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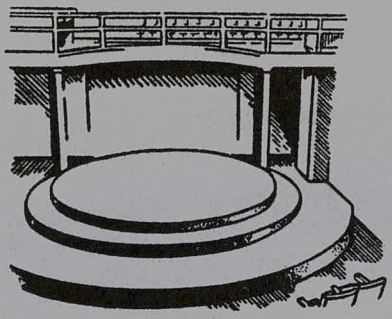
A Quarterly



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INTERNATIONAL SECTION

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TWENTY YEARS OF PSYCHODRAMA AT SAINT ELIZABETHS HOSPITAL

WINFRED OVERHOLSER, M.D., SC.D., AND JAMES M. ENNEIS, M.S.

Superintendent, and Supervisory Psychodramatist, Respectively
Saint Elizabeths Hospital, Washington, D. C.

Administrative Climate of Saint Elizabeths

It has always been the policy of Saint Elizabeths Hospital to further research and to give new ideas a chance to prove themselves. Thus, Saint Elizabeths Hospital was the first large mental hospital in the United States to pioneer group psychotherapy, sociometry and psychodrama. Dr. E. W. Lazell used a lecture technique in 1921, under the administration of Dr. William Alanson White. This was primarily a didactic method but, even so, no other mental hospital in the United States had employed such practice. Joseph Pratt of Boston, for instance, a pioneer indeed, lectured to tuberculous rather than mental patients; Lazell was the first to do that. Shortly afterwards Dr. J. L. Moreno came to the United States and set the pace for the modern group psychotherapy movement by introducing the term group psychotherapy and the principle of therapeutic interaction among the patients themselves.

Dr. White recognized the value of Moreno's group plan for a mental hospital setting, and spoke and wrote on the subject. He sponsored the first sociometric study (1934-35), under the direction of Dr. Winifred Richmond concerned with the interaction of the nursing staff in a mental hospital setting, *Sociometric Tests in a Training School for Nurses, Saint Elizabeths Hospital, Washington, D. C.*, published in Sociometric Review, February 1936, republished in Sociometry, A Journal of Interpersonal Relations, Volume XIII, p. 29-38, Beacon House, 1950.

In 1939, two years after Dr. Winfred Overholser had become Superintendent of Saint Elizabeths, in line with the Hospital policy of providing the efficient and thorough care for patients and of trying newer therapeutic methods, he launched and supported the psychodramatic movement at

* The authors are grateful to: Dr. J. L. Moreno; Miss Margaret Hagan; Mrs. Frances Herriott (Sargent); and Miss Blanche Parcell, Chief of Social Service, Saint Elizabeths Hospital, for their suggestions and criticisms. The views expressed are those of the authors.

Saint Elizabeths which helped carry the idea to international recognition. Today there are over 100 theaters of psychodrama in the United States and in various other parts of the world, used in mental hospitals, universities, and educational institutions. Many of these have looked to Saint Elizabeths for guidance in forming and developing their programs. This is perhaps but to be expected, as the Hospital is a Federal institution in the Nation's capital, and a large hospital with a long tradition.

The Cradle of Saint Elizabeths Psychodrama

It was in 1939 that Dr. Overholser formed a committee[1] from Saint Elizabeths Hospital to visit Dr. Moreno's theater of psychodrama in Beacon, New York, to study the theory, method, and techniques used in the treatment of mental patients and in the training of hospital workers. In addition, they were to observe the combination of psychodrama and group psychotherapy and Dr. Moreno's sanitarium as a therapeutic community.

The committee returned to Saint Elizabeths, and with great enthusiasm set about building, according to Dr. Moreno's specifications, the first psychodrama theater in a large public hospital in the United States.

Approximately one year after their visit to Dr. Moreno, the Saint Elizabeths' theater for psychodrama opened. Writing at that time, Dr. J. L. Moreno makes the following acknowledgments:[2]

> ". . . to:
>
> "Dr. Winfred Overholser, Superintendent of Saint Elizabeths Hospital, without whose energy, vision and support this work could not have been accomplished:
>
> "Mrs. Anne Archbold, whose understanding generosity enabled the Hospital to secure a director of unusual training and ability, Miss Frances Herriott:
>
> "The American National Red Cross, for material aid and

---

[1] Drs. Roscoe Hall, then Clinical Director; Alexander Simon, now Professor of Psychiatry, University of California, San Francisco, California; Leslie Farber, now Chairman of the Faculty, Washington School of Psychiatry, Washington, D. C.; Margaret Hagan, then Field Director of the Red Cross unit at Saint Elizabeths; and Frances Herriott, Stage Manager, Theatre Guild, New York, and student of the Hollywood produced Mamoulian.

[2] Herriott, F. and Hagan, M., *The Theatre for Psychodrama at Saint Elizabeths Hospital, Sociometry,* Vol. IV, No. 2, 168-176, May 1941.

for the help of their Field Director, Miss Margaret Hagan, in organizing the work; and

"The Medical Society of Saint Elizabeths Hospital, for their continuing courtesies."

Patients from the Military

This was 1941, and Saint Elizabeths was receiving a considerable number of psychiatric casualties from the Navy; thus, it was natural that the program would center around Navy personnel. The sessions dealt primarily with the problem of preparing them to return to their homes. The session content dealt with such questions as "What am I going to tell the family at home?," "How can I get a job?," "What do I say when people ask, 'Why aren't you in uniform?' "

Some sessions were run on a semistructured basis. Participants were given a general outline of the situation and of their role, but the production was spontaneous. In other sessions the situations and roles evolved spontaneously as a part of the "warm-up" process.

Psychodrama at Saint Elizabeths was built in a free-flowing, informal atmosphere. The theater lent itself to many forms of creative therapies, and at this point in its development the psychodrama section included art therapy, music therapy, dance therapy, and drama therapy, the latter being differentiated from psychodrama in that it involved preparing for the production of plays which had already been written, as opposed to the more spontaneous nature of the psychodrama itself.

Training Social Workers

The Saint Elizabeths Red Cross unit was extremely active in training hospital workers, and under the imaginative guidance of Miss Hagan and Miss Herriott, psychodrama became an integral part of the educational armamentarium. Hospital workers were trained in developing an understanding of their problems in relating to patients and to patients' families as well as the patient's problems stemming from his having been mentally ill. During the war and in the postwar year it is estimated that approximately 3,000 Red Cross workers received some training at Saint Elizabeths through the use of psychodrama; and partly through the impetus received at Saint Elizabeths, psychodrama has become an important teaching tool in many schools of social work throughout the country.

Psychodrama Becomes Official

By May of 1942, psychodrama in general and Miss Herriott in particular, had proved their value to the Hospital. Accordingly, Miss Herriott, who had until then been working under private auspices became a part of the Hospital's permanent staff in the position of Psychodramatist, under Civil Service. She remained with the staff until March of 1948. During this period, in addition to numerous training activities, she directed 433 psychodrama sessions, comprising 843 patients. During this time the groups were small, 2 to 15 people, and were centered around the individual's needs, with a special emphasis on reintegration into the community.

Staff Meeting

When Mr. Enneis was appointed Supervisory Psychodramatist (probably the only person with such a title in the whole Federal Service) in September 1949, several staff meetings were devoted to describing psychodrama and to discussing the type of program which would best fit the needs of the Hospital. We were attempting to build a miniature society or therapeutic community in which most of the attitudes of the community at large would be reflected.

Contact with Ward

At first groups of acute patients from the receiving services were formed, gradually extending the program's patient coverage to those who had attained continued therapy status. Groups were to be made up of both men and women, and were to have a range of sickness from people who were extremely withdrawn to people who were about ready to leave the Hospital. From the point of view of diagnosis, treatment, and age, a heterogeneous group seemed desirable. On the wards group therapy, occupational therapy, nursing care, and recreational thrapy were being carried out and part of the function of the psychodrama sessions was to begin to help the patient intergrate participation in these activities into a meaningful hospital experience.

Problems of interaction with the patient and personnel working on the wards were worked out in action. These ran the gamut from dealing with feelings about raids being made on hoarded materials to how to get to see a specific professional person in the hospital and how to let it be known that the patient wished to attend social or other recreational functions.

In the sessions, if the ward personnel were present in the group they

were asked to work with the patient on stage. If not, other patients taking their roles would present the problem as it appeared to the patient and numerous approaches would be tried to determine their feasibility. Where indicated underlying motivations would be explored and related to past experience within the community or family structure as a part of developing an understanding for the patient and the group of the difficulty being treated.

Sociometric Grouping

Original groups were chosen sociometrically by going to the services and explaining what psychodrama was like, giving a demonstration in the ward, and then making a sociometric study of those patients who said that they were interested. On this basis individual patients to make up the groups were selected, and their names submitted to the chiefs of service for approval. The staff have continually worked through the wards to choose patients in order that the psychodrama experience would not be separated from their hospital experience.

Thus, we began with a group of patients who were enthusiastic. Their enthusiasm was contagious and soon more patients wished to come to psychodrama than could be included. The group grew until it numbered 50, then by another sociometric study this group was divided into two. A limit of 20 to 25 patients was placed on acute groups, where it was anticipated that the more intensive therapy would be offered.

Categories of Patients

The patients may be divided into two broad categories: (a) Acutely ill, newly admitted patients. There is general agreement that these patients should receive maximum of treatment as their prognosis is very favorable. (b) Patients who have been ill longer; these patients are often slower and less dramatic in their response than are the acutely ill, but we have found them responsive. It is important to note that work with these groups does much to dispel the attitude on the part of patients and staff that the longer-term patients have little chance of recovery.

In order to give a sense of completeness to the program and at the same time to illustrate the usefulness of the technique with patients who had been ill longer, groups were formed for the continued therapy services, starting with a ward of women, mostly regressed schizophrenics, who were still fairly active. Later, in order to help the group to become more self-

sufficient in its productions, a comparable group of men was added, making a large group of 40. As this unit developed, it was found that with patients who had been hospitalized for a long time the emphasis of the sessions began to focus more on attitudes developed during hospitalization which seemed designed to keep the patients ill. These attitudes had to be successfully attacked before much could be accomplished in working with the original pathologies.

Methods of Treatment

The core of the psychodrama program has always been with groups with a relatively stable membership meeting in the psychodrama theater for intensive therapy. Here problems active with group members are met. Efforts are made to limit the size of these groups so that three meetings a week permit expression from all who need it. Session content is drawn from the group and may deal with psychotic material, intrapersonal or interpersonal difficulties within the group, and problems brought from the hospital or home environments. Patients are confronted with the reactions of a micro-society represented by the group as well as individual group members and their own ambivalences. Efforts are made to afford opportunities for experiential learning through correctional emotional experience.

In addition, there are numerous special projects for mass therapy approaches used throughout the hospital. Treatment includes consideration of the sociometry of the groups and psychodramatic encounters and relates them to existential problems of living.

A need developed for the type of session in which there is confrontation with social cultural problems through central problems using, for instance, psychodramatic exit tests.

These situations permit confrontation of the patients with problems of reentering community life. Psychodramatic situations are established based in individual fears and on specific situations presented by the group and acted out by them. Not in the sense of merely repeating this situation but in terms of extending it to bring about a clearer understanding of the limits of threat and reward offered.

For example: A young woman returning to her family may have discovered during visits that they were overprotective as a result of her illness. Sometimes watching her very carefully when she is in the kitchen, almost denying her the use of a knife and fork at meals, arranging for relatives or neighbors to be with her whenever the husband is away from the house, all

of which tends to panic her, and to bring about questioning in her mind concerning her capacity to return to them.

Through the use of role reversals, asides and other psychodramatic techniques, we are able to help her develop the ability to bring into the open the inner personal problems implied by this type of behavior and to learn to handle them satisfactorily, not only on the psychodramatic stage but to gain enough width of perception to transfer experience gained in Psychodrama to the actual home situation.

The patient develops a self-consciousness in defining problems areas as she works on the psychodramatic stage. It is this process of becoming conscious of the problem and of her contributions to it, and to dynamics of her interaction processes with others who are pertinent socially to her adjustment, that leads to the development of the capacity to continually assess appropriateness and accuracy of perception and responses.

Since the Social Service Section dealt with many concrete problems of the patient's exit from the hospital and readapting to the community, they collaborated in establishing a rehabilitation group. This group consisted of patients about ready to leave the Hospital and to return to the community. Sessions were designed to give a confrontation of problems and a rehearsal of situations which the patients anticipated or had encountered while on visit. These meetings were under the direction of Miss Blanche Parcell of the Social Service Section, and represented a group approach to social case work. Special emphasis was placed on attitudes to be met in the family, job, social and community situations. Role practice and training were used as indicated by the group and individual patient's need. When practical, guests from vocational guidance and personnel units were brought in to aid through giving clear perceptions of the problems of obtaining employment and methods of meeting these. This also served to teach these visitors something about the nature of mental illness and people who were mentally ill.

Teaching and Training of Psychiatric Residents, Nurses, Attendants, and Others

Teaching groups were formed for interested staff members. These met one evening a week and on occasion included representatives of all Hospital echelons. The goal was in part to familiarize the staff with psychodrama in order to minimize distortions by rumor of what we were sure was going to be a very dynamic and powerful program. These sessions included teaching

techniques and the philosophy of psychodrama. Later, intensive teaching programs were established for different professional groups in the Hospital.

Training sessions were held for different groups of professional people in which psychodramatic techniques were used to train them for their role in the Hospital. For example, sessions might be devoted to training student nurses in the role of the resident in the hospital.

The psychodrama theater and its activities became one of the show spots of the Hospital and were visited by numerous professional people from this country and abroad. Many of these stayed long enough to receive some training and went on to set up programs in their own institutions.

Maximum Coverage of the Hospital

Therapy groups continued to expand as we tried to give maximum coverage to the Hospital. It was in 1950, prior to local general acceptance of integration, that psychodrama held its first racially integrated groups. These were all men of the "sex psychopath" group from the maximum security building. Work was started with these patients while they were in the maximum security building, then continued with them as they became well enough to be moved out into sections of the Hospital permitting greater freedom.

Essential changes occurring in the basic program over the years have been in terms of increasing breadth of patient coverage through the development of specific projects; for example, wards of patients who have reached a plateau in their response to drug therapy or geriatric wards where attitudes about community living may need restructuring. Most projects have dealt with attempts to bring about social revolution on wards whose structures have become static and pathology-preserving. Here are applied many of the lessons learned while working with the first group of deteriorated and regressed patients. Projects have ranged from groups of 100, (50 men and 50 women), all deteriorated schizophrenics, to geriatric wards of about 45 patients.

Results

The need for a mass therapy approach to reorient large groups is most clearly shown when social homeostasis is achieved on a pathological level; the over-all social structure and interaction seem geared toward the maintenance of pathology. This may be seen through a static social order, concomitant with attitudes tending to isolate group members except for pathological interaction.

There has been increasing evidence that the success of such massive programs is dependent in large measure on obtaining the participation of staff members directly concerned in the care of these patients. During sessions and in the course of role and role relationship, and questions of initiative as related to role function can be defined and worked through. As this occurs, many blocks obstructing alteration of the social structure of the ward seem to disappear.

Work on wards with deteriorated patients requires a thorough evaluation of the interpersonal or human relations structure in order that the therapist may be able to utilize his interaction in a deliberate and defined way, to change this structure. The goal being to make use of the therapeutic potential inherent in existing structures and at the same time to bring into awareness those patterns of relationship which seem to perpetuate psychosis. Usually this will be done by interpreting essential needs expressed through sick behavior and building situations gratifying these in new ways.

For example: On one ward the group standards had evolved in a manner that permitted tenderness to be expressed only after aggression. When patients attack each other, the defeated one could accept sympathy and condolence from the attackers and from other members of the patient group.

This standard evolves largely through the adjustment of the informed or sociometric leader who ruled the group through a pecking order type of structure. The therapist, by using his relationship to people key to the leader, produces first social chaos. As the informal leadership structure comes into doubt, psychodrama affords acceptable ways of aggressive expression and opportunities to express tenderness without the fear of loss of individual strength. Thus the group is helped to begin redefining acceptable behavior standards.

When such changes are initiated, it becomes necessary to maintain them through bringing in other disciplines such as occupational therapy, recreational threapy, social service, nursing, and so on, so that progress may be guided on a continuing basis toward goals as set forth by the project.

Through the use of sociometric studies, it becomes possible for these workers to direct activities toward the achievement of a more vital and healthful social structure. Coordinating the efforts of different disciplines working in the same project leads to a continuing improvement in communication between the individuals and hence to better patient care. Progress is often startling in its rapidity. Clinical observation on the part of the psychiatric staff and ward personnel has shown that attitudinal changes begun

during therapy sessions are transferred to daily living. Patients who have felt defeated, whose response to their illness and to the lack of satisfaction in hospital living, had resulted in apathy and adaptation to often unbelievably disquieting circumstances began to show initiative in bringing about changes within their living situations.

Psychodrama training activities for the staff have increased and broadened their scope. Programs are established with staff members selected both horizontally and vertically, and vary in content from sensitivity training to dealing with complex interpersonal situations and their effect on patient care. Training leading to some degree of efficiency in the directing of psychodrama therapy is offered to appropriate personnel.

In addition to the work at Saint Elizabeths, the psychodramatist is active in consulting on programs of supervision, communication, and human relations in administration for many governmental and, nongovernmental organizations. The psychodrama section serves as a resource center for other institutions: medical, educational, governmental, and individuals whe seek advice and training regarding applications of psychodrama to their particular situation.

Psychodrama to date (November 16, 1959) has held 2,896 therapy sessions for patients and has had contact with 3,547 patients. There have been 650 training sessions, in the course of which orientation demonstration sessions have been given for approximately 2,500 student nurses. The section has been host to over 400 visitors from the United States and abroad, and has consulted with 16 states requesting information and guidance in establishing their own psychodrama programs.

The psychodramatist is active in the training program of the Hospital for psychiatric residents; psychologists; and student chaplains, social workers, occupational therapists, nurses, et alii. Through this, the philosophies and techniques of psychodrama have become widely disseminated, since people receiving training at Saint Elizabeths are scattered throughout the world.

We at Saint Elizabeths Hospital are happy to have had the opportunity to pioneer in this fertile field.

SPONTANEITY TRAINING AND ROLE PLAYING IN INDUSTRY

MALCOLM SHAW

Cornell University

Spontaneity training begins with the basic idea that people improve social skills by becoming involved in meaningful experiences and learning from these experiences. However, it differs significantly in the techniques and rationale it utilizes to reach this objective. Before an attempt is made to define spontaniety training a common misconception must be clarified. The misconception arises because of confusion between the goal of spontaneity training and its central technique. The basic training technique in spontaneity training is role playing. Role playing had been introduced into business situations (by Moreno) in the early thirties (1). Applications spread to all fields of management and business education.

The growing concern in industry with the development of social skills coupled with the new training approaches developed by Moreno and others lead to growing acceptance and utilization of action methods in industry. Although the techniques in use have a common origin, they have moved in two diverse directions. One direction has been labeled the Laboratory Method (also known as T-group Training or Sensitivity training). The other has been identified as Spontaneity Training and Role Playing.

It should be clear that not all role playing or role training is positive training in spontaneity. In fact many industrial applications of role playing are oriented toward the development of specific skills through "analysis" of role playing enactments. In these instances the technique is being used as an analytical or diagnostic tool, *not* for the development of spontaneity. Descriptions of industrial role playing by Argyris (2), Bavelas (3), Bradford (4) and many others emphasize the opportunity that the technique provides for the discussion and evaluation of role players performances. In this context, role playing is used primarily as a basis for interpretive and analytical comments regarding the behavior of the players. Maiers (5) provides a rather complete rationale for this approach to training and points out that the role playing enactment provides a focus from which general principles of human relations can be extracted. Thus, although role playing is used to produce emotional involvement, the actual learning process occurs after the

fact. At least this is the point of view of many of the practitioners who are using it. When role playing is used with this analytical frame of reference, the trainee may become defensive and resistant to training.

Role playing has a clear place as a technique for diagnosing problems and for practicing specific skills. Moreno pointed out from the very beginning the diagnostic and analytic value of role playing, but he never limited it to analysis. However, when used in this way only it suffers from some of the same limitations as other didactic and analytical methods (6).

Spontaneity Defined

Moreno (7) has defined spontaneity as "an adequate response to a new situation or a new and adequate response to an old situation." Moreno suggests that the trainer should not concern himself primarily with teaching group members to conform to some predetermined standard or norm, rather that he should attempt to create a climate in which new approaches, new methods and new responses are created. Spontaneity theory certainly implies that an individual should become more sensitive to the forces which are present in a given situation. However, it also suggests that the individual should be trained to respond adequately to what is going on. The rationale for this approach can best be clarified through an analogy:

We now take it for granted that a child learns the language of his time and place through guidance, imitation, feedback and training in the traditional sense. But what of the origin of language? In the genesis of the development of language there must have been a time when the possibilities for imitation, guidance, and feedback were minimal. Practicing and learning by experience must have been preceded by the creation of the thing to be practiced or learned. In effect, there wer no norms or standards—*the only standard was the adequacy of the response to the environment in which man found himself.* His own spontaneity and creativity developed in interaction with the environment. Presumably, at the start, he discovered that he could make sounds. The mere production of sounds must have been the first step in the development of language. One can argue that the sheer production of sound with no manifest results and no interaction is merely random behavior. However, one can take the point of view that this is the beginning of learning and that guidance, imitation, and analysis are refinements of the learning process. Thus the learning of language begins with action *in situ.* Moreno (8) summed up this point of view when he said:

"The baby languages are spontaneous language formations of an autistic character. Although they differ from the organized language of the adult, they have a structure of their own which is more actional and verbal, closer to the spontaneous act than to the frozen word."

This analogy serves to illustrate the two concepts which are basic to spontaneity theory: (1) The individual brings something of his own to the learning situation. He brings creative and spontaneous forces within himself which he may tap to meet the needs of the situation in which he finds himself and ultimately shape to conform to the standards of the society of which he is a member. (2) The sheer act of creating and experimenting with new responses precedes the shaping of these responses to fit predetermined standards of behavior, and in fact, precedes the establishment of the standards themselves. Spontaneity training depends upon action to produce results. Its objective is to increase the participant's awareness of the range of responses which are available to him. Results are not accomplished through analyzing his behavior but rather by creating conditions which make it possible for the trainee to discover and utilize his own potentialities. The frame of reference is not a predetermined set of values, but rather the forces present in the here and now demanding specific responses. Thus spontaneity training attempts to create a kind of primal learning situation in which creativity action and external environment are blended to maximize the effectiveness of the individual's responses.

Critical Differences

One of the critical differences between spontaneity training and the laboratory method is the role of feedback in the training process. Both approaches stress the importance of learning from the on going experiences in the group. That is, the participant must receive feedback from the experience in order to learn. A brief example of the feedback process in laboratory training and in spontaneity training will serve to illustrate the differences in the role that feedback plays in the learning process. For purposes of the illustration let us assume that a group member has been punitive and aggressive in his relationships with other members of the group. Here is how the problem might be handled in each of the approaches:

(1) The Laboratory Method

There are actually many ways in which the effects of the group members behavior might be fedback to him in a Laboratory session. He might for example find himself rejected by the total group. He might find that his

suggestions are ignored or meet with strong opposition from other group members. He then might receive direct feedback from the trainer or a group member who would say in effect: "You've been pushing people around and have not been considerate of the feelings of others." This would be followed by a discussion of incidents in which the group member demonstrated these qualities, the other group members might feedback their reactions and interpretations. Another possibility is that the group member himself might ask the group why they had become resistant to him. Again he would receive direct feedback from group members and perhaps the trainer. Thus from the T-group point of view, the unstructured group setting creates an atmosphere which rapidly exposes the group members punitive behavior, in addition a sufficiently permissive atmosphere has been established to make it possible to discuss this behavior. Although the group members awareness of his impact on others may have been on the "feelings" level and in that sense part of his feedback comes in action from the situation, the primary tool in increasing his sensitivity is direct process or personal feedback observation from the group. As the T-group moves on the member who has now been sensitized to the impact of his behavior on others often continues to fall into the same pattern and group members can stop him and say: "See, you've done it again." Ideally the group member gradually becomes aware of the kinds of situations and the kinds of relationships which produce this negative behavior. He then has an opportunity to experiment with *new* approaches.

(2) Spontaneity Training

In spontaneity training the individual receives his feedback from the situation, from the action, and in the here and now. Rather than being told that he is too aggressive or punitive he becomes involved in a role playing enactment (or identifies with someone else playing a role) and begins to experience resistance or withdrawal from another individual or group of individuals participating in the enactment. Through doubling, role reversal, and other psychodramatic techniques, the individual member and other members of the group are encouraged to explore all dimensions of the problem under consideration. In the process of this training in action the individual begins to drop rigid patterns of behavior and to experiment with new approaches and feelings. Role reversal helps him to see himself as others see him. Doubling gives him an opportunity to examine underlying feelings and attitudes. Soliloquy helps him to reflect on his own feelings. However, these insights are incidental to the central process of producing spontaneity.

Perhaps the learning process in spontaneity training can best be understood by examining the total development of the session. The first phase of spontaneity training is a warm up in which existing sociometric relationships are briefly examined and areas of commonality are isolated. During this process each group member is warmed up to a common problem. Therefore when role playing enactments begin the individual participant does not move into the enactment as one isolated individual but rather in a sense he brings a part of the group with him. He is simultaneously an actor and an observer. For although he moves to the center of the role playing area he is still aware of the audience and in fact psychologically is still a part of it. The marriage of the acting and observing function is further reinforced by the use of psychodramatic techniques such as role reversal, doubling and soliloquy. Thus, as the individual acts in the situation, he is also observing, sometimes through the eyes of others (through the mirror or double); sometimes through his own eyes as he reverses roles or soliloquizes. This action process creates an atmosphere in which new patterns of behavior can be evoked and utilized. Thus spontaneity training rather than feeding back negative reactions from the trainer or other group members produces new responses. Rather than criticizing or punishing negative behavior, spontaneity training assists the trainee in finding more satisfactory and effective ways of behaving.

A second significant difference between the laboratory method and spontaneity training lies in the handling of group norms or standards:

(1) Laboratory Method

The Laboratory Method leads to the development of new social norms. The unstructured group comprised of participants who have no previous sociometric ties along with the process observation by leaders who are typically oriented in the direction of democratic leadership facilities the development of these new norms. Lectures and theoretical discussions along with method centered role playing tend to buttress the development of these group standards. Thus group members begin to place a heavy value on such things as permissiveness, democratic leadership, sensitivity and non-directiveness. Members frequently leave these sessions with a new and somewhat confused image of the ideal leader. They also become aware of some of their own conflicted feelings about authority, dependency and inter-dependency. Therefore important questions which require more study and serious consideration by Laboratory Method practitioners are: Does the set of standards and norms which tend to be established through a Laboratory experience

comprise the best possible standards of behavior for leaders in industry? On the other hand, do these new standards and expectations create new areas of conflict which may inhibit and constrict the individual's on-the-job behavior?

(2) Spontaneity Training

Rather than attempting to substitute one set of norms for another, the spontaneity training group uses the potentialities of its members to establish a climate in which the constricting and inhibiting effect of group standards or cultural conserves is minimized. The basis of the T-group theory of change is a combination of ideas concerning the role of group standards and an analytical approach that assumes that feedback is the primary tool for change. Spontaneity theory on the other hand depends upon the creative and spontaneous behavior of individuals to bring about change. Rather than substituting one set of group standards for another spontaneity theory suggests the creation of an atmosphere in which the norm for the trainees behavior is the situation itself, the here and now. The goal of spontaneity training is not to establish a standard of permissiveness or any other specific set of behavioral values. The goal is to increase the individual's ability to respond to the ever changing standards of reality.

Applications and Differences of Action Training Methods

The critical differences between the laboratory method and spontaneity training may be summed up as:

(1) The laboratory method is more analytical. It leans heavily on interpretive comments to assist group members in understanding their own behavior and the various group forces influencing individual behavior and group activity.

(2) Spontaneity training is primarily concerned with the development of an action climate in which participants learn to respond to whatever forces are present in the moment of interaction. It shuns analysis *per se* as much impossible. It is concerned with what the individual can do rather than with what he has done or what he could do.

(3) The two methods are not mutually exclusive. T-group sessions do provide opportunities for experimentation and devlopment of spontaneous responses. Spontaneity training sessions permit some analytical comments and some intellectual considerations involving group presures and standards.

These differences have been defined and presented in terms of approach in developing individual effectiveness. There is a significant difference in the

role that group dynamics plays in the separate rationales of the two training methods. It has been pointed out that the laboratory method leads to a critical examination of *existing group standards*. It encourages group members to question existing standards and provides a setting for the development of new standards. Permissiveness, tolerance toward others, willingness to examine feelings, and acceptance of democratic procedures tend to become the frame of reference for judging member behavior.

In spontaneity training sessions group participants are trained to respond to what is going on in terms of the feelings evoked and inherent in the situation as it occurs. There is no attempt to evaluate these responses against any existing standard. Rather, the trainee, through expanding his range of responses, begins to discover new patterns of behavior which produce better results in the existence of the here and now. Essentially, the trainee is learning to warm-up and respond adequately to the changing sociometric interpersonal and cultural forces existing in the group. The spontaneity method develops the ability for creating *new group standards*.

A GROUP COMPARISON OF NEGRO NARCOTIC ADDICTS WITH NON-ADDICTED NEGRO AND WHITE CONTROLS

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One hundred active heroin addicts in the negro residence sections of Chicago and forty incarcerated (forcedly withdrawn) heroin addicts in the Cook County Jail were studied by means of a personality inventory[1] and a detailed socioeconomic status and family background information sheet. In addition, for purposes of normal controls, a Negro and a white group of about 200 individuals each were similarly studied.

Subsamples of 25 randomly selected individuals from each of the addict groups and the Negro control group were studied in more detail by means of the Rorschach, projective drawings and stories, parts of the Wechsler Adult Intelligence Scale, and clinical interviews.

The present report will be limited to findings based on the analysis of the Negro narcotic addicts' attitudes, as reflected in the 160-item inventory.

The Inventory was administered under the title, "The Personal Opinion Inventory" (POI). It consists of two parts. Part One contains seventy items which are of the indirect attitude measurement type (1). Included in this part are an abbreviated version of the California F-Scale (11 items), and three scales devised by L. Srole (2): the Anomia Scale (10 items), the Social Prejudice Scale (7 items), and the Rigidity Scale (6 items).* These scales are interspersed with 36 buffer items which were designed for indirect estimation of various attitude clusters.

Part Two of the Inventory, 90 items, is of the direct, or self-descriptive, attitude measurement type (such as the MMPI, Bernreuter, etc.). Included in this part are 18 MMPI depression items, and 14 Taylor Manifest Anxiety Scale (MAS) items validated by Buss for psychiatric patients (3). Other items are adapted and newly devised for the purpose of estimates of aggression, suicidal tendencies, dependency, sexual inhibition, etc. All items are of the agree-disagree variety.

[1] The Inventory was developed by M. S. Zaks in a study of heart patients at Northwestern University Medical School.

* Personal communication—The authors are indebted to Dr. Leo Srole, visiting Professor of Social Psychiatry, Cornell University Medical College, for permission to use his scales in this research study; some of these scales have not yet been published.

First, a general discussion of significant attitudinal differences, as reflected in Inventory items, between narcotic addicts and non-addicts, will be presented. Then results obtained from 4 particular scales included in the POI will be discussed in some detail. These are the Aggression Scale, the Dependency Scale, an abbreviated Taylor Manifest Anxiety Scale (MAS), and an abbreviated MMPI Depression Scale. A brief description of these scales follows:

The Aggression Scale

The 12-item Aggression Scale employed in this study has been developed by Zaks and Walters, and is reported elsewhere. The Scale has been validated by Walters and Zaks for normal subjects as well as for pathological manifestations of aggression.

The importance of aggressive drives and motives in narcotic addiction is of definite interest, as Eisler, Glueck and other investigators of delinquent behavior have consistently stressed that in antisocial acting-out conditions, aggressive drives are directed against the social environment.

The Dependency Scale

As this Scale has not yet been discussed in any publication, a brief description of its development and validation will be presented.

The Dependency Scale was developed by means of a comparison of Inventory item responses of 50 normal, adult, white subjects rated high in dependency by close associates, and 50 subjects rated low in dependency by their associates. The Dependency Scale developed on adult individuals resulted in 15 items significant at a better than .05 level.

The validation method was essentially the same as in the modified "guess who" peer rating technique employed with the Aggression Scale. In all, 10 small living and leisure activity groups, ranging in size from 11 to 27 members, were included in the Dependency Scale validation study.

The reliability of ratings as determined by means of Kendall's coefficients of concordance was found to be highly significant. A comparison of dependency scores obtained by a pool of the highest ranking third and the lowest ranking third of members in each of the 10 groups, indicated that the provisional 15-item Dependency Scale discriminated significantly between individuals characterized by a high and low degree of dependent behavior, as judged by peers.

A relationship of dependency conflicts to narcotic addiction can be

expected to exist on theoretical grounds. In psychoanalytical studies, oral fixation is frequently stressed in this context.

The Abbreviated Taylor Manifest Anxiety Scale (MAS)

The MAS is too well-known an instrument to need detailed description. It was developed by Janet Taylor, and consists of 50 MMPI items. In a cross-validation study on neuropsychiatric patients by Buss (6), the number of discriminative items shrunk to 14. These 14 items have been included in our 160-item Personal Opinion Inventory, and the scores obtained on the 14-item Anxiety Scale have been used in our study.

The reason for the inclusion of a measure of anxiety is two-fold. First, the possibility exists that narcotic addicts are highly anxious individuals and that narcotics are used to some extent to reduce anxiety. Another possibility is that the narcotic habit is responsible for a heightened anxiety state, that is, the addict gets anxious and even panic-stricken when being faced with a loss of narcotic supplies.

The Abbreviated MMPI Depression Scale

This Scale consists simply of 18 of the 60 MMPI Depression Scale items, interspersed amongst the 90 items in the self-descriptive part of the Personal Opinion Inventory. It was expected that 18 items may be sufficient to estimate group mean differences between depressed and normally functioning individuals.

That narcotic addicts show considerable depression has been frequently reported by previous studies. The nature of these depressions, however, has remained ambiguous. As with anxiety, it is not clear to what extent depressive trends are primary, that is characteristics of the narcotic addict's personality, and to what extent they are secondary, or repercussions, of the narcotic habit.

Population

In our first analysis, 100 free Negro active heroin users were compared with 40 Cook County Jail incarcerated Negro heroin addicts and 100 non-addicted Negro controls. While no attempt has been made to match the groups, a comparison of average age and education was made by means of *t*-tests and the groups have been found roughly comparable, that is, no statistically significant differences between the groups were found.

All active heroin users were tested at the St. Mark's Episcopal Church in the heart of the Negro belt in Chicago. All these actively addicted indi-

viduals came to the church in order to participate in the newly-established narcotics anonymous type of rehabilitation program conducted by the minister, Father Robert Jenks, in the church basement. The program provided for the achievement of withdrawal from heroin addiction by means of medical tranquilizer prescriptions by a competent physician, minor financial assistance, counseling, and help in obtaining jobs and shelter. Group therapy sessions were also conducted by clinical psychologists. Attendance in any of the activities was completely voluntary. The psychological tests were administered on a voluntary basis. Many of the addicts came to the church but once and received the tests on that occasion, while some of the others subsequently followed through with some or all of the rehabilitation activities offered.

The prison sample consisted of 40 inmates and was determined by means of narcotic addiction entries on the prisoners' jail classification cards. These prisoners were serving time for crimes connected with narcotic addiction and were mostly convicted through the special Narcotics Division of the Criminal Court in Chicago. They represented about 25 per cent of the total narcotic addict prisoner population in the jail during the period of data collection for this project, which was in 1957.

The 100 Negro male controls were pulled from various neighborhoods in the Chicago Negro ghetto. They consisted of a number of subgroups. Subjects were chosen so as to represent lower socioeconomic status individuals.

The 100 white subject control group consisted of 75 students at the Greer Vocational School, located in a Negro-white fringe area of Chicago, and 25 students at the Central YMCA High School Evening Division.

Results

A comparison of the 100 active Negro narcotic addicts with the 100 Negro non-addicted controls of the 160 items in the Personal Opinion Inventory, indicates that the number of significant differences between proportions of agreement with the various items is highly significant. Fifty-three of the total 160 Inventory items (that is, 33 per cent of all items) discriminated significantly between active Negro heroin addicts and non-addicted Negro controls. However, it is interesting to observe that of these 53 discriminative items, only 7 items are from the first part of the Inventory. As some significant differences may be expected to be due to chance sampling variation within a context of 70 items, the 7 discriminating items comprising 10 per cent of the indirect attitude measurement items, is not impressive.

In the second part of the Inventory, however, 46 out of the 90 self-descriptive items (50 per cent) reached significance beyond the .05 level. Of the 46 discriminative items in this part of the Inventory, 11 discriminated at a better than .01 level, and 22 items discriminated at a better than .001 level—a very highly significant proportion.

Considering the wide variety of indirect attitude items in Part One of the POI reflecting the testees' evaluations of other people, their actions and values, it appears that the active narcotic addicts vary but little from their non-addicted peers in perception and estimation of other people and their social environments.

On the other hand, it is apparent that when the narcotic addicts are asked to describe themselves in various ways, rather than others, as is reflected in the self-report items in Part Two of the POI, very striking differences come to the fore.

Evidently, then, the active Negro narcotic addicts perceive the world around them in essentially the same manner as do non-addicted individuals. However, the narcotic addicts evaluate themselves as quite different from others in many ways.

The Cook County Jail narcotic addict prisoners reacted to the indirect attitude items in a manner comparable to the non-incarcerated addicts; that is, of the 70 items in the first part of the Inventory, only 9 items (13 per cent) exceeded the .05 level of significance. In the second or self-descriptive 90-item Inventory section, 20 items (22 per cent) reached statistical significantly between the non-incarcerated addicts and the jailed addicts, indicates that some real differences between the active and jailed narcotic addicts are also present.

Among the items the active narcotic addicts most frequently agree with, many are indicative of feelings of inability to cope with the considerable pressures and tensions which they experience. They report as being unhappy, feeling useless, dreading to wake up in the morning, lacking self-confidence, being distrustful toward people, feeling as if approaching a nervous breakdown, and similar disturbing feelings.

In the jail setting, many of this type items show a significant decrease in frequency of occurrence. On the other hand, the jailed addicts show increased reactions in other areas. For example, while none of the 11 California Authoritarianism Scale items reached statistically significant elevation in the active addict group, 3 of the 11 F-Scale items reached statistical significance in the jailed addict sample. This increase in authoritarianism

might be due to a situational variable, namely, the influence of the jail environment.

Another finding is that while the active addicts do not differ on religious attitude items included in the Inventory from normal Negro controls, the jailed addicts clearly differ from both the normal Negro controls and the active addicts on items related to religion; e.g., they deny church attendance, the need to pray to the Lord for guidance when faced with important decisions, and the need for faith in some supernatural power.

In some respects, however, both addict groups describe themselves as different from their unaddicted peers. Individuals in both addict groups describe themselves significantly more frequently than non-addicts as being "a very nervous person." Both groups are similar in reporting inability to hold a job for a long time, and in their pronounced feelings of restlessness and of being tied down when they make attempts to hold down a job. Also, both addict groups report with a high frequency that their sex life is unsatisfactory.

It is of particular interest to note that suicidal tendencies are reported more frequently by both the active, non-incarcerated narcotic users and the jailed narcotic addict group, than by control. To the item, "At one time I attempted to take my own life," 13 per cent of the active addicts and 10 per cent of the jailed addicts answered with agreement, while only 3 per cent of the non-addicted Negro controls did so. This impression is strengthened by the significantly high agreement of both active and jailed narcotic addicts with another item reflecting a possible presence of latent suicidal tendencies, namely: "Sometimes I feel so disappointed or worn out that I just want to go to sleep and never wake up again." The group similarity of both addict groups in response to items related to aggression and dependency deserves special consideration, and will be discussed next.

The general descriptive analysis of the differences found in Inventory results indicates that Negro heroin addicts, independently of active addiction or forced withdrawal in a jail setting, perceive themselves as being nervous individuals, unable to make a satisfactory adjustment in their personal life, with pronounced difficulties in the spheres of affectionate relationships and adjustment to stable, gainful employment.

Some of the feelings of unhappiness, uselessness, and lack of self-confidence are more pronounced under the conditions of active addiction, while in the jail setting, some authoritarian attitudes and denial of needs for religious comfort seem to come to the fore. It is not really surprising to

find a heightened self-reported suicide attempt rate in a context of such an extensive disruption of the heroin addict's confidence in his ability to cope with his internal and environmental adjustment problems.

We shall now turn to the analysis of some scales concerned with personality variables.

For purposes of an exact comparison, the active addicts, the jailed addicts and Negro and white control groups were closely matched as to age and education. Thirty-five individuals in each group were included in the matched group comparisons. The averages follow closely the age and educational distribution observed in arrest and conviction data analyses in Chicago over a number of years.

The following results were obtained in comparison on scales for aggression, dependency needs, depression and manifest anxiety:

(a) The active addicts and the jailed addicts alike were significantly more aggressive than the Negro and white control subjects. There were no significant differences found between the white and Negro control groups on the *t*-test. Notice that both active and incarcerated narcotic addicts do not differ between themselves in aggression, but each of the narcotic addict groups is significantly higher than the control groups.

(b) The active addicts, as well as the incarcerated addicts, scored significantly lower than the Negro control group on the Dependency Scale. In this they tend to resemble the white normal control subjects who score significantly lower in dependency than the Negro controls. Notice that the *t*-test differences are not significant between the two narcotic addict groups, but that both jailed and free narcotic addicts are significantly lower in admitting dependency needs than their non-addicted Negro peers. In this respect, the narcotic addicts tend to hold attitudes more similar to those expressed by the white population.

(c) The active, non-incarcerated addicts had elevated *manifest anxiety* scores, differing significantly from incarcerated addicts who did not show heightened anxiety states, as measured by the MAS is complex, is evident in that the white normal control group, which was taken from a Negro-white fringe area and consisted of a large proportion of individuals who recently immigrated from the South, also tended toward some elevation in manifest anxiety scores.

(d) Depression was elevated only in the active heroin addict group, but not in the jailed narcotic addicts. As expected, the mean depression

score for active addicts was significantly elevated also in comparison with the Negro and white normal control groups.

Summary

These results indicate that active heroin users, as well as forcedly withdrawn addicts in a jail setting, possess significantly elevated tendencies toward aggressive behavior. At the same time, they resent or deny dependency needs with a frequency significantly beyond the degree characteristic of the normative Negro population and, in this respect, they express attitudes more closely resembling those of white controls. This implies a denial of a deprived social role and lack of socioeconomic security and is a reflection of an internal conflict and an unrealistic attitude toward the environmental limitations presently existing.

As these two characteristics—aggression and dependency denial—appear consistently and independently of active heroin intake or forced withdrawal conditions, they may be suggestive of enduring or more or less permanent personality traits of the Negro heroin user.

AN ATTEMPT TO CATEGORISE CULTURAL VARIABLES IN THE APPLICATION OF PSYCHODRAMATIC TECHNIQUES

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According to English and English,[1] the definition of Psychodrama is: "The improvised enactment by a client of certain roles and dramatic incidents, prescribed by the therapist and designed to reveal what certain kinds of social relations really mean to the client . . .". Made quite explicit here is the importance of the therapist's perception: the roles and dramatic incidents are "prescribed" by the therapist, on the basis of what he perceives as disturbing elements in the patient's personality composite. Thus, we may assume the validity of the therapist's initial diagnosis to be positively correlated with the temporal efficiency of the treatment, and to some extent at least, with the final results of the therapy.

Inasmuch as the Psychodramatic methods are primarily utilised in the treatment of non-organic pathology, the focus of attention must of necessity be upon (a) the veridicality of the patient's perception of environmental demands, and (b) the appropriateness of his behaviour in the light of these demands. Performance of optimal therapy is thus contingent upon complete understanding of the environmental forces which interact with the individual personality factors.

We must note that the above definition is perhaps overly stringent in stating that the whole of the psychodramatic incident is "prescribed" by the therapist. It would be more correct to state that the therapist "steers" the dramatic incident on the basis of clues afforded by the patient. Nevertheless, perceived importance of the patient's behavioural manifestations do provide the clues through which the therapist aids the patient toward veridical social perception. It is suggested, inasmuch as treatment is dependent upon the correct perception of the individual vis a vis his environment, that if Psychodrama is to transcend the limitations imposed by the ideographic conceptualisation of the relationships extant between individual and environment, a universal framework must be constructed, whereby those components of any particular social environment which determine or influence organismic behaviour may be classified into pre-existing modes,

[1] English, H. B., and English, A. C., *A Comprehensive Dictionary of Psychological and Psychoanalytic Terms* (N. Y., Longmans, Green, & Co., 1958).

immediately providing the therapist with a pattern for evaluation and guidance. When there is a definite universal coding schema, upon which may be superimposed the behavioural manifestations of the individual, Psychodrama will permit of wider application and utilisation, having become a truly nomothetic, or "super-individual" science.

To illustrate, consider the hypothetical case of the social worker attempting to persuade the first-generation Italian immigrant, living in the midst of a New York Italian subculture, that is important to go to college in order to rise. If the social worker realises the achievement is an American activity value orientation not shared by Italians, a meaningful Psychodrama could be conducted whereby the Italian is brought to the realisation that his values are not compatible with those of his adopted country; a rational basis for inducing change. If, on the other hand, the social worker were to employ Psychodrama without consideration and allowance for cultural derivatives, little would be accomplished in changing the aspiration level of an individual who, is after all, perfectly in tune with his particular subculture. Without an empirical means for assessing the particular value structure present, the Therapist would have to rely on intuition in each individual case; with an empirical evaluation framework, he could study the factors present, classify them, and apply a culturally universal pattern within the Psychodramatic treatments.

We would suggest, as the basis for our cultural framework, Florence Kluckhohn's value orientation scheme,[2] through which the self-perceived values of any culture may be classified into five categories, which under the heading "Human Problems and Type Solutions," are as follows:

1. Time Orientation: Past, Present, or Future.
2. Relational Orientation: Lineal, Collateral, or Individualistic.
3. Activity Orientation: Being, Being-in-Becoming, or Doing.
4. Human Nature: Evil, Mixed, or Good.
5. Nature Orientation: Subjugated to, In Harmony With, or Over.

Although this coding schema may be found not to include a sufficiently minute fractionation of cultural value derivatives, it does at least provide a testable working hypothesis, of which the sufficiency can be assessed through application of individual Psychodramatic therapy.

[2] Kluckhohn, F., "Dominant and Variant Value Orientations" in Kluckhohn, Murray, and Schneider, *Personality in Nature, Society, and Culture* (N. Y., Alfred A. Knopf, 1956).

Having seen the importance of knowing something of the culture in which one is to employ Psychodramatic techniques, we should like to offer another illustration, this time of the Irish culture, of the way in which certain problems are culturally determined so that the Psychodramatic director who is aware of these special problems can conduct more meaningful sessions.

In terms of the value orientation scheme presented above the Irish have the following profiles: *Time Orientation:* Past greater than Present, greater than Future; *Relational Orientation:* Lineality, greater than Collaterality, greater than Individualism; *Activity Orientation:* Being, greater than Doing, greater than Being-in-Becoming; *Human Nature Orientation:* Evil, greater than Mixed, greater than Good; *Nature Orientation:* subjugated to, greater than Over, greater than In Harmony With.

In turning first to the time orientation, we see that the Irish Past Orientation is in striking contrast to the American Future Orientation. Americans tend to think that the future will be the most glorious period of all, that progress is inevitable; for the Irish, however, ". . . the past reflects their glories and is a convenient vehicle for the expression of their superiority, so the present can be measured against the past in the same terms, usually only to be found lacking."[3] It is the old who are respected among the Irish Society, since they are the representatives of the past, whereas in America it is the children who are given the greatest attention, since they represent the all-important future. Whereas American culture, is on the whole, child-centered, Irish culture is adult-centered. Hence, in American culture, since it is the future which is looked to as the most glorious period of all, the son is expected to surpass the father in his "success" and achievements; on the other hand, in Irish culture it is the hope of every son that he will achieve as much as his father has. The Psychodramatic Director and Auxiliary Egos working in a session in Ireland might then afford the individual the opportunity of working out any fears he might have of not living up to the past heritage and role-model provided by the father. Hence, the technique of role reversal would seem particularly important, since, given the opportunity to play his father, the son would have a chance to act like this revered model which otherwise he might not dare to try.

[3] Arensberg, G. M., and Kimball, S. T., *Family and Community In Ireland* (Cambridge, Mass., Harvard University Press, 1948), p. 171.

This adult centeredness is further given support by the First Order Lineal Relational Orientation. Authority lines are fairly distinct from father to son; this paternal dominance continues as long as the father lives. Even though the major work on the farm is done by the sons, they have no control of the direction of farm activities nor of the disposal of farm income. The Irish marry later and are dependent upon parents longer than the people of any European nation. ". . . the sons even though fully adult, work under their father's eye. and refer necessary decisions to him."[4] It is not at all unusual for a man of thirty-five or forty to be living at home under the rule of his father and to be dependent upon him for everything he needs. "Even at forty-five or fifty, if the old couple has not yet made over the farm, the countryman remains a 'boy' in respect to farm work in the rural vocabulary."[5]

PERCENTAGE OF UNMARRIED PEOPLE AT A GIVEN AGE LEVEL*

Age	% Unmarried Males	% Unmarried Females
25-30	80%	62%
30-35	62%	42%
35-40	50%	32%
55-85	26%	24%

* Source: Kimball & Arensberg: this table was compiled by the authors from the Kimball & Arensberg data.

Certainly, such long submission to the father must foster a great deal of resentment, and the Psychodramatic Director who was aware of this problem would probably conduct a session which would be highly meaningful to both the protagonist and the audience were he to afford the opportunity for a free acting out of this resentment. Furthermore, it seems that if an individual has been treated as a dependent, irresponsible child until the age of forty, the thought of eventual taking-over of the farm and becoming responsible for the welfare of his family must be frightening. Here, the Psychodramatic tehnique of projection into the future would be particularly helpful, since the Director could give the Protagonist the opportunity of acting out, of living through, the situation where he will for the first

[4] *Ibid.*, p. 41.
[5] *Ibid.*, p. 56.

time assume responsibility and become an adult. Such rehearsal of his future role would be particularly meaningful to the Irish "boy" of forty.

In turning now to the activity orientation we note that the Irish Being orientation is quite different from the American Doing orientation. If we consider the case of the Irishman who comes to this country to work, we can readily see the conflicts which might arise between an American supervisor who is used to men with a desire to succeed, to get ahead, to *Do*, and the Irish worker, who is far more casual, refuses to be driven, and who revolts against the mechanisation and depersonalisation of his job, wishing instead to be the craftsman and to enjoy the company of his fellow workers. A Psychodramatic role reversal between these two might show the foreman how the worker perceives his hard-driving demanding efficiency, and would afford the worker the opportunity of learning something of what was expected of him and why.

The Irish view of human nature is that it is evil; their sense of sin and guilt has been observed clinically, has been portrayed by novelists,[6] and is evidenced by their lack of and late marriage. Relations with others are based primarily upon the basis of duty and obligation. "When asked especially why they were cooperating, the farmers' answers were that they 'had right to help' . . . . Now the phrase 'have right' expresses an obligation, duty, or the traditional fitness of an act."[7] Helping others, controlling impulses, and doing what is expected has an obligatory character to it, and is made verbal in a highly explicit and rigid moral code. What the individual wishes to do must give way to what he should do; egocentricity is, in this culture, controlled by feelings of guilt and by rigid adherence to the imperatives of the moral code. Antagonism between the sexes is traditionally strong; to be near women constitutes a great threat, since all impulses must be held under tight control. As Arensberg and Kimball have pointed out: "Men and women are much more often to be seen in the company of members of their own sex, and there is of course no opportunity for adolescent sex play and experimentation; the country people yield to no-one in the strictness of their sexual morality."[8]

We can readily perceive the lack of preparedness of the Irish male or

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[6] See, for instance, Sean O'Casey, *Mirror in My House* (N. Y., Macmillan, 1958) and Robinson, H. M., *The Cardinal* (N. Y., Simon & Schuster, 1950).

[7] *Op. cit.*, Arensberg and Kimball, *Family and Community In Ireland*, p. 75.

[8] *Ibid.*, p. 202.

female for marriage when neither of them has had much experience with dealing with members of the opposite sex, and when sexual impulses have been for so long held in check. The Psychodramatic Director, aware of these problems, could conduct a series of highly meaningful sessions in which men and women would have the opportunity of interacting, where by use of the projection into the future technique, men and women might rehearse their forthcoming marriage, and where by use of role reversal techniques they might gain some further insight and understanding of their future partners. Furthermore, the tremendous sense of guilt about sexual activity could be portrayed and in this manner somewhat alleviated.

And finally, there is tremendous conflict for the Irish who are dependent for their livelihood upon the yield of their land, and yet believe that nature is stronger than they and that they are subjugated to it. The Director who had to start a session "cold" could well use this problem since it would be meaningful to the entire audience, and would get everyone involved and eager to participate in the session.

On the occasion of our visit to the Moreno Institute, the protagonist was a boy who was concerned about what role he should play in life, and whether or not he was making the right choice of friends, clothes, etc., in order to be a success. Since this problem of "Success" is a highly American one, William James once having characterised Americans as worshipping "The Great Bitch-Goddess Success," the audience became very actively involved in the boy's portrayal of his conflicts and strivings. In any culture with a Doing Orientation, where the emphasis was on mastery and achievement, such a portrayal would be one which would "strike a bell" with the audience and would be highly meaningful. However, in a culture with a Being Orientation, such as we have described for the Irish, this question of "success" would not be likely to induce involvement.

Another highly American problem is the general lack of close friendship among males, which is at least in part due to the fear of homosexuality. The emphasis is not on friendship, but on popularity, not on mutuality of interest but on casual acquaintance. Psychodramatic sessions centering around the problem of the isolation of the American boy from any real friendship with his male peers would be highly meaningful in this country; however, in France, for instance, where close friendships among men are readily formed and maintained, a Psychodramatic Director would not be able to really warm up his audience to such a problem since it is not pertinent to the experiences of the French people.

We have thus seen how the type problems best dealt with by Psychodramatic Techniques within a particular culture is a function of the particular values germaine to that culture. We have further suggested a coding schema by which values may be classified into any one of three categories within each of five general classifications. In order to provide the sought-for scientific basis for application of Psychodramatic Techniques, it now remains for research to be performed in order to empirically determine what particular problems are especially germaine to each culturally evinced composite of values; when this is accomplished, there will exist a truly universal basis for the application of Psychodramatic Techniques.

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THE USE OF EXTRAMURAL ACTIVITIES IN GROUP PSYCHOTHERAPY WITH HOSPITALIZED FEMALE CHRONIC SCHIZOPHRENICS*

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In recent years numerous techniques have been employed to increase the effectiveness of group psychotherapy with hospitalized chronic schizophrenics. Didactic material has been introduced to compensate for the patients' diminished spontaneity (1). Active participation by the therapist has been advocated to minimize the possibility of patients' withdrawing into their own autistic fantasies (2). Ancillary therapies have been used to foster the development of group cohesion (3). Chewing gum and chocolate have been made available to patients during the group session to satisfy their intense oral deprivation, and more significantly, to enable the patients to receive food from the parental figure (therapist) and to partake of it in the family setting of the group (4).

The purpose of this paper is to report another method of enhancing the effectiveness of group psychotherapy with hospitalized chronic psychotics. Specifically, it will be shown how the group's participation in extramural activities—social events that occurred in the homes of hospital volunteers—served to overcome the patients' reluctance to discuss their personal problems and enabled them to adopt more constructive attitudes towards their illness.

The female patients who participated in the project were members of an occupational therapy group that had been in existence approximately six months. The patients had reached the point where they did not hesitate to call on each other for help as they worked together in the daily occupational therapy periods, and their social behavior had improved considerably. However, their performance in the twice-weekly group psychotherapy sessions left much to be desired. Here they maintained their emotional

* The work to be described in this paper was accomplished while the author was a member of the Psychology Department at Winter VA Hospital, Topeka, Kansas. Dr. Cohen is now Chief, Psychology Service at the Philadelphia VA Hospital, Philadelphia, Pennsylvania. He wishes to acknowledge his appreciation to Ethel M. Bonn, M.D., present Chief of the Womens NP Service at Winter Hospital and at this time on the staff of the Menninger Foundation, for their collaboration, advice and encouragement.

detachment and they thwarted every effort to increase their involvement by engaging in "small talk" or becoming silent when they felt threatened. Frequently they externalized their problems contending that others were responsible for their circumstances and hence there was little to be gained by talk because "you can't change the doctors." When it was pointed out that their difficulties antedated hospitalization, they insisted on blaming the personnel or retreated in silence. When the latter situation prevailed, one of the patients usually reopened the discussion by introducing some innocuous material and the cycle was completed again.

This situation had persisted for a number of therapy hours when the patients were offered the opportunity to attend an evening social activity in the home of a member of a newly organized volunteer group. They were told that the volunteers, a group of young women who belonged to the same church guild, could not come to the hospital, but they were able to serve on an extramural basis by inviting patients to their homes.† The group was informed that inasmuch as this was a new activity, the co-therapists and other staff members also planned to be present. Anticipating an enjoyable evening away from the institution, the group quickly agreed to accept the invitation.

The social was indeed a pleasurable occasion for the twelve patients in the group, the equal number of volunteers, and the personnel. Following the patients' departure, the volunteers and staff compared their favorable impressions of the social with the very positive remarks that the patients had made during the evening. Several volunteers freely expressed their surprise as to how well-mannered and well-behaved the patients were.

The next morning the patients arrived for group therapy and immediately launched into a spirited discussion of their reactions to the social. With an enthusiasm that was in marked contrast to their characteristic participation in the group, each attempted to outdo the other in verbalizing what she found to be especially gratifying about the experience. Such comments as the following were typical: "The hostesses were so congenial; they sat alongside of us on the floor; it was good to be away from the hospital and in such a nice home; it was real nice of her to allow us to walk through the house; weren't the refreshments delicious?" etc., etc.

The tempo of this interchange continued unabated for half the session,

† A description of this manner of volunteer functioning will appear in a forthcoming article entitled "The Extramural Volunteer."

and then the group lapsed into an extended silence. This was finally interrupted when one member proclaimed that she had trouble falling asleep the night of the social. In rather quick succession the other patients indicated that they, too, had encountered this difficulty. As this point was taken up in the discussion, it soon became evident that the social was not an exclusively pleasurable one for the group. Now feelings of bitterness and jealousy poured out as it became clear that the patients had compared themselves invidiously with the volunteers. Where earlier they had spoken favorably about the ease with which some of the volunteers had talked about their husbands and children, now they regarded this behavior as an indication of the volunteer's insensitivity and indifference to the painfulness of the patient's separation from her own family. The volunteer's home, about which so many positive statements had been made previously, now was cast in a disparaging light as the patients felt that it brought into sharper focus the poverty of their current existence. A few patients went so far as to assert that the purpose of the social was to satisy the volunteer's morbid curiosity about the mentally ill.

Before the therapy session terminated, however, the patients spontaneously had begun to question the validity of their resentful feelings. They wondered, for example, whether the volunteer's mention of her family implied a failure to appreciate the patient's situation. Some members suggested that such an action could be considered quite appropriate to the social setting and one argued that it might even be construed as a friendly gesture. By the end of the hour, the group had moved towards viewing the event in more realistic terms. Probably playing a large part in facilitating this process was the role assumed by the therapists who several times reminded the group of the very positive feelings they had expressed in the first half of the meeting.

As the discussion was pursued in subsequent therapy sessions, the full impact of the experience began to be realized by the patients. Whereas previously they had relied heavily on the mechanism of externalization to account for their difficulties, the tenability of this defense was placed in serious doubt by their initial admissions. How could they continue to rationalize away the need to look into their own behavior by blaming their problems on others when even under such optimum conditions as prevailed at the social, their feelings of pleasure were contaminated by bitterness and resentment? Confronted with this reality, the patients' involvement in therapy markedly increased and they started to introduce more conflict-

laden material. The catalytic effect of the activity on the group's performance was striking.

Invitations to extramural activities were received on the average of once every three weeks. Following the first affair, three members had reservations about participating, but they all attended the next two events. At least two factors accounted for the perfect attendance; the feeling in the group that to absent oneself was tantamount to capitulating to the illness, and the sizable pressure exerted on those members who were opposed to going by the ones who were in favor. After the third social however, the former were able to attain their end by developing a variety of somatic complaints on the evening of the event, only to have these magically disappear the next day. It became necessary to analyze the significance of this behavior when several members who had been faithful in their attendance refused to participate unless the others joined them. Two members suggested that attendance be made compulsory, but this was vetoed by the group. Since the patients were highly involved in the discussion of important personal material, after the sixth social it was decided to make the extramural activities available to another occupational therapy group. Although many members continued to accept individual invitations to visit with the volunteers, a practice that had started shortly after the program's inception, the action to terminate participation on a group basis resulted in a marked decrease in the number of references to the extramural activities in the therapy sessions.

The second group consisted of patients who were on the average more withdrawn and seclusive than the first group. Since these patients were considerably less verbal, their reactions to the initial extramural activity were not nearly as apparent. In a rather bland way, most patients initially expressed their appreciation for the evening's entertainment, and only after the therapist inquired about negative feelings did a few patients haltingly mention some aspects of the social which had also disturbed members of the first group. Because there was no pressure from within the group on the members to attend the affairs which followed, several patients who had verbalized only positive feelings to the initial event, indicated by their refusal to attend the ensuing socials that they too had been adversely affected by the experience. The program then was opened to all schizophrenic patients on the Womens Service who were able to attend extramural activities.

Our findings suggest that all patients experience extramural activities as tension-producing, those who verbalize their reluctnce to attend perhaps

to a greater degree than their more willing counterparts. Confirmation of this fact came from the patients themselves in the group therapy meetings, from the reports of volunteers, and from the author's personal observations during many of the evening functions. When these sources of data are pooled, three additional features of the extramural activities can be delineated which give rise to tension and frustration in patients.

Of primary importance is the apparent desire of many patients to modify their behavior to conform to the social occasion. From the time that such a patient discards her conventional hospital garb for the clothes she will be wearing at the social, to the time that she arrives unescorted at the volunteer's home in the taxi she has requisitioned in order to divorce herself further from her patient status, she is preparing to assume a role which her illness has made very difficult. Although she may be quite successful in concealing her peculiarities and eccentricities, she accomplishes it by the application of rigid controls over her feelings, thoughts, and actions. In this psychological state her tension mounts as she interacts with the volunteers.

If she seeks to avoid the interpersonal contcats, she can only withdraw physically within the narrow limits of the place set aside for the event. As a result, her attempts to isolate herself from direct personal involvement probably will be periodically frustrated by a volunteer who endeavors to engage her, and she will be incapable of sealing herself off from the social interactions of others. Here then is a second major tension creating aspect of the extramural activity; the restricted area exposes one to continuous social stimulation.

The third source of tension has to do with sibling rivalry. This has been discerned in some patients and may exist in many others. As the patient begins to respond to the kindness and warmth of a particular volunteer, she may become upset when the volunteer turns her attentions to another patient. In one such instance, the remarkable improvement derived by a patient from her relationship with a volunteer was seriously jeopardized when the volunteer appeared to be neglecting her in favor of some other patients. It was the volunteer who provided the first clue to account for the patient's set-back. Rapid intervention halted further regression and the relationship was quickly restored. Several months later, the patient, who had had a particularly poor prognosis, was discharged. For the volunteer who continued her contact with the patient, it was extremely gratifying to have been able to accompany the patient on the first day at her job.

