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PSYCHOANALYST VS. PSYCHODRAMATIST
A DIALOGUE*

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Let me try to make my discussion remarks in a form congenial to the topic of our discussion. Let me present them in a dialogical form, choosing two protagonists as my principal spokesmen: the *Psychoanalyst* and the *Psychodramatist.* This, I suspect, is quite an artful device of sitting on the interdisciplinary fence, giving me a chance to speak with my tongue in other people's cheeks, while at the same time forcing them—that is my protagonists—to use my script for their discourse. Of course, I know full well that I am not likely to deceive you and that you will readily recognize my device for what it is: a feeble attempt to take a leaf out of Dr. Moreno's book—pretending, for a brief moment of grandiosity and expansiveness, to be Dr. Moreno himself. But you will note that I shall do so for brief moments only, followed by a deplorable change of personality in order to become an innocent mouthpiece of Dr. Moreno's psychoanalytic critics.

I begin with giving the Psychoanalyst the floor.

Psychoanalyst: "Psychodrama, Mr. Psychodramatist, is certainly one of your most lively and adventurous brain children. But didn't you admit yourself that its paternity reaches back to ancient Dionysian rites, Orphic mystery cults, Socratic dialogues and to the tradition of Greek tragedy and Aristotelian catharsis? In short, does not psychodrama amount to turning the clock back from the modern dynamic approach to obsolete ego-oriented methods of admonition, exhortation, persuasion or moral therapy? Does not psychodrama dispense with the most important accomplishments of psychoanalysis: with the part played by insight into unconscious dynamics? Does it not substitute continued acting out for systematic understanding, interpreting and working through of the patient's problems?"

Psychodramatist: My friend, your objections are of the common, garden variety type and have repeatedly been refuted by the psychodramatist. Acting out in psychodrama is something different from acting out in the psychoanalytic situation. It has a cathartic, liberating purpose. It is done with the full approval of the director. Indeed, he encourages it, leads up to

* Presented at the Nineteenth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama.

it, helps to bring it about. Acting out in psychodrama is the counterpart of free association in psychoanalysis. Yet by contrast to the patient's productions on the couch, it is truly free, free from what Ehrenwald described as "doctrinal compliance." It is spontaneous, creative and unrehearsed. It brings the past back from oblivion and makes it real, life-like, *here and now.* Moreover, with the psychodramatist's direct cooperation, it enables the patient to cope with his current difficulties better than before. To quote Dr. Moreno: "The crux of the matter is that acting out be tolerated and take place within a setting which is safe for execution and under the guidance of therapists who are able to utilize the experience." Thus spake Dr. Moreno and so you see that psychoanalysts, by prohibiting acting out, dispense with one of the most powerful tools in the psychotherapist's armamentarium.

Psychoanalyst: (trying to control his counter-transference) There are several flaws in your argument. First, you adopt a psychoanalytic term for your own convenience and do not tell us exactly in what way it differs from the accepted psychoanalytic use. Psychoanalytically speaking—that is quoting Hinsie and Schatzky—"acting out is the partial discharge of emotional tensions that is achieved by responding to the present situation as if it were the situation that originally gave rise to it." Acting out, therefore, is nothing but a dramatic manifestation of the neurotic symptom itself. By encouraging acting out you psychodramatists merely help the patient to hang on to his symptoms and thus to reduce temporarily his anxiety. Secondly, you are wrong in suggesting that we analysts actually prohibit acting out. We do no such thing. We interpret its meaning to the patient and in so doing relieve him of the need for continued acting out, both inside and outside the psychoