the psychic causality of the moment. This standpoint, however satisfying it may be by and large, is unfortunately of little relevance to individual cases because it offers no practical clue to psychological treatment. For it also happens to be true that psychic causality exists between parents and children regardless of all the laws of heredity; in fact, the heredity point of view, although undoubtedly justified, diverts the interest of the educator or therapist away from the practical importance of parental influence to some generalized and more or less fatalistic regard for the dead hand of heredity, from the consequences of which there is no escape." "It would be a very grave omission for parents and educators to ignore psychic causality, . . ." Jung of course is hard to pin down; he is so inclusive, yet avoids any real conclusions by enumerating all the possibilities.

COMMON DENOMINATORS IN THEORY FOR PSYCHOTHERAPY

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In the current climate of thought, the task of effecting a reconciliation of ideas to achieve a single system of theory for psychotherapy appears formidable. The difficulties are both great and obvious. In the first place, psychotherapy is a body of practice rather than a sicence. The practitioner here, as in medicine, brings to his work an accumulation of observations and workable generalizations issuing from day-to-day treatment. He draws from a range of sources but rarely bases his ideas upon a single system of knowledge. The neurophysiologist may be in a position to address himself to problems falling within a single frame of reference so that his theoretical ideas may relate to one order of data. But even when the psychotherapist reaches over into a field like biochemistry, such as in the exploration of the uses of re-

serpine or chlorpromazine, he is only adding to his eclectic fund of resources to supplement rather than to supplant his approach to the treatment of mental disorders.

Secondly, when the psychotherapist steps out of his role of practitioner and assumes the role of the theorist, he addresses himself to problems which cut across systems of knowledge on differing levels of organization and exhibiting differing properties unique to each. The patient is at once an organism, a person and a part of social system units. The state of scientific stabilization of each of the specialized disciplines involved not only varies but each of them is continuously changing. It is hardly possible that a single comprehensive system of theory will be available for the practitioner in the near future. It is, therefore, no disservice or indignity to observe that psychotherapy is not a science. It is a body of practice and ideas which approaches definitude and effectiveness as the various fields of knowledge it draws upon become more adequate and as it weaves that knowledge and the insights of practice into theories yielding more dependable directives and principles of treatment.

At the moment, a sound but more modest aspiration for psychotherapy stands as both timely and urgent. The present theory of psychotherapy is on two levels of formulation. First, it consists of clinical generalizations which practitioners have accumulated out of the wealth of observation, because they have been found to be usable and productive. Second, it consists of higher order generalities, partly deduced and partly constructed in speculation, and formulated as models providing schema of organization for otherwise disconnected ideas. Such models are highly useful and represent a stage in the development of any body of information moving towards increasing exactitude and adequacy. Psychoanalytic theory is such a model and the fact that it has contained so much that is speculative and even akin to myth-construction is not to deny its utility in time and place. But what is important is to recall always that as psychotherapy's own body of experience accumulates and the sources upon which it draws extend and deepen their content, the clinical and model theorizing of the practitioner must keep pace with them.

The time is always ripe for such assessments and particularly so at this moment. The levels of psychotherapy theory referred to above are represented by numerous "schools" which sometimes give the delusive appearance of diversity so great as to be mutually exclusive and incompatible. A little scrutiny reveals that however much they may differ in model formulation, their long address to common clinical problems has resulted in a body of

generalizations that is impressive, at least as much for what they have in common as for their distinctive differences. It may be tactless to observe in public what is commonplace in private that what practitioners of the various schools do results in successful and unsuccessful outcomes not notably different whatever the interpretation advanced, and that in any event, rigorous school orthodoxy tends to be replaced by a selective eclecticism. Of course, theory in psychotherapy is not only still in the stage of clinical development but in a sense it must always continue to be, although moving perceptibly towards a more adequate body of organized concepts and propositions with which to make the operations of therapy more adequate.

It is both practicable and of great importance, however, to recognize that there is a manifest strain towards consistency. There are common points of articulation in the widening range of therapy practice and model theories. It is not so important and certainly it would be recklessly brash to ask for any immediate master synthesis. More modest and certainly more strategic is the task of singling out the common reference points from which the ideas and practices of the various schools stem. Such common denominators at the very least provide for an increase in communication and at most for reformulating the base lines in the development of theory. And what is at least as promising is that by meeting on the emotionally neutral ground of such conceptual common denominators, the interflow of communication between psychotherapy and the specialized disciplines of the relevant sciences may be facilitated. The day-to-day work of the practitioner should be a testing ground not only of the generalizations which the students of psychotherapy construct but also the products of the various sciences across which psychotherapy cuts.

Historically, of course, the development of psychotherapy could not wait upon developments in the related sciences. Treatment has its own exigencies and the clinician had to accumulate his insights and methods largely without benefit of the scientific disciplines, each of which was concerned with only a segment of the data thrown up to the practitioner. If the models of theoretic interpretation which resulted were often speculative inventions which at best were useful, at worst they were blocks, sometimes critical ones, to effective therapy. Clinical observation must proceed with whatever body of resources is available to it, but it invites wastage if it isolates itself from accessible knowledge in the relevant fields of the sciences.

For example, the most focal single assumption common to psychotherapy as method or model theory is that the pathologic states with which it deals are "social" in origin and must be "social" in treatment. That such an

assumption was implicit rather than the main reference point is understandable in view of the fact that the pathologic states to be treated were localized in the individual, and that the practitioner's attention, following that of the neurologist, was oriented to the organism. Nevertheless, whatever its expedient conceptualization, psychotherapy in practice and interpretation has always gone outside the isolated individual. The symptoms it describes, the states it classifies, the methods it devises to deal with change of state, its diagnostic measures and prognostic stages are social in reference. Its model theories build essentially upon concepts of social relationships no matter how mixed with ideas about the organic etiology of normal and pathologic behavior states.

A common denominator of such initial generality may seem to be a dull instrument to serve as the cutting edge, but in its power to generate questions it may be the sharpest kind of a tool. It not only sets the base line for the clinical setting of varied schools of psychotherapy theory and practice but their linkage to the theories and data of disciplines which specialize upon cognate problems. One of these disciplines, for example, is sociology whose special field of investigation is precisely the social data with which the psychotherapist as a clinical observer finds it necessary to deal. Indeed, it is not surprising that the psychotherapist, no matter what his bias of school or phrasing, has always had to invent a heuristic sociology. Focussing his attention upon the individual structure of personality he has, unlike the neurologist, found that he could not treat that unit as a closed system, but only by recognizing that the matrix of the social is constitutive of it. The observations of clinical practice rest upon diagnostic categories of not merely how the patient handles his relation to others but especially the relations of normative social organization. Treatment objectives are oriented to and their success measured by changes in capacity to deal with a "reality" which could only be defined in terms of what others do, by the phenomena of consensus, by the operating requirements of units of interaction. And the methods devised for treatment, when they are specifically psychotherapeutic, derive from the dynamics of social interaction. Even the classic method of individual analysis is precisely the formalized utilization of forces of a dyadic group to effect a change in state of the patient's interaction relationships. The involvement of the therapist in what is called transference and countertransference is an example of that reciprocal contingency of forces peculiar to the group so that the therapist appears not merely as one person manipulating a second individual but as a part of a unit which affects both participants if the objectives of therapy are to be achieved. No more sterilizing procedure

could be imagined in genuine therapeutic practice than flows from the view that the therapist is merely a skilled technician operating upon processes located in the patient. The therapy situation is itself constituted by the involvement of the therapist in the dynamics of group interaction. The main distinction between the therapist and the patient is that the former plays his role with a purposeful awareness of how that role may be managed so as to use the natural forces of the group to move the patient's participation into a "normal" state of interaction instead of isolating substitutes or withdrawals. Indeed the sociologist stands to learn much from the clinical experimentation of the therapist, even while the latter draws upon the sociologist's study of the nature of the interaction unit and its relevance to the personality organization of the individual.

All psychotherapy is of course group psychotherapy, that is, it is the treatment of kinds of behavior disorders by means of the resources that are the unique and distinctive properties of groups. That this has not always been explicitly avowed is not surprising. Historically, a neurological bias, clinical exigencies, a properly naive address to the problems of dealing with the disorders of behavior located the interest of the therapist in what goes on inside the individual. It is a mark of the intractable reality with which the practitioner dealt that he was compelled to treat his material as if it were social. The basic instrument of the therapist-patient relationship may not have been defined in the explicit terms of group dynamics but both method and interpretation derived from observations of the processes of the primary dyadic group. Only more recently has there been emerging widely an extension of the number of participants in the therapy situation identified by the label of group psychotherapy. In principle it is no innovation. It merely extends the size of the group and undertakes to make available for therapy purposes the additional and in some ways different dynamics of the larger unit. Having launched into the task of developing a body of clinical experience and generalization, it has already become clear that in adding to the dimensions of the treatment situation, new and powerful resources become accessible to the therapist. For long, the therapy of the dyadic group methods was thought not to be capable of dealing with the more serious and resistant types of disturbances. It is similarly held by many at the present stage that larger group psychotherapy is not appropriate to depth therapy. But it may be that, with the accumulating experience and refinement of concept and method, larger group therapy may prove to be not only alternative and supplementive to older methods of the dyad, but a preferred way of treatment in certain types of cases or situations. In any event, the present task of

examining the whole range of developing psychotherapy through the common denominators of schools of dyadic and group therapy, along with the disciplines which are at work in the identical areas, points up the essential collaboration called for at the present moment.

CLARIFICATION AND SUMMARY

J. L. MORENO

There are several focal points in the comments of the second session: 1) The relation of tele and transference came up again; 2) the function of the unconscious; is a system of Ucs of heuristic value? 3) the function of communication-therapeutic society, therapeutic democracy and therapeutic community; 4) scientific validation of therapeutic processes and role-playing techniques.

1) TELE AND TRANSFERENCE

There is again convergence as to the value of the tele concept. ACKERMAN: "Transference reflects the one person's unreal perception of the other; tele, by contrast, represents the one person's correct intuitive estimate of the actualities of the other. In psychotherapeutic practice today, there is increasing concern with the dynamics of interpersonal relations, with the importance of current experience as against the past." CHOLDEN: Tele is "the awareness of the patient whether by intuition, subliminal clues, or clear evidence of the therapist in reality, it (tele) would be undistorted by the transference aspect of the relationship. However, as I read on and attempted to get a clearer concept of tele I became somewhat unsure, for it would seem that tele is another way of describing transference. I came to this conclusion inasmuch as the patient's tele awareness seems to change as a result of closer association. While this may result from increasing amount of 'reality' data, it also makes the concept of tele seem much more like the concept of transference than the original definition which Dr. Moreno offered. If the tele is an intuitive and integrative awareness of reality based on cues that are below our limen of awareness, this is a very important formulation and really requires much further study." The above opinions seem to be shared by WHEELWRIGHT, JAMES, STANDAL and TURNER.

The term "tele" appears increasingly in various contexts as the root word; in neurological contexts, tele-perceptor, telencephalon; in psychological contexts, telepathy, tele psychology; in sociological contexts, tele net-

works of influence; in technological communication media, telephone, telegraph, television; as a scientific technical term standing by itself tele has been used first by sociometrists as a unit of socio-emotional communication which seems to lend itself to measurement (at least to an extent). Tele research has hardly begun. According to sociometric findings it has three aspects, a conative, a cognitive and a psychomotoric aspect which cannot be neatly separated from one another.

Tele does not change, it is a growing awareness. Many things were there from the start but the subject remained blind to them, due to a narrowing focus of warm up. If there is a change in the relationship and in the situation, the tele dynamics will register the change, but there is no change in the tele process itself. In transference the changes which occur are provoked by irrational factors, by non-present, spatially distant and past experiences; they are not provoked by the "cues" in the present perception, cognitive, conative or psychomotoric, but supplant or distort them. Tele and transference both are linked to one another and usually are present in varying proportions. When a man sees a girl he loves for the first time, he is overwhelmed by her loveliness, the rhythm of her walk, the flash of her eyes, and he doesn't register that she has freckles although they are quite obvious. He does not see them specifically until he has seen her three or four times. They have been a part of his experience of her all along, nothing has been added except a growing awareness of her physical and mental characteristics. She wears her hair combed back in a natural fashion without benefit of permanent or bob, but it took two weeks before he realized that she combed her hair the same way his mother did. It is a growing awareness on *both* sides. She wears her stockings sloppily and bites her nails in moments of embarrassment or excitement. All this she did from the start but he noticed it only after a long period of acquaintance. This, too, is growing awareness. On the more subtle side, he realized after several months that what pleased him most about her was that she smiled and agreed warmly with him whenever he said something, although it may not always have been very clever. She never failed to smile or to agree and he always felt comfortable whenever she showed her approval of him. What we may call tele-love is enduring and mutual acceptance of such fundamental experiences. Many tele cues are not conscious at the time of a first encounter, but an infra-tele may grow and become a full tele.

Children have acute perceptions of the people who love them or who are threatening to them. A child between 24 and 30 months has definite likes and dislikes for the people around him and makes accurate decisions

when he moves towards a person or withdraws from her. Attraction or rejection of his own mother is evident very early and children do not err in their assessment. This, too, is tele and not transference. It is an error to assume that children are particularly bombarded by transference feelings. Observation of infants and children point rather to the conclusion that it is the adolescents and adults who are bombarded by transference, whereas the infant and young child is particularly prone to correct tele evaluations without being aware of it. The dominant conflict in the infant is between tele and chance; children have a weak tele because of their level of social growth, but not because of transference. The conflict in adolescents and adults is between transference and tele.

Three other high-point remarks in this area are: STANDAL: "Tele and transference appear to lie on a single continuum." BROMBERG: "Tele is to be considered as a positive bond, an ongoing force, seen in its most simple form, when one group member becomes interested in helping another." STANDAL: "I must admit that I fail to find in the writing of client-centered authors (including my own) so much of the warmth and rough-and-tumble humaness which stands out in Dr. Moreno's discussion of therapy, and I feel dissatisfied that it is not there."

2) THE FUNCTION OF THE UNCONSCIOUS

MASSERMAN: "Freud did *not* deal exclusively with the 'individual unconscious', any more than a roentgenologist deals only with 'individual' shadows." This is clear, and we agree that for Freud the unconscious was of one piece; it is Jung who differentiated an "individual" from a "collective" unconscious. MASSERMAN: Psychoanalysis is a "progressive science"; yes, but the psychoanalytic "system" may still be passing. A good case could be made that it is passing slowly, since about 1923. (To MASSERMAN, thanks for directing our attention to Freud's Autobiographic Note, p. 48.)

SMITH: "The system of insights should not disappear with the entity (unconscious)." I am sure we agree on that. "The central issue in Moreno's interpersonal therapy as I see it, involves communication both from the standpoint of pragmatics, that is, signs and users of signs, and communication science *per se*. It appears reasonable that much of the elaboration of unconscious phenomena could be explained on the basis of avoidant behavior, sign learning, associative conditioning, problem solving patterns, etc., and be discussed in the language of learning theory. Each patient, in communication terms, is capable of sending, receiving, channelizing and evaluating. All these aspects of communication occur at various points along the continuum of awareness. Since man is a social being, the descriptive

unit must be large enough to study him meaningfully in proper perspective —in interactional process. Although the group method increases the field of observations, greater and smaller detail is made possible with the therapist's magnifying glass. A frequent change of level provides a variety of foci to enable a more complete sample." All this is helpful and in the direction in which I have been travelling; it raises the question whether the psychoanalytic system of the unconscious can be supplanted by alternative systems, avoiding an excess of meta psychological commitments. There is also the possibility of integrating the system of the unconscious as a subsystem within a larger frame of reference as a system of spontaneity-creativity-cultural conserve. In my fourth lecture some of these ideas will be further explored with reference to any support from experimental evidence.

LOOMIS: "The concept of co-unconscious, however, has implications for symbiotic states. *Interpersonal syndromes* and *interpersonal therapy* are terms which deserve examination and application. The possibility of linkage of the associations of one patient with the unconscious of another has implications for therapy, interpersonal relations, communication theory, extrasensory perception, and the earliest kinds of communication between mother and child. Whether there is a common unconscious or not, the synchronicity of two persons in a close relationship is strikingly evident: the mother who knows when her children are hungry, and the husband who knows when his wife is sad. The implications of these ties for therapy deserve exploitation." Loomis' astute observations converge with the notion of "matrix of identity" (mother-infant symbiosis) and the auxiliary ego of psychodramatic theory.