Discussion

In a very thoughtful article dealing with reservations concerning group psychotherapy with hospitalized psychiatric patients, Polansky, et al. (5) suggest that with prolonged institutionalization there may occur "a dimming of time-perspective and absence of goals." These authors point out that: "As the requirements and responsibilities of a patient's real life situation are cut off from view by the sheltering walls of the hospital, each day may become monotonously like the next. When there is little that must be done today, there tends to develop an expectation of infinite time in which to reach any given goal. Lack of time dimension begets a condition analogous to having no goal at all. If a person's environment presents him with no hierarchy of what is expected or required, or what is most important or most urgent, everything may seem as important as everything else—or as unimportant. There is a loss of guide-posts of reality which again even the relatively intact person finds useful, which have for him a mobilizing, ego-supportive effect."

The significance of this malignant side-effect of extended hospitalization was recognized by Kramish (6) when he introduced the technique of "letter reading" in group psychotherapy. In order to keep patients in contact with the problems experienced by individuals in the external environment, he had his patients read aloud and discuss the personal letters that were sent to editors and counselors by people seeking help with their problems. The letters were gathered from various newspapers and magazines. According to the author, the introduction of this material increased patient interest and active participation, and fostered movement into more fruitful areas for discussion. Kramish concludes his stimulating report with the remark that "The patient must be moved in the direction of facing and sensing the situations as they present themselves outside the hospital."

The experiences of the present author suggest that participation in extramural social activities creates in patients a sense of urgency and immediacy about their problems which increases their involvement and productivity in the group sessions. With the first group at least, it was clear that the patients' resistance and defensiveness diminished after they attended the social ,and in a short time, the conflictual feelings about the self, family, and home which were activated, became the subjects for group discussion. The group continued to function on this level despite the fact that they stopped attending the extramural events.

The second group, it will be recalled, was comprised of patients who were more withdrawn and decidedly less verbal. Perhaps it would have been more prudent to try to involve this group in an extramural project, an activity which is more task oriented. These projects would take place in the volunteer's home and would be available to small groups of patients. The nature and variety of the projects would be contingent upon the particular talents or skills of the volunteers and the facilities they have at their disposal.

Another means of involving a group of this caliber would be to make attendance compulsory. When this issue arose in the first group, the staff was of the opinion that the activity should be placed on a prescription basis because avoiding participation in the extramural program was viewed as a form of resistance. The volunteers opposed this on the grounds that they would not feel comfortable if the patients were compelled to attend the socials. This was the determining factor in abandoning the prescription proposal. It may be that other volunteer groups will not be averse to such an idea in which case its merit can then be evaluated.

Summary

Extramural activities were introduced in order to improve the effectiveness of group psychotherapy with hospitalized female chronic schizophrenics. The extramural socials raised tensions in patients and some of the reasons for this were mentioned. In the first group the heightened tension served to decrease the patients' resistance towards discussing their personal problems and to increase their active participation. In the more regressed and less verbal second group, no appreciable change resulted after attending one social.

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MODIFIED CHILDREN'S GROUPS AND MORENO'S IMPROMPTU THERAPY

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Nobody who writes about therapeutic groups and describes a modification of the accepted techniques in the manipulation of the therapeutic and psychodynamic factors, could do so without being aware of J. Moreno's pioneer work, particularly in the field of group therapy with children. It was with this in mind that I ventured to record at the 4th International Congress for Psychotherapy at Barcelona in 1958, and subsequently elsewhere in print, a modification in the accepted and described technique of group therapy for maladjusted children. It referred to play groups, based on a pilot experiment in an English rural town, and later extended to other clinics under my direction in the same County. These groups appear to be clearly psychotherapeutic agencies in the sense of J. Moreno's definition because the therapeutic welfare of the individual members of the group is the immediate and sole objection, and this is being attained by the means of psychiatric principles, including the analysis and group dynamics, in order to clarify the diagnosis, make a prognosis and treat maladjustments of the personality.

Pioneer Work

Moreno's first group therapeutic efforts were with children, (see J. L. Moreno: Home Juvenis, Das Kinderreich oder Koenigreich der Kinder 1908), but these early psychotherapuetic attempts were largely through psychodrama and relatively shortlived, because his Stelgreif Theatre, which in 1911 engaged hundreds of children of varying normality and maladjustment, was soon taken over by adult patients, who continued to occupy the stage and aggregate in groups under his direction long after the Augarten Stage at Vienna was dissolved. In those early days of therapeutic pioneering the time was not ripe for a full appreciation of the seriousness of the neuroses in childhood and the immense prophylactic possibilities of child psychiatry for the individual and communal mental health of adulthood were unknown. Alfred Adler, Sigmund and later Anna Freud, who were among the pioneers for psychotherapy of children, did not recognise the advantages of group treatment and preferred to treat them in the isolation

of a consulting room, or in the case of Adler, individually on a platform before an audience. It was not until Moreno in 1928 et seq. presented the 'Impromptu School' at the Plymouth Institute in Brooklyn that group methods and group therapies for children were re-introduced, and the foundations for modern psychotherapeutic techniques for children were laid.

The present modification

When proposing a modification of accepted and proven rituals of therapy one is bound to compare the new with the old to evaluate advance and to give credit to what had already been achieved. Scientific progress depends not only on such monumental original research, as was achieved in the field of psychiatric science by the genius of such men as Kraepelin, Freud, Moreno, Wagner Jauregg and Sackel, but it benefits also by the interpretations and adaptions of these outstanding original milestones of progress by lesser men. Their work is necessary to adapt the new methods to practical needs and to keep them in touch with the changing climate of scientific research and social attitude. If, however, such adaptations are suggested they must be layed for criticism and approval before the tribunal of fellow workers before one ventures to apply them in practice or hails them as stepping stones to further advance. It is in this sense that I have composed this paper. It is an explanation of an earlier described technique and an acknowledgement of the original work on which it is based.

Comparison with Moreno's Impromptu Groups

As I have pointed out earlier, I claim no essential difference between the general psychodynamic principles of my therapeutic groups and the classical impromptu group treatment for children as described by J. Moreno. Verbal communication, discussion and acting out are encouraged in both. Moreno's principles of therapeutic interaction and group participation with a view to catharsis are of course adhered to and need not be further explained. They form a considerable portion of the group's matrix, and I shall discuss only those points in technique which differ from the usually accepted group methods.

Modified Technique Explained

1. My modification is more permanent and allows for a floating population, without any set number of sessions and is theoretically at least without end. Major breaks are of course determined by extraneous circum-

stances, such as school holidays, illness of therapists, epidemics or 'bus strikes, but the patients will resume treatment at the earliest possible moment after such interruptions. I have therefore described it as a "non-stop" or "infinite" group, and children can join or leave at any time, while the average number of cases is kept reasonably constant between six and twelve children. New cases can join any time, while those sufficiently improved, or unlikely to benefit from further treatment, are encouraged to leave when their mental state permits it. There is no predetermined number of sessions. It appears to me that this is a characteristic of the group in which it differs from the usually more formally arranged sessions with a definite set number of attendances where all the participants are expected to begin and finish treatment at the same time.

2. The therapist remains more than in the conventional group aloof of the children's activities and retains his distinct position by guiding, observing, advising, sorting out tensions and making spontaneous suggestions or interpretations as the situation demands. This also is to my mind a new approach, as the therapist's participation is here a priori expected to be very active and selective. He must not allow himself at any moment to be completely drawn into the group matrix, but he should remain distinct in his function to control consciously the varying intensities of tele-like reactions of the group's social atoms in an effort to achieve not only an equilibrium within the group but also to help to adjust the pathological responses of the individual children. The group, while remaining interactionally centred in Moreno's sense, is not entirely self-directed and could be described as therapist-teleological.

3. This approach is fortified by the therapist's constant look-out for children who do not seem to fit into the group or who are bewildered by a specific group situation. He invites them for individual interviews with him while the other children continue their activities. This affords such patients an opportunity for discussing, without embarrassment, their difficulties, which may be diagnostic of a personal problem or an indication for the need of specialised abreaction within the group.

This possibility of combining the advantages of an individual approach with group techniques appears to me the essence of my modification. While deriving the benefits of group psychotherapy each child has the opportunity of getting, when he requires it, within the group the individual help he needs.

Psychopathological Considerations

The last point mentioned, the combination of group techniques with individual therapy is perhaps the most original and, as all innovations, very vulnerable by critical review. It may seem to offend not only against our accepted views of group spontaneity, but even more against the prerequisite of seclusiveness for individual therapy. Some may even claim that the value of the suggested modifications stands or falls with this point. It therefore requires further elucidation and explanation. As I have pointed out in my original presentation it appears to me that while acting out and relief of tensions in group lay are most valuable, there remain, in dealing with children, less so than adults, certain complexes, anxieties and frustrations of a deep and personal nature which cannot be dealt with and improved by the spontaneous agents afforded through the members of the group themselves. Such morbid attitudes could be treated by individual therapy, which would be more time consuming and would deprive the children of the advantages of group interaction. By selecting the children within the group as required for spontaneous short interviews with the therapist in the same room as the group continues to play he affords them, if skillfully managed, the opportunity of individual attention within the beneficial atmosphere of the impromptu group. A child's normal self-centredness, which is usually increased in maladjusted children, makes him amenable to this treatment, while this would be impossible for adults who could not ignore the group around them and have an all or nothing attitude towards any special form of therapy.

The Therapist's Role in the Group

The adult therapist easily becomes powerless to help in a children's group when he ostensibly tries to be a mere participant and forsakes the role of the leader. A leaderless group is undoubtedly therapeutic when vociferous adults can express the nature of their emotional difficulties in adequate words, but it is much too superficial, in my view, for children, who have not yet learned to express their abstract and subjective experiences through words or even symbolic gesture.

The child before he reaches adolescence requires for his treatment the presence of a father-figure (or a mother-surrogate), in the shape of his therapist, to benefit within a group with other children. He needs somebody mature, without much difficulty on his part invested by him with the omnipotence of the ideal parents, on whom he can shed his problems

or anxieties. He cannot yet form any true transference with his peers because he regards them rightly as equally helpless as himself and this would ultimately increase rather than relieve his tensions.

Conclusion

It therefore seems to me that the leaderless group as originally described by J. Moreno remains an effective therapeutic agent for adults, but when dealing with children we must make allowance for their particular relationship to the adult world, exemplified by parents or therapists, which is idealised by them in the process of consolidating their super-ego through adult introjection. We have to provide for the group a patriachal leader, who can unobtrusively direct the children's activities and is always available to help them when needed. This concept is actually less original than it may appear, because most successful group therapists with children have always implicitly performed this guiding rather than participating role, even if they were not fully aware of it, because they were too intent to follow the precepts of group techniques to observe the spontaneous modifications the children had themselves enforced through their reactions to them. The mistake of some therapists, in my view, is to see the children in groups as diminutive adults and to apply to them techniques primarily meant for grown-ups, instead of making allowances for the specific requirements of childhood's nature. Even the most free activity class in any school needs its teacher, and so also does the most spontaneous group for children require its distinct therapist and parental leader.

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IMPLICATIONS OF ART FOR PSYCHOTHERAPY AND PSYCHODRAMA*

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Psychiatric Art Therapy is based on the encouragement of spontaneous expression in drawing, painting, and clay modeling. The use to which this activity is put may vary from creative recreation at one end of the scale, to a major form of communication in a process of intensive psychotherapy at the other.

In the graphic and plastic arts, feelings are released and realized through a combination of motor and visual expression. Thus the patient, at whatever level he starts, may find therapeutic values in experiencing the artistic process itself. If he is in the habit of warding off fear by imposing excessive control on his performance, he can discover in a relatively safe situation rich sources of feeling and expression that have been dammed up. As his critical demands upon himself become greater, he voluntarily undertakes to learn art techniques, a form of self-discipline in which the goal is greater freedom.

The patient is encouraged first of all to set his own standards. If in turn his work gains recognition from others, he can feel respected for something which is uniquely his own, an extension of himself.

For the mute adult as for young children, graphic expression sometimes precedes the ability to communicate verbally. Image-making, even at a very primitive level, may serve better than words for the expression of nonvebal feelings and memories, and for the direct, concrete communication of consciously recalled dreams and fantasies. Where psychotherapy proceeds toward the development of insight and the resolution of unconscious conflicts, some patients' reactions to their own artistic products speed their understanding of themselves. If the therapist delays going beyond the patients' own immediate interpretations, the picture or sculpture remains for later use, a record not subject to distortion in recall.

In a diagnostic center such as D. C. General Hospital, patients' art

* Presented at the monthly meeting of the District of Columbia Chapter of the American Society of Group Psychotherapy and Psychodrama, June 14, 1957, Windsor Park Hotel, followed by a discussion.

products, seen as the result of many free choices both conscious and unconscious, sometimes dramatically reveal facets of personality not easily accessible either through verbal interviews or through the observation of less highly individualized forms of activity. Pictures and sculptures also can be used to supplement and refine information gained by psychological testing techniques, and to illustrate changes in mental and emotional status under various forms of treatment. In using art products as an aid to diagnosis, the patient's manner of working and any comments he makes about the meaning of what he has done are always taken into account.

Free art productions by psychiatric patients have been used in a variety of ways. Some psychoanalysts have encouraged their patients to make spontaneous pictures at home, and have used these as a basis for free association. In other cases, art therapists have collaborated with psychoanalysts, supervising a patient's art activity and consulting with the doctor. Sometimes art therapists working under medical supervision conduct sustained analytically oriented treatment. Experiments in group art therapy have been reported both in the United States and Canada. At the Alcoholic Rehabilitation Division of the District of Columbia Health Department, an outpatient clinic, the author conducted art therapy sessions in a group setting. While the atmosphere was encouraging to interaction between the members of this very informal and loosely organized group, patients' art products were used more intensively to supplement their program of individual psychotherapy. The scattered use of art activity in mental hospitals runs the gamut from recreation to research.

An instance in which art activity became part of a therapeutic process at the D. C. Alcoholic Clinic was during a psychodrama session. Patients who had jointly produced a drawing the previous evening began talking about it. They placed the picture on the psychodrama stage, and there reenacted the production of it, using it as a stimulus to bring out two things, feelings about each other during the making of the picture and also rival interpretations about its symbolic content. This experience was spontaneously evoked by the needs of the patients.

SOCIOMETRY AND PSYCHODRAMA IN INDIA

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INTRODUCTION

Sociometry and Psychodrama, in the sense of the techniques and approaches to the study of interpersonal relationships and adjustment procedures associated with Moreno and his co-workers, apparently have not had a widespread impact on the social scientists in India, and this writer was rather diffident about undertaking the review of work which was expected to have hardly any existence. Since his undertaking the assignment, however, he was surprised by the discovery of the interest taken by investigators in India in both of these subjects as revealed by the reports he received from different quarters in the country, which, though rather sparse and scattered, is yet fairly encouraging. This is so inspite of the fact that none of the investigators could have any special training opportunities or educational facilities at the University level in these subjects, because none have been available in the country. There is therefore evident in these studies a genuine and spontaneous interest in the investigators in the approaches of Sociometry and Psychodrama. It is, therefore, possible that with suitable introduction in the University curricula of these subjects in a better than the incidental and tangential manner as it obtains to-day which has been by way of passing references in sociology and psychology textbooks, more and more of younger scholars will get interested in these approaches and will take to them more seriously and with better preparation and skills.

We propose to present, in the following pages, a brief account of the work done in India in the two areas of Sociometry and Psychodrama so far.

SOCIOMETRY

In a recent investigation at the B.M. Institute of Psychology and Child Development, Ahmendabad,* 116 boys and 81 girls belonging to six grades

* The late Professor H. P. Maiti, a member of the International Committee on Sociometry, was the Director of this Institute till his death in January 1959.

of a school were asked to give their choices from among their classmates in the following four activities:[1] sitting, playing, taking home for a visit, and disliking most. The age range of the pupils was from 5 years and 8 months to 17 years. Majority of them came from middle class families belonging to the upper castes. They gave their choices on two occasions, with an interval of about five months. In the intervening period, Raven's matrices Test was administered to them to assess their intellectual ability. Results from the analysis made so far for the academic grade variable show that stability of sociometric choices increases with the educational levels of the children. Other possible aspects of the data, such as (i) whether the sociometric pattern changes from grade to grade and partly according to criterion of choice, (ii) whether along with increasing opportunity of mutual association from grade to grade, number of isolates also tends to decrease, and (iii) whether sociometric status of an individual is influenced by such variables as age, criterion of choice, intellectual ability, school work, and family milieu, are under examination from the data collected.

Another study was conducted at the Institute on the same lines as above on 94 boys and 63 girls with an age range from 6 years and 6 months to 17 years and 7 months, belonging to eight grades of a School. They came from different castes and also different religious groups (Hindu, Jains, Parsis, Christians, Muslims) and predominantly belonged to upper economic classes. Data on these subjects have been collected as in the first study above, and are being analyzed.

At Saugor University, Miss M. P. Sethna used sociometry in an investigation aimed at discovering the types of inter-personal relationships existing in a student community and also at studying the factors associated with the phenomenon of "popularity-isolateness."[2] A total of 425 students of VII and VIII classes of two High Schools—227 from a Boys' High School and 198 from a Girls' High School, with a mean age of 14 years, were given a sociometric questionnaire of 20 questions depicting different aspects

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[1] The brief outline in the next two paragraphs is based on a personal communication from B. Gupta, Jt. Director, and A. A. Khatri, Psychologist, B.M. Institute of Psychology and Child Development.

[2] The two investigations of Miss M. P. Sethna are: (i) *A Sociometric Investigation of Popularity-Isolateness and Some of its Correlates.* M.A. Psychology dissertation, Saugar University, 1955-56. (ii) *Preferences Obtained of the Nursery School Children.* Dissertation in partial fulfilment of the requirements for M.Ed. degree of Jabalpur University, 1959.

of life in which social action is necessary and asking for their choice of associates in the same. On the bases of the responses, two extreme groups were selected, 18 each from the boys and th girls with top scores, called the "leaders," and again 18 each from the boys and girls receiving the lowest scores, called the "isolates."

Then, these groups were compared by further tests and measures, as indicated below, on the presence or absence of th following factors: I. Personality Traits, viz. sociability, self-confidence, perseverance, cooperativeness, emotional control, leadership, and trustworthiness; II. Mental Traits, viz. intelligence, and scholastic achievement; III: Physical Aspects, viz, height, weight, physique (general body build), and age; IV: Interests, viz. games and sports, and other extra-curricular activities; V: Tendency towards being behaviorally problematic; and VI: Environmental Factors, viz. ordinal position in the family; parental education, and socio-economic status. The tests and measures used for these purposes were graphic rating scales (for personality traits, to be marked by the teachers) compared with social adjustment and emotional control questionnaires (self-administered); General Intelligence Test (developed by the Prantiya Shikshana Mahavidyalaya of Jabalpur) compared with marks obtained in two consecutive annual examinations; Olson's checklist of Problem Tendencies in Children (marked by the class teacher); and a Personal Data Sheet (for miscellaneous information).

The results were as follows: Preferences of the group (popularity) seemed to be concentrated upon a few individuals. The general quality of leadership was better in the case of boys than in the case of girls. The 28 sociograms prepared from the study showed the usual patterns of stars, pairs, and unchosen. But in addition one particular pattern, isolates or 'self-confined' (i.e. individuals who preferred nobody and nobody preferred them), which seems to be peculiar to this investigation, was revealed among girls only. 'Pairs' were more prevalent in girls than in boys. 'Unchosen' were more prevalent in boys than in girls. 'Stars' were approximately in same number in the two sexes. Leaders were definitely superior to the unchosen on all the personality traits named above, in general intelligence and scholarship, parenthal education, and socio-economic status of the family. The difference between leaders and the unchosen in height, weight, physique, facial appearances, participation of games, and extra-curricular activities was statistically not significant. Similarly, the difference between the leaders and the unchosen of both the sexes for all the behaviour problem

tendencies included in Olson's check list also was statistically not significant. Sethna's conclusion is that "the study points out the importance of training emotional and temperamental aspects of the child in order to produce better relationships amongst the students which in turn would raise the standards of mental health in schools."

Sethna used sociometry at Jabalpur University in another investigation which concerned preferences of companions among Nursery School children,[3] which is comparable to B.M. Institute studies mentioned above. A schedule of ten questions pertaining to situations common to the group and suited to their level of age and experience was used with a view to finding out the best preferred children in the group. The questions were naturally not directly administered to the children, but were ingeniously mixed up in the midst of several other queries made in a casual and random way to each child while the children were engaged in some activity.

From the study of the data collected and the sociograms based on it, Sethna's findings are as follows: In a group of not less than 19 and not more than 35 children, a most preferred child was preferred by not more than 4. This, according to her, "speaks of the child's limited equipment operative in the choice of friends." "Children's preferences are known to be more of an accidental character," she writes, "for their attention and interests are subject to shifts depending upon momentary influences. They do not possess clear cut ideas as to why they prefer some and not others. It appears that their associations are the result of superficial gains, as known from some of their explanations." In the group studied, 70 % showed a high constancy in preferences, which, in Sethna's view was "the result mainly of family acquaintances and propinquity." The remaining 30 % were not preferred by any other member of the group. She concludes that "at the pre-school stage there are no definite patterns of relationships. The different capacities observed clearly in higher age groups are so to say vaguely structured at the lower level." She further suggests, though without any evidence in this regard, however, that since these different capacities observable clearly at higher age levels are vaguely structured at the lower level, "it may be assumed that those units brought out by the previous study (i.e. presumably her first study mentioned above) are also operative at lower level—their functioning being not so conscious."

Sociometry is being profitable employed by the Psychological Research

[3] No. (ii) above.

Wing of the Defence Science Organization, Ministry of Defence (referred to hereinafter as PRW (DSO), on a project in connection with assessment of leadership in the armed forces.[4] The potential officer for the Armed Forces is selected by the Services Selections Boards, with the help of certain tests designed mainly to bring out the leadership qualities in a candidate. In addition, however, cerain experiments are being carried out by this Organization to see whether the group effectiveness of a candidate could be graphically and quantitatively measured by using the sociometric tests.

At present there are two methods of administering these tests: 1) Each member ranks the other members of his group in the order in which he would appreciate their friendship or leadership; and 2) Each member is asked whether he would like to have as companions the other members of his group in various situations in Social, Garrison and Tactial spheres, with answers in the form of 'Yes' or 'No' or 'Neutral.' The purpose of these tests is to measure the group effectiveness of a candidate. Some details of experiments conducted in this regard at the PRW(DSO) are given below:

(a) 92 students of St. Stephens College were put through the Services Selection Board procedure and at the end of a three-day period of testing, they were administered the Sociometric Test No. 1 and the result compared with the assessment of the group by the members of the Board.

(b) A group of 25 cadets from Jodhpur Air Force Flying College was administered the same Sociomertic Test No. 1 and the results compared with the assessment by Instructors of the College.

(c) 58 Cadets of Military College, Dehra Dun, were administered Sociometric Test No. 2 during their camp and the results compared with the assessment by the Instructors and the representatives of this Organisation.

(d) A suitable Sociometric Questionnaire was administered to 36 groups at the S. S. Board after the groups had completed all their usual tests. Their assessments were compared with the findings of the S.S. Board.

The overall impressions so far gathered from these experiments are as under: (a) The individuals in the group are capable of interpersonal

[4] The brief outline in the next few paragraphs is based on a personal communication from the Psychological Research Wing, Defence Science Organization, Ministry of Defence, Government of India.

objective assessment to a significant extent, if comparison with the assessment of the Board members can be taken as an indication of the degree of objective and interpersonal assessment. (b) Scores from Sociometric Tests are highly correlated with assessors of groups. (c) Sociometric Tests could be applied to groups as a predictor of groups performance.

Bishwanath Mukherjee of the Bureau of Educational and Vocational Guidance, Patna, has been engaged upon the following sociometric projects:[5]

1. *An Investigation Into The Relationship Between Social Acceptance Score & Accuracy In Estimating Group Opinion About Individual Member's Behaviour:* The hypothesis that group members having high social acceptance score can estimate the group opinion regarding the individual member's behaviour more accurately than those obtaining low acceptance score is being tested by administering to two groups of school students (a) A sociometric questionnaire, (b) A "Guess Who" Questionnaire, and (c) A Questionnaire to determine individual member's prediction of group opinion concerning the members who are most clever, naughty, popular, intelligent and such other characteristics included in the Guess Who Questionnaire. The accuracy score obtained for each individual member by comparing his estimate of the group opinion and the actual group ranking based on the analysis of Guess Who Questionnaire items are presently being studied in relation to the social acceptance score. The report of the project is expected to be out within two months.

2. *A Study Of the Relative Difference in Estimation of Self-Popularity and Popular Members of the Class between Stars and Isolates:* Seven items corresponding to the items of Sociometric Questionnaire were incorporated in the Guess Who Questionnaire in order to determine how accurately individual members can estimate their own popularity in the class. This type of accuracy score in conjunction with another accuracy score obtained by comparing the individual member's prediction of the first ten popular members of the class and the actual ranking in terms of social acceptance score will be studied shortly in order to find if there exists any difference between the Stars and Isolates of the group in making such prediction. The report on this project is likely to be out within a couple of months.

3. *Reliability Study of Sociometric Scores In Different Types Of Group:* Test-retest reliability of acceptance score, rejection score and mutual choice score derived from a Sociometric Questionnaire in which the respondent

[5] From a personal communication from B. Mukherjee.

could indicate only 3 choices for each item will be worked out for different types of groups varying in socio-economic status, age, sex and group cohesiveness. The project is still in data collection stage.

4. *A Study of Certain Socio-Psychological Factors Associated With Classroom Popularity:* Groups of school students coming from different schools and academic grade indicated their sociometric choice on a questionnaire from which the social acceptance and rejection scores were derived for each subject. Statistical analysis is in progress to find out the relationships these scores might show with scores obtained on a Socio-economic Status Inventory constructed by the author, class rank, judged personality characteristics as revealed by a Guess Who Questionnaire and sex.

R. M. Loomba of Lucknow University, who has been working on the psychology of interest for some time, has already published some papers on educational interest, while his work on the nature of interest in general is in progress.[6] Social interest, however, has been his main area of study. In all this work he has been using choice as an indicator of interest. He has planned a study of the psychology of social interest on the basis of data of interpersonal and intergroup choice obtained though the sociometric technique. With the scant material available about his study, however, it is not possible to have a clear idea of the methods, scheme and objectives of the study. But his use of intergroup choices in Sociometry is possibly an innovation.

From the Indian Institute of Science, Bangalore, J. C. Prakash has published a paper on estimating the probability of chance occurrence of obtained scores in sociometric tests in which multiple criteria are employed and the number of choices allowed on each criteria is either fixed or not fixed.[7] In sociometric tests, each individual in a defined group on N members is asked to choose a number of other members from the group with whom he would like to associate in one or more specific interactional situations. These interactional situations are termed the 'criteria for choice.' Such criteria usually refer to proximity criteria such as 'sitting in proximity,' 'living in proximity' and 'working in proximity.' There are other variants wherein sociometric techniques find some modification as in asking members

[6] From a personal communication from R. M. Loomba.

[7] Prakash, J. C., "Estimating the Probability of Chance Occurrence of an Obtained Score in Sociometric-Type Tests", in *Indian Journal of Psychology* III-IV, 1957. Also in *Education and Psychology* IV, 3-4, Sept. Dec., 1957 (*Sastry Memorial Volume*), pp. 273-276.

to nominate for leadership, for team-membership, committee membership and so on. The choice of criteria depends upon the specific requirements of the given research problem.

Generally the number of choices allowed is fixed. Prakash's paper seeks to provide a probability model for estimating the probabilities of chances occurrence of obtained scores in those types of sociometric tests in which multiple criteria are employed and the number of choices allowed on each criterion is either fixed or not fixed. The obtained score here refers to the total number of mentions or nominations received by each member from all the other members of the group.

Thus the number of members in the group is N, the number of criteria is *m*, the number of choices allowed is *d* for *each* individual on *each* criterion with the restrictions that (i) he cannot choose himself on any criterion, and (ii) he cannot choose the same individual more than once on the same criterion.

Now, in order to compute the probability of chance occurrence of an obtained score certain assumptions are necessary. Prakash states these assumptions in the case 'where the members are regarder as automata allocating their selection at random'[8] as follows: "First, independence is assumed between the different choices made by any single individual"; "Second, the choices of any subject are taken to be independent from those of any other subject"; and "third, there is a restriction that the subject may not choose the same other person more than once"[9] i.e. on the same criterion.

Prakash then considers the following five cases: 1. Case in which members are asked to choose a 'fixed' number of others. 2. Case in which scores on several criteria are combined into a single score. 3. Obtaining the probabilities of chance occurrence by approximating the binomial distribution to normal form. 4. Case in which it is desired to divide the distribution into above and below a given probability level. 5. Case in which the number of choices allowed is not fixed, or in which all the allowed choices are not utilised.

Psychodrama

At the B.M. Institute of Psychology and Child Development of Ahmedabad, role-playing is being utilized as one of the techniques for the purpose

8-9 Tagiuri, R., and Others, "Estimating the Chance Expectancies of Diadic Relaships within a Group," *Psych. Bull.*, 52, 1955—quoted in the above article by Prakash.

of training workers in interviewing skill to be employed in case work, research investigations, etc.[10] For example, one worker may be asked to take up the role of the mother or the father of the problem child which is the subject of investigation, while another may take up the role of the case-worker or research investigator. Role-playing is found to be an effective instrument in training these investigators.

By and large, therapy systems in India so far have emphasised the individual and have concentrated their efforts on bringing about a change in the individual in a more or less isolated way. H. N. Murthy, however, has tried to use the hospital setting for therapeutic purposes on three groups of schizophrenics, consisting of 35 males and 45 females in all, at the Hospital for Mental Diseases, Kanke, Ranci.[11] Each group met once a week for an hour-and-a-half, and sufficient scope was given for spontaneity. Though careful observations and recordings by means of modern methods (like one-way screen, tape-recorder, etc.) and by means of a number of trained observers was not possible, some recording by an observer was maintained.

Simple sociometric measures were used for assessing the quantitative aspects, suited to the level of understanding of the group, like "the desire to remain in the group," and "in-group sociometric choice vs. outgroup sociometric choice." From these, indices were derived, such as "the ratio of attraction, ratio of interest, choice status, compatibility, group cohesion etc.," and sociograms based on these were prepared to give meaningful pictures of the situations and relationships and to suggest ideas for the useful working of the groups. In the beginning these measures were taken once a month. But in the hospital setting it was not possible to keep the groups closed so as to prevent the coming in of a new member now and then, and so later the measures were taken just before the arrival of a new member and again some time after his arrival. Even this system had to be abandoned subsequently, as the measures tended to be too frequent owing to the new arrivals.

An additional technique used by Murphy was to compare the individual sociometric choices with the expectations of being chosen as indicated by

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[10] From a personal communication from the B.M. Institute of Psychology and Child Development.

[11] Murthy, H. N., "Group Therapy with Schizophrenics", *Journal of the All India Institute of Mental Health*, Bangalore, II, 1, Jan. 1959, 1-7.

the same individuals resulting in two kinds of sociograms called "I choose" and "They May Choose Me." The inference was that the greater the discrepancy between choice and expectation in the case of an individual, the more unrealistic he was and the less his ability to create relations with others.

An analysis of the content of verbal exchanges within each group (presumably as recorded by the observer), was also made. Though the tendency to keep silent was frequent, occasionally there were conversations concerning the treatment in the hospital, difficulties experienced in the wards, fears about rehabilitation, desire to leave the hospital, nature and problems of mental illness, mutual inquiries, confessions, social problems, and even international situations—and at times even art, religion, philosophy and science. Poor integration of schizophrenic patients results in a poor capacity to use formal symbols (difficulty in verbal expression) and lack of interest in others (socialization). The group situations provided the necessary environment and stimuli for an effective use of both verbalization and socialization.