3) THE FUNCTION OF COMMUNICATION

CORSINI: "This (Moreno's) concept divides all therapies into two real camps: those which are directive, analytic, interpretative or repressive versus those that are non-directive, permissive and accepting. In the first class the therapist assumes that he 'knows better', 'is wiser' or 'more capable' than the patient; in the second class the therapist views the patient as capable of meeting his own problems and patients as capable of helping one another." This may stand for the moment as it is until we will hear about the views of communication therapy in later sessions.

4) SCIENTIFIC VALIDATION OF THERAPEUTIC PROCESSES

CHOLDEN: "I wonder about the validity of studying the psychotherapeutic situation by the 'role playing' method. For no matter how much psychotherapists and subject are attempting to imitate the therapy situation,

it seems quite impossible that the situation can be successfully acted out. For by definition the major drive in the psychotherapeutic situation would be lacking, namely, the motivation to achieve a therapeutic goal." The misunderstanding may come to an extent from the abusive use of the term role "playing." I coined the term but it has gone out of hand and it is now used without discrimination. The emphasis that something is played has obvious connotations that it is not sincere and real. As a matter of fact, the technique of setting up a therapeutic experiment of the type described is to make it as "role-real" as possible and as little as possible "role-played". What are the criteria involved in the "motivation" to achieve a therapeutic goal? a) It must be a *real* patient and a *real* therapist, that is, the patient must have an actual problem which needs treatment and the therapist must be a professionally trained person. b) The patient must have chosen this particular therapist to treat him. They are not forced upon each other. c) The therapist is compensated in the customary way for his services. In our culture he is paid in money, in other cultures it may be a method of charity or honor. If these criteria are met then there should be a "motivation" emerging to achieve a therapeutic goal. The only modification from the normal therapeutic process is the presence of a third person, a professional therapist himself, who asks questions and interviews both parties during or after the session. If patient and therapist agree to his presence (or that of a jury) and if it is made clear to him that it may be of benefit to the therapeutic session, he may appreciate this modification as an asset rather than a disadvantage. It is obvious that this must be carried out in accord with the therapeutic format and an honest desire of a third party to consolidate it and not to disrupt it. The "experimenter" is a protective agent and not a cold judge.

In order to meet with the special character of psychotherapeutic processes, the difficulty of framing them into an experimental design, it may be useful to differentiate two kinds of validity, scientific validation as currently considered unexceptional in the scientific fraternity, and *"existential" validation* which looms in all psychotherapeutic practices and is the cause of many misunderstandings of what is scientific and what is not. The meaning of existential validation should be clearly spelled out as making claims of validity only in situ, in the here and now without any attempt to confirm the past or to predict the future. It should be classified as more than art, although when people talk about the art of psychotherapy it is implied that what takes place has existential validation. Scientific and existential validation do not exclude one another, they should be constructed as a continuum.

SUGGESTED PROGRAM OF THE SOCIETY FOR THE COMING YEAR

JAMES M. ENNEIS

President Elect

Rapid growth in the field of group psychotherapy and psychodrama necessitates examination of current training methods and facilities and greater structuring of existing organizations to foster interchange of information and ideas. It seems the duty of the American Society of Group Psychotherapy and Psychodrama to assume leadership in extensions of the movement.

Some areas in which this might be done are:

There are many problems faced by group therapists in community and institutional life. There is inadequate communication between therapists concerning these problems and methods of handling them. Everything possible should be done to form *local* organizations of group therapists for the purposes of discussing mutual problems. I believe that these organizations should be made up of all people who are working in the field regardless of their membership in the Society. The Society should sponsor these meetings and should encourage qualified people to join the national organization. However, this should not be prerequisite for fully participating membership in the local organization.

Every effort should be made to stimulate the formation of training centers for group and action methods throughout the country. These centers should offer reasonably formalized standard programs of training and should be run only by people who are qualified (fellows of the Society?).