By the sociometric measures and other methods used the results of the study showed which individuals were approaching the level of mental integration required for discharge from the hospital and when. Murthy concludes, finally, that sociometric measures could be used further, as suggested by Zerka Moreno,[12] "by moving individuals of low sociometric status out of the group and moving into it individuals of high sociometric status." On the whole, the therapeutic ends were gained more easily in the group situation for the schizophrenics than by other means.

Murthy's report of his exploratory study leaves some loose ends. It also lacked the means for rigorous control and for scientific and detailed observation and recording of all the events. But all this was probably unavoidable in the current hospital setting under which he embarked upon his trial study. The results he obtained, however, would at least possess a highly indicative value if not a rigorously proven one.

At the All India Institute of Mental Health, Bangalore, its Director, M. V. Govindaswamy, has set up a Psychodramatic Stage with a view to using it "for sociometric tests, group psychotherapy, psychodramatic tests

[12] Moreno, Zerka, "The Significance of Cohesion in Group Psychotherapy", *Premier Congress Mondial Psychiatric,* Paris 1950, Section V, p. 292—quoted by Murthy in the above mentioned article.

and psychodrama as an adjunct to individual therapy."[13] Before standardizing these techniques, the Bangalore group felt it necessary to develop objective tests to assess quantitatively the intra-personal and interpersonal variables which interact in group-therapy sessions and psychodramatic settings, and have undertaken the construction and standardization of such tests as also of projective tests for the purpose.[14]

At present, the psychodramatic theatre of the Institute is mainly used for group therapy, which aims at socialization, development of insight into mental abnormality and recreation. The group psychotherapeutic sessions are usually preceded and occompanied by individual therapy including occupational therapy. Some of the main stumbling blocks at the group psychotherapeutic sessions, according to Govindaswamy, are the diversity of language and culture (apparently meaning mainly the sub-cultures), intergroup social distance, and wide differences in educational levels prevalent in India.

Details of plans for developing suitable and efficient techniques of psychodrama at the Institute are still in a tentative stage, and would be finalized after the preliminary work regarding the objective and projective tests (mentioned in an earlier paragraph above) and determination of the interplay of different cultural factors on different groups is concluded.

R. M. Loomba has been trying to use sociodramatic techniques in handling personal counseling on students' problems at Lucknow University, in a somewhat novel and interesting approach.[15] By arousing the interest of students in sociodrama through his lectures in Clinical Psychology, he finds that they become willing partners in the sociodrama sessions for the solutions of student's own problems, one of which is then chosen by them for a session. Some of the student volunteers then take up the roles of the persons involved in the actual problem situation while others act as the audience. Dramatizing of the situation and dialogues take place spontaneously, without any prior preparation. Thereafter, the whole episode is discussed together by the actors and the audience. The actors' feelings while playing their respective roles, their mental reactions to each other, their own behaviour and the effects they expected this behaviour to produce

[13] From personal communication from M. V. Govindaswamy.

[14] Preliminary reports of these tests have been published in the *Journal of the All-India Institute of Mental Health,* Vol. I, 1958 and Vol. II, 1959.

[15] From a personal communication from R. M. Loomba.

on others, possible better alternative ways in which they could have acted, and other matters considered relevant by the group are included in the discussion. The situation is then redramatized, but with an exchange of roles between the actors, which is followed by discussion as before, and this again followed, for a third time, by dramatizing by different members of the group than before, followed by a discussion again. During this last winding up discussion of the session in which the whole group and the therapist take part, the latter tries to bring to the fore and summarize the personal gains and insights which seem to accrue from the entire session together with the difficulties experienced and the improvements possible. Loomba has found that judging from the statements of gains made at this last stage by the members of the group, the sessions have proved very encouraging and gratifying.

A question which may be raised here in regard to the procedure of repeated discussion and redramatization is, what happens to the element of spontaneity in the successive reenactments? Is it not likely that after each discussion, on the second and the third occasion of redramatizing, a great deal of planning and pre-determination in acting out parts and role would enter into the situation controlling and even inhibiting the spontaneity increasingly? On the other hand, it is also possible that each successive discussion contributes only to a better insight into the total situation, stimulating the imaginativeness of the new actors and making them sensitive and alert to newer clues for quicker and therfore fresh spontaneous responses, without predetermining any procedures of course of actions for them. Besides, for each successive enactments, the actors are different, and this must help bring out spontaneity with much greater assurance than if the same actors were to repeat the same roles in all the three dramatizations.

Sociometry and Psychodrama—The Future

As mentioned at the beginning of this account, this writer feels that the subjects of sociometry and psychodrama need to be given their due weight in framing the University curricula and prescribing textbooks for the under-graduate and graduate classes—especially the latter. Loomba, as mentioned above, seems to be giving some emphasis on thse techniques in the lectures and practicals in the postgraduate classes in Lucknow University, as mentioned above. The present writer, who has recently joined the Gujarat University, has just taken the opportunity to revise the M.A. courses

in Psychology in the University, and in doing so, he has tried to give due weight to the subjects by including standard books in the subjects like Moreno's *Who Shall Survive,* the *Psychodrama* volumes, Jennings,' Northway's and Proctor and Loomis' writings, and also the *International Journal of Sociometry* and *Suriatry and Group Psychotherapy* in the reading assignments in the Papers on Clinical Psychology, Psychometry, and Research Methods.† Recently he wrote an article on sociometry for the *Encyclopaedia of Religion, Ethics, Philosophy and Psychology* to be published in Telugu language. The article is written in English and will be translated in Telugu. The English version has been already published in a journal.[16] The article is meant to give a brief outline of the approach and method of sociometry for Indian readers. A similar article on Psychodrama is also planned for publication by the writer.

† The revised courses are expected to be sanctioned in due course by the Academic Council and the Syndicate of the University.

[16] Prabhu, Pandharinath H., "Sociometry", in *Indian Journal of Social Work,* XIX, 1, June 1958, 1-10.

DEFINITIONS OF GROUP PSYCHOTHERAPY

Definition 1: "A method which protects and stimulates the self-regulating mechanism of natural groupings. It attacks the problem through the use of one man as the therapeutic agent of the other, of one group as the therapeutic agent of the other." From *Application of the Group Method to Classification*, p. 104, 1932.

Definition 2: "The groups function for themselves and the therapeutic process streams through their mutual interrelationships." From the same publication, p. 61.

Definition 3: "Group psychotherapy is the result of well calculated, spontaneous therapy plus proper social assignment. . . . The leader is within the group, not a person outside." Same publication, p. 94.

Definition 4: "Group therapy will be advantageous for persons who do not recover by themselves or through some form of psychological analysis or medication, but only through the interaction of one or more persons who are so coordinated to the patient that the curative tendencies within are strengthened and the disparaging tendencies within checked, so that he may influence the members of his group in a similar manner." Ibid., p. 97.

Definition 5: "Spontaneous formation of social groups based on the enthusiasm of the participants or on common interests and aims achieves often miraculous results, but cannot be called grouping in our sense as most of the interrelations remain unanalyzed." Ibid., 1932, p. 72.

Definition 6: "Group psychotherapy treats not only the individual who is the focus of attention because of maladjustment, but the entire group of individuals who are interrelated with him." *Who Shall Survive?*, 1934, p. 301.

Definition 7: "A truly therapeutic procedure cannot have less an objective than the whole of mankind." Ibid., p. 3.

J. L. MORENO

DEFINITIONS OF THE TRANSFERENCE-TELE RELATION

There is a tendency to ascribe many irrational factors in the behavior of therapists and patients in group situations to transference and counter-transference.

I. It takes *tele* to choose the right therapist and group partner, it takes transference to misjudge the therapist and to choose group partners who produce unstable relationships in a given activity.

II. The greater the temporal distance of an individual patient is from other individuals whom he has encountered in the past and with whom he was engaged in significant relations, direct or symbolic, the more *inaccurate* will be his perception of them and his evaluation of their relationship to him and to each other. The dynamic effect of experiences which occur earlier in the life of an individual may be greater than the more recent ones but it is the inaccuracy of perception and the excess of projected feeling which is important in transference; in other words, he will be less perceiving the effect which experiences have on him the older they are and less aware of the degree to which he is coerced to project their images upon individuals in the present.

III. The greater the social distance of an individual patient is from other individuals in their common social atom, the more inaccurate will be his evaluation of their relationship to him and to each other. He may imagine accurately how A, B, C whom he chooses feel towards him, but he may have a vague perception of how A feels about B, A feels about C, B feels about A, B feels about C, C feels about A, or C feels about B. (Analogous to transference we may call these vague, distorted sociometric perceptions—"trans-perceptions.") His transperceptions are bound to be still weaker or blank as to how people whom he has never met feel for E, F, or G, or for A, B, or C or for how these individuals feel about each other. The only vague line of inference he could draw is from knowing what kind of individuals A, B, and C are.

IV. The degree of instability of transference in the course of a series of therapeutic sessions can be tested through experimental manipulation of the suggestibility of subjects. If their sociometric status is low, they will be easily shaken up (sociometric shock) by a slight change, actual or imagined, in the relationships of the subjects around him. It is evident that transference has, like tele, besides psychodynamic, also sociodynamic determinants.

CONCERNING THE ORIGIN OF THE TERMS GROUP THERAPY AND GROUP PSYCHOTHERAPY*

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: In a review of Corsini's *Methods of Group Psychotherapy,* in the March 1959 issue of this Journal, p. 840, Mr. Illing says: "Moreno claims for himself the first coinage of the term 'group psychotherapy' (1932), without, however, substantiating his claim, although he cites many 'witnesses' for his testimony, such as William Alanson White, Winfred Overholser, Pierre Renouvier, S. H. Foulkes. . . ."

Here follows the record in my *own* publications: *Application of the Group Method to Classification,* Congressional Library, No. 32-26884, Publisher: National Committee on Prisons, New York, 1931-32, a chapter "Concerning Group Therapy," pp. 60-61; "Illustration of Group Therapeutics," pp. 74-76; "Group Therapy in an Institution of the Insane," pp. 77-79; "Definition of Group Therapy," p. 103.

The *Group Method* monograph was the topic of a Round Table at the annual meeting of the APA, May 31, 1932, Moderator: William A. White. At this meeting the term "group psychotherapy" was first given currency by the author.

The term "group *psycho*therapy" is recorded in my book *Who Shall Survive?* with a Foreword by Wm. White, Nervous and Mental Disease Publishing Co., Washington, D. C., First edition, 1934, Congressional Library No. 34-18502; see p. 437, referring to chapter "Group Psychotherapy," and the definition, p. 301, "Group therapy treats not only the individual who is the focus of attention because of maladjustment, but the whole group of individuals who are interrelated."

Group psychotherapy owed its emergence to sociometry and small group dynamics which was expounded by the author between 1931 and 34; he formulated group therapy as a scientific methodology with the help of Drs. White, Whitin, Branham and Jennings. There have been forerunners of pre-scientific group methods in the U. S. A. and Europe *before* 1931. The most important influence came from Vienna since 1909. Many of these methods (psychodrama, 1911, interaction methods, 1913, psychodrama combined with group therapy, 1923) have been launched by this author and described in his German books.

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* Reprinted by permission from *The American Journal of Psychiatry,* Vol. 116, No. 2, Aug., 1959.

It is farfetched to trace the origins of group psychotherapy to European sociologists. One could equally quote American sociologists. Every new idea has forerunners but the moment of emergence of the scientific group psychotherapy movement into scientific history, its *kairos*, was the year 1932, within the fold of the American Psychiatric Association.

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Beacon, N. Y.

IN MEMORIAM

DR. EMIL A. GUTHEIL

The well known New York psychotherapist Dr. Gutheil died on July 7, 1959 of a heart attack at the age of sixty. Already as a student he became a pupil and later principal assistant of the Viennese psychoanalyst Dr. Wilhelm Stekel. Stekel was one of the first associates of Sigmund Freud. He later separated himself from his master and created his own psychotherapeutic school of "active analysis." In this he was strongly supported by Gutheil, who was his private assistant, directed his clinic, edited his journal, etc. After emmigrating to the United States in 1937, and especially after Stekel's death, Gutheil could easily have become head of the Stekelian school of psychoanalysis. Instead he became interested in breaking the mutual feuds and isolation of the various "schools." He succeeded in 1939 in something which seemed impossible at that time: in creating through the Association for Advancement of Psychotherapy a forum in which all schools, including the orthodox Freudians, could meet, discuss their problems and learn from each other. There soon followed the creation of the American Journal of Psychotherapy and his active role in the foundation and direction of the Postgraduate Center for Psychotherapy, in which he was, among other activities, director of public education.

Those who participated in the "creative moment" of the foundation of the Association will never forget it. Composed mostly of new arrivals from Europe, especially Vienna, the new group was exposed to numerous difficulties and attacks. Nevertheless, it had enough spontaneity not to take a defensive position but to create something new. Naturally, it was also interested in psychodrama and Dr. Moreno was among the original members and lecturers of the group. Let us hope that Gutheil's work will be continued and that the period of intolerance among psychotherapists, who should have least of it, is a matter of the past.

JOSEPH WILDER

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BOOK REVIEWS

"EXISTENTIALISM AND EDUCATION." By George F. Kneller. Philosophical Library Inc., New York, 1958

This book offers a sound, intelligible view of the basic tenets of existentialism. The author points out the historical background of the movement and offers a glimpse into the thinking of such men as Kierkegaard, Marcel, Sartre, Heidegger and other noted proponents of the various forms of the existentialist philosophical movement. The basic thread running through the diverse positions discussed is that man has lost himself in the morass of organized, institutionalized evils that surround him. He has lost his freedom, and is unable to cope with the inevitable tragedies and perplexities of life. If he cannot learn to preserve his freedom by committing himself to basic choices compatible with *both* his emotional and rational being, he will become an anachronism and eventually lose his chance for survival and the realization of his potential.

As Dr. Kneller develops his ideas, one gets the feeling that he is hard put to apply existential concepts to education in this country. It would seem that our American educational system, in which there is a great emphasis on acceptance of á priori values, and scientific analysis, has little room for a system of free choices, self-affirmation and exploration. Dr. Kneller cannot help but point out that the very structure of our educational system militates against emphasis on uniqueness of the individual, and natural diversity.

This reviewer felt that some of Dr. Kneller's negative criticisms of the existential movement were not well substantiated. In fact, his positive critique, in some respects, contradicts his earlier criticisms. Again, the emphasis here is on existentialism, while the relationship of existentialism to education, the purported problem of the book, is not presented as challengingly and helpfully as one might wish.

For those of us interested in group processes (education, group therapy, psychodrama, social organizations) there is much provocative material. The remarkable similarity between some of Kierkegaard's thinking as related to emphases on the single phenomenon, the single act, the situation and their significance, strikes us as having similarities to Dr. Moreno's psychodramatic concepts. The problems, too, of man as part of the social group and man as apart from the social group are cogently raised.

Dr. Kneller's book offers a fine, down-to-earth exploration of existential-

ist ideas. Thus, this book is highly recommended for those who have not been able to find a simplified, applicable break-down of the concepts of existentialism.

EUGENE ELIASOPH

"PSYCHOLOGICAL PROBLEMS OF COLLEGE MEN." Edited by Bryant M. Wedge, M.D. Yale University Press, New Haven, Connecticut—1958.

When psychiatrists, psychologists, social workers, and sociologists get together to write a book, one would hope that an interdisciplinary fusion will result to produce a work that is more than the sum of its parts. In "Psychological Problems of College Men," a book composed of the contributions of eleven staff members of the Division of Student Mental Hygiene of the Department of University Health at Yale University, each author presents his study within the methods and theories of his own discipline. The topics range from "Personality and Academic Achievement: A Questionnaire Approach" and an actuarial study of "Who Uses a College Mental Hygiene Clinic" to "Group Psychotherapy and College Students" and a theoretical paper concerning "The Relationship of Intellectual Achievement to the Processes of Identification." Although it was the deliberate design of the book to maintain the method and language within each approach, it seems a pity that there was no summary chapter making even a minimal attempt to integrate the various findings reported. It seems an especial pity since the focus of concern as indicated by the title of the book is not psychological or social problems of college men but *psychosocial* problems.

EUGENE TALBOT, PH.D.

SECOND INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY (Zurich, August 29th-31st, 1957). Edited by Berthold Stokvis, Leyden.—Basel-New York, S. Karger, 1959.—596 pages.

This authentic report fulfills several tasks simultaneously: *firstly,* it gives, it appears, a well-rounded picture of the "goings-on" of the contents and of the very atmosphere of that recent magnificent Zurich meeting even to those who did not have the good chance to be personally present; *secondly,* it evolves, in the almost astonishing multiplicity and variety of the contributions recorded, a rather good picture of the history and development as well as present and of the discernible future trends of group

psychotherapy as a "movement" of increasingly widening supra-national character (among the 65 individual papers presented by 74 authors, the 28 contributions coming from the U.S. and Canada seem to indicate an at least "numerical" prevalence of publications originating from North America, so far). *Thirdly,* it ought to be added: the richness and authenticity of the recorded Congress contributions suggests (to this reviewer, at least) that this volume ought to be contemplated for use as one of the "required reading" materials in any advanced *teaching* of group psychotherapy anywhere.

The very wide gamut of this "Report from Zurich" makes a full enumeration of all constituent parts an unfeasible task for a brief review. However, it may be pointed out that *besides* the earlier mentioned 65 "individual" papers, it contains the certainly no less significant "Reports of the Work of Some Groups" (i.e. groups working during the Congress), namely of discussion groups and workshops (panels). Of these, the following are reported: (1) Group therapy with *Drug Addicts* and *Alcoholics* (M. Brunner-Orne, U.S.A., with panelists: D. Langen, Tuebingen, O. Martensen-Larsen, Denmark, and N. Beckenstein, Brooklyn), pp. 582-84. (2) *Group Psychotherapy and Medical Practice* (this interesting report given in German only), pp. 584-85. (3) *Group Psychotherapy and its Techniques:* Chairman L. J. Hut, Holland, with discussants from Holland (Stokvis, von Emde Boas), Germany (v. Xylander), Britain (Boenheim, Senft), Switzerland (Shneider), U.S.A. (Morgan, Ormont, Greenbaum), pp. 585-87. (4) *Social Psychiatry* (Chairman W. L. Meyering), p. 587. (5) *Group Psychotherapy with Delinquents* (Chairman G. K. Stuerup, Denmark, with 6 panelists and 5 participants, from U.S., Canada, France, Holland, Scandinavia), p. 588. Unreported are *Group Psychotherapy and Sociometry* (W. J. Warner), *Group Psychotherapy and Psychodrama* (F. Soccoros), *Psychodrama: Denomination* (J. L. Moreno) which presented a psychodramatic motion picture directed by Roberto Rosselini, the Italian producer.

The *Final Report* by S. Lebovici (Paris), chairman of the Program Committee, presents a summary, brief and brilliant, of the gathering; it is rendered, regrettably, in French only.

The closing part is comprised by the "Official Report," pp. 591-96. This states, among many other important data, that 550 persons from *34* countries attended this Congress, (148 from the U.S.); it may be added that 34 "nations" constitute more than half of the United States. For all those interested in the future of *Organized* International Group Psychotherapy,

this "Official Report" contains the significant "Proposals of the Executive Committee to the International Committee of Group Psychotherapy," as *foundations* for future work of the "International Council" and coming Congresses.

The *scientific* session of the Congress was opened with a paper by its first President, J. L. Moreno, "The Scientific Meaning and the Global Significance of Group Psychotherapy," pp. 42-61. Among the individual papers, three others should be particularly mentioned: "Critical Analysis in Some Concepts in Present Day Group Psychotherapy" by J. Bierer, pp. 4-12; "Unification vs. Union in Diversity" in *Group Psychotherapy* by W. C. Hulse, pp. 32-41 and "The Era of Group Psychotherapy" by S. R. Slavson, pp. 61-90. As for the rest of the individual papers, it would be unwarranted —to say the least—to try to pick out any single ones for reporting, no matter how interesting or original they may be. Suffice it to state that they comprise virtually all or surprisingly many, different aspects, areas, techniques and applications of Group Psychotherapy, Psychodrama and Sociometry. The *"interactional"* school (Moreno) as well as the *"psychoanalytic-oriented"* trends of thought are represented; with "existentialists" also present.

The "focal" viewpoints range from art work in therapy groups (with 28 photo illustrations) to work with children, with mothers, to work in "patient clubs," to changing community attitudes, to therapy in schools, sociometry in psychiatric clinics, psychodrama in private practice, in hospitals with somatic as well as mental patients, to ethnotherapy, to failures in individual therapy treated by group therapy, to group catharsis, to projective tests in group therapy, to sexual deviations; they range from high, abstract conceptualizations like sin doctrine or clinical and theoretical implications of the alternate meeting—to the lowly budget problems of group patients fees. And these are but a few examples.

To sum up: this report of the "Second International Congress" edited ably by Berthold Stokvis with the cooperation of Wellman J. Warner, presents a most meritorious enterprise. For future sequences of International Congress reports, two desirable additions I would want to mention here are: (1) tri-lingual summaries of *all* articles, (2) An author and subject index.

All in all: widest dissemination is to be wished to this fundamental book in Group Psychotherapy; its place is in each and every college, hospital and public library—on the book shelf of every psychotherapist.

DR. JOSEPH I. MEIERS, *New York, N. Y.*

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Annual Conference

The 19th Annual Conference of the Society will be held in New York City at:

BARBIZON-PLAZA HOTEL
106 Central Park South
New York, New York

on April 30, May 1 and 2, 1960.

The Conference Committee is preparing a program that will be challenging and informative. Focus of the program is to illustrate and teach diverse methods and therapy. The prime reason for establishing active workshops rather than presentations of papers by competent professional associates is to take advantage of the current application of successful group methods and show them in action. A secondary reason is implicit: active workshops are more stimulating and informative and will result in a greater dissemination of information on contemporary theories and applications.

The Conference is open to members and non-members, and both members and non-members are requested to participate actively in the workshops. In order to do so, contact: Dr. Lewis Yablonsky, Department of Sociology, University of Massachusetts, Amherst, Mass., latest by March 15, 1960.

The scope of the workshops and meetings is to augment recent understanding of group and action methods with insights and new ideas gained by professional workers. Chairmen selected at this time include: J. L. Moreno; Zerka T. Moreno; Ruth Fox; Hannah B. Weiner; James Enneis; Lewis Yablonsky. Areas of interest cover: Techniques and Applications of Group Methods; Treatment of Alcoholism and Drug Addiction; Values and Goals in Setting Up Group Therapy Programs, and Psychiatry versus Psychotherapy, Contrasts and Trends.

For program write to:

American Socity of Group Psychotherapy & Psychodrama
Office of the Secretary
P. O. Box 311
Beacon, N. Y.

Local Chapter Progress

The Midwest Chapter held a successful one-day meeting on Group Psychotherapy Methods applied to Industry, Private Practice, Education and the Community. Program Chairman was Dr. Raymond J. Corsini. Participants included: Dr. Glenn Bacon, Racine, Wisconsin; Dr. Robert S. Drews, Detroit, Michigan; Dr. Boris Speroff, Munster, Indiana; Dr. Rita James, Chicago, Illinois; Dr. Bernard Shulman, Chicago, Illinois; Dr. Jordan M. Scher, Chicago, Illinois; Dr. Arnold D. Tobin, Chicago, Illinois; Dr. Misha Zaks, Chicago, Illinois; Dr. Roderick Pugh, Chicago, Illinois; Dr. Stanley Lipkin, Chicago, Illinois.

For membership applications and information regarding the Midwest Chapter contact: T. W. Franks, President, Midwest Chapter, 2900 West 36th Street, Chicago 32, Illinois.

The Missouri Chapter: Dr. Abel Ossorio and Mr. Leon Fine have initiated an outstanding Psychodrama television program on the CBS Network, entitled "Montage." The program is being submitted for the Albert Lasker Award and copies of the kinescope may be made available for rental.

For information regarding this chapter contact: Mr. Leon Fine, St. Louis State Hospital, St. Louis, Missouri.

The New York Chapter initiated officers for 1960 at a conference-dinner at the Henry Hudson Hotel in New York City. The honorary guest speaker was Dr. J. L. Moreno who enlightened the members and guests with his provocative impressions of Russian-American trends and beliefs regarding the scientific approach to the study of human behavior. The newly elected officers are: Dr. Gustav Machol, President; Dr. Hanna Machol, Treasurer; Dr. Sylvia Heimbach, Secretary. Membership to this chapter includes a quarterly newsletter and special rates on local meetings. For information contact: Dr. Gustav Machol, Medical Arts Building, 142 Joralemon Street, Brooklyn, New York.

Formation of New Chapter

A number of inquiries have been received regarding information on the requirements and qualifications needed to form a chapter to the Society. Attention is called to the following statement in the By-Laws:

ARTICLE V

State Chapters

When a group of not less than twenty of the membership of the Society residing in any state shall make application to the Council of this Society to organize a state chapter of the Society and the Council approves, the Council may recommend to the Society at an Annual Meeting the establishment of such a chapter to be named according to the state where it is to be organized. The recommendation may be adopted by a vote of not less than two-thirds of the Fellows and Membership of the Society registered and voting at the session at which the recommendation is submitted; provided, however, that *no one shall become a member of the state chapter who is not already in the membership of the American Society of Group Psychotherapy and Psychodrama.* Each chapter may elect its own officers, arrange its own programs of meetings.

CZECHOSLOVAK PSYCHIATRIC CONGRESS

September 7-11, 1959

The Czechoslovak Psychiatric Congress with international participation took place from September 7th to 11th, 1959 in Lazne Jesenik (Graefenberg). The Czechoslovak Congress was the first international gathering in which psychiatrists of East and West met to exchange their views. The distinction to be one of the official spokesmen of American psychiatry was placed upon Dr. J. L. Moreno and he accepted the invitation.

Excerpt from the letter of invitation:

Dear Dr. Moreno:

The Czechoslovak Ministry of Health and the Czechoslovak Medical Society, Psychiatric Section, would be honored by your attendance at the Czechoslovak Psychiatric Congress with international participation which is to take place at Jesenik Spa [Graefenberg] from 7th to 11th September 1959. The theme of the Congress is NEUROSES, Toxic psychiatric Disorders, Alcoholism. For seven days of your stay in Czechoslovakia Congress with international participation which is to take place at Jesenik Spa [Graefen- in connection with the Congress you would be a guest of our Health Ministry and Medical Society and all expenses incurred during your stay in this country would be taken care of by them.

Signed by Prof. Milos Netousek, President of the Czechoslovak Medical Society, Prof. Josef Lukas, Vice-Minister of Health, and Dr. E. Wolf, Secretary of the Psychiatric Congress.

The Congress took place in the beautiful setting of Jesenik. The accommodations were excellent and the spirit of hospitality of the hosts was of the highest order. A real battle of minds took place between leaders of psychiatry from East and West. It was an auspicious beginning for a growing cooperation.

At the Congress there were 500 attendants of whom 110 came from abroad. From Western countries there were four guests of honor, two from the U.S.A. (Drs. Moreno and Masserman), one from Canada (Dr. Wittkower) and one from Austria (Dr. Hoff). All four were at the same time principal speakers, being allotted thirty minutes speaking time each. Dr. Myasishchev headed the Russian group. The Czechoslovakian principal speakers on Neurosis and Psychotherapy were Dr. Knobloch, Vymetal, Vondracek and Wolf. The crucial days of the Congress were the first day on the Theory of Neurosis (Dr. Knobloch, Vymetal, Myasishchev, Masserman and Wittkower) and the third day on Psychotherapy and Prevention of Neurosis (Drs. Hoff, Wolf and Moreno).

The speakers on the program consisted of 50 delegates from Czechoslovakia, 21 from Soviet Russia, 15 from the U.S.A., 7 from East Germany and 7 from France, 5 from Hungary, 5 from England and Canada, 3 from Italy, 2 from Poland and 2 from Jugoslavia, 2 from Bulgaria and 1 from Austria, a total of 120, 89 from communist countries and 31 from democratic countries. The ethnic and ideological differences produced a complicated but significant sociogram.

Group psychotherapy was well represented on the program. The following speakers dealt with this topic: H. Faure (Bonneval), Sept. 7th; H. Szewcyk (Berlin), Sept. 7th; J. L. Moreno (New York), Sept. 9th; R. A. Zachepitskii (Leningrad), Sept. 9th; D. Blazevic (Zagreb), Sept. 9th; R. W. Crocket (London), Sept. 9th; A. Bertrand (Paris), Sept. 11th.

J. L. Moreno spoke on sociometry and gave a demonstration of Psychodrama on Thursday, September 10th, 1959.

SPEAKERS ON THE PROGRAM

Arranged According to Countries

CZECHOSLOVAKIA

O. Janota
Z. Stich
J. Rubes
F. Knobloch*
J. Lat
J. Srnec
O. Vymetal*
J. Stuchlik
J. Fischer
J. Vitek
A. Matova
J. Skala
V. Vitek
Z. Juncova
E. Nespor
G. Horkovic
V. Vondracek*
E. Guensberger
J. Masarik
G. Horkovic-Kovac
V. Wiedermann
K. Freund
K. Nedoma
V. Vojtechovsky
J. Synkova
M. Oterova
O. Andrasinova
Z. Ledinska
Z. Servit
E. Klimkova-Deutschova
Z. Macek
B. Roth
C. Michalova
V. Bartonicek
J. Skachova
D. Svorad
E. Wolf*
R. Konecny
J. Mecir
B. Chalupa
A. Matova
I. Major
N. Polak
I. Horvai
J. Gross
S. Hanzal
M. Bazany
J. Roubicek
H. Bultasova
S. Grof
E. Kuhn
E. Horackova
K. Rysanek
V. Student
M. Sevcik
J. Duba
V. Pitha
O. Masin
Z. Klima
V. Mensikova

* Principal speaker.

SPEAKERS ON THE PROGRAM (Continued)

U.S.S.R.

V. N. Myasishchev*
T. P. Simson
V. P. Kudriavtseva
V. V. Borinievich
I. H. Piatnitskaia
J. V. Strelchuk
G. M. Pivovarova
E. A. Popov
P. K. Anokhin
A. Povorinskii
B. Alapin
A. A. Portnov
F. V. Bassin
D. D. Fedotov
E. K. Yakovleva
A. J. Straumit
S. Leder
F. Detengov
V. A. Jasov
R. A. Zachepitskii
A. S. Chistovich
T. A. Nievzorova
P. N. Yagodka

U.S.A.

J. L. Moreno*
Jules Masserman*
T. P. Hackett
A. M. Freedman
S. T. Michael
B. J. Harte
P. E. Stokes
O. Diethelm
J. H. Mendelson
F. Ervin
E. Kahn
H. Leiderman
J. Wexler
P. Solomon
P. E. Kubzansky

EAST GERMANY

K. Höck
E. Bartsch
G. Destunis
H. Szewczyk
D. Müller-Hegemann
H. Keyserlingk

FRANCE

H. Faure
L. Bonnafe
P. Jean
C. Koupernik
J. C. Dubois
J. Carrere
A. Bertrand
H. Baruk

HUNGARY

I. Hardi
F. Volgyesi
K. Szilagyi
Z. Böszörmenyi
R. Pertorini

ENGLAND

M. Shepard
J. H. Rey
R. W. Crocket
J. Y. Dent

BULGARIA

E. Sharankov
H. Schipkowensky

ITALY

H. Terzian
F. Basaglia
G. B. Belloni

POLAND

A. Chalisov
M. Marszynski

YUGOSLAVIA

D. Blazevic
S. Betlheim

AUSTRIA

H. Hoff*

SWITZERLAND

A. Tongue

BELGIUM

H. Casier

CANADA

E. D. Wittkower*

* Principal speaker.

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