During the past year, there has been a tremendous increase in interest from personnel workers, administrators and training officers. Their interest is not only in technique and group processes but primarily in the area of developing interpersonal perception for themselves and methods of teaching greater perception to their training groups. The teaching of perception of interpersonal activity seems best achieved through actual experiencing. Therefore, these groups should be run by people who are capable of gaining a maximum of group participation and interaction on meaningful levels rather than by mere intellectual or academic presentation of the material and manipulative systems.

Special efforts should be made by qualified personnel to instigate courses in universities. Although many such courses are currently being

offered, the subject matter is often misleading and inaccurate. It might be useful to have the Society sponsor a study of what is being called group work, action methods, psychodrama, sociometry and group therapy in the academic world.

The Committee on Standards for Psychodramatists in various fields has been active this year. Some suggested standards have been made. These are subject to the approval of the Society. Further study needs to be made in these areas.

ANNUAL MEETINGS OF THE AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Friday and Saturday, May 6 and 7, 1955

Theme—THE APPLICATION OF GROUP PSYCHOTHERAPY IN ADJUSTING TO CHANGING TIMES

Held at: The New York Academy of Sciences, 2 East 62nd Street, New York 21, New York

Registration: Registration fee for nonmembers will be $2.00. Fee for the reception and cocktail party (subsidized) is $1.50.

Friday, May 6, 1955 at 2:00 P.M.

Virginia Axline, Ph.D., *Group therapy as a means of self-discovery for parents and children.*

Jerome D. Frank, M.D., *The role of group psychotherapy in fostering self-confidence.*

Dean Florence Beaman, *The value of group experience in the normal educative process.*

Rudolf Dreikurs, M.D., *Adlerian analysis of interaction.*

Edgar F. Borgatta, Ph.D., *Research, pure and applied.*

Friday, May 6, 1955 at 7:30 P.M.

Helen Hall Jennings, Ph.D., *Presidential Address . . . . Psychodrama and sociodrama as interdependent research techniques in Group Psychotherapy.*

The presidential address will be followed by an informal reception and cocktail party. The subsidized fee for the cocktail party is $1.50. *Our cocktail parties are always extremely successful.*

Saturday, May 7, 1955 at 9:40 A.M.

Ruth Clark, *Group therapy with parents of preadolescent stutterers.*

Rudolf P. Hormouth, M.S.W., *Group approaches in aiding mentally retarded adults in adjustment to community living.*

Lloyd W. McCorkle, Ph.D., *The Highfields experimental treatment project for youthful offenders.*

Norman A. Polansky, Ph.,D., Stuart C. Miller, M.D., and Robert B. White, M.D., *Some reservations regarding group psychotherapy in inpatient psychiatric treatment.*

Louis E. DeRosis, M.D., *The role of group psychoanalysis in our changing times.*

Saturday, May 7, 1955 at 1:00 P.M.

Membership Meeting.

Saturday, May 7, 1955 at 2:00 P.M.

Henry Guze, *Lecture demonstration on the application of hypnosis to Group Psychotherapy.*

Saturday, May 7, 1955 at 3:20 P.M.

Samuel R. Kesselman, M.D., *Group procedures in narcosynthesis (with film).*

Margaret Phillips, *The relationship between muscle stance and group adjustment.*

George Goldman, Ph.D., *Group Psychotherapy and the lonely person in our changing times.*

Howard Newburger, Ph.D., *Experimental design in psychological research.*

For further information write: Prof. Howard Newburger, New York University, Washington Square, New York 3, New York.

ANNOUNCEMENTS

Sociometric Conference, University of Basel, Switzerland

Professor Meng organized a conference held on November 19, 1954, at the University of Basel, dedicated to sociometric problems. A detailed, carefully elaborated introduction to theoretical and practical problems of sociometry as developed by Moreno was given by F. Böckli, a judge, who is a follower of R. Spitz, and a researcher in sociology. Dealing with the same sort of problem, Dr. Hildebrand Teirich of Freiburg, Breisgau, Germany reported on a sociometric inquiry made in an Austrian factory where native and foreign workmen worked and lived side by side and where numerous trouble in interpersonal relations arose. The sociometric inquiry threw new light on the situation and on the basis of its findings the lodgings of the workmen were reorganized according to their sociometric affinities. Dr. Teirich also referred to his sociometric experiences with his therapeutic club and plans to continue sociometric investigations among animals, as inaugurated by Moreno in 1945. (See Moreno's Symposium on Subhuman Groups, *Sociometry,* Volume 8, No. 1.)

British Psychological Society

The General Meeting of the Society, taking place at 8:00 p.m., Gustave Tuck Theatre, University College, Gower Street, London, W. C. I, England, will be devoted to a lecture by J. L. Moreno, "The Therapeutic Community Based upon Sociometry, Group Psychotherapy and Psychodrama".

Moreno Institute Workshop Program

The following workshops are planned: Independence Day, July 2-4; Labor Day, September 3-5 and Thanksgiving, November 24-27. Enrollments are now being taken. Write to Moreno Institute, 259 Wolcott Avenue, Beacon, N. Y., for details.

New Books Received

Nabointeraktion. Sociometrisk analyse af ni danske naboskab, by Kaare Svalastoga, assisted by Erik Högh, Copenhagen, Denmark.

Transactions of the Second World Congress of Sociology, Volumes I and II, International Sociological Association, London, W. C. I, England.

THE PEER STATUS OF SIXTH AND SEVENTH GRADE CHILDREN

By FRANCES LAUGHLIN. 85 pages, $2.75.

This is a study of the ways in which sixth and seventh grade youngsters were accepted by their classmates. The author investigated two specific questions: What factors influence the peer status of adolescents? Does a change of school, with changes in class membership, affect the way children are accepted by their peers? Concrete illustrations of the kinds of studies of groups and individual classroom teachers can make are included in the book.

A CLASS FOR DISTURBED CHILDREN: A Case Study and Its Meaning for Education.

By LEONARD KORNBERG. 157 pages, $3.75.

This book describes the day-to-day life of a class in a school in a residential institution for disturbed children. The data cover a period of five months in this class as observed, participated in, and recorded by the teacher as he sought to guide his pupils into a world of reality.

IN SEARCH OF SELF.

By ARTHUR T. JERSILD. 147 pages, $2.75.

The author believes that one of the most crucial tasks of the schools is to help youngsters discover themselves. A study of the self-evaluations of some 3,000 young people, and information obtained through observation in classrooms where teachers have tried to promote self-understanding, as well as through interviews with teachers and pupils, form bases for this book.

THE NATURE OF NONDIRECTIVE GROUP PSYCHOTHERAPY: An Experimental Investigation.

By LEON GORLOW, ERASMUS L. HOCH, AND EARL F. TELSCHOW. 143 pages, $3.25.

Specifically, three basic questions were considered: What seems to characterize nondirective group psychotherapy? When in the course of a group's cycle of activity do various features occur? Why do certain phenomena take place? One author directed his efforts toward an analysis of the leader's behavior, another studied the behavior of members as therapists for one another, and the third analyzed the therapy process itself with relation to specific variables.

BUREAU OF PUBLICATIONS

Teachers College, Columbia University

New York 27, N. Y.

PSYCHODRAMA AND GROUP PSYCHOTHERAPY 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)

No. 16. Psychodrama and the Psychopathology of Inter-Personal Relations—J. L. Moreno (List Price—$2.50)

No. 17. Origins and Development of Group Psychotherapy—Joseph I. Meiers (List Price—$2.25)

No. 18. Psychodrama in an Evacuation Hospital—Ernest Fantel (List Price—$2.00)

No. 19. The Group Method in the Treatment of Psychosomatic Disorders—Joseph H. Pratt (List Price—$1.75)

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)

No. 25. Action Counseling and Process Analysis, A Psychodramatic Approach—Robert B. Haas (List Price—$2.50)

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)

No. 28. The Prediction of Interpersonal Behavior in Group Psychotherapy—Timothy Leary and Hubert S. Coffey (List Price—$2.75)

PSYCHODRAMA, VOLUME I
J. L. MORENO
$8.00

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)

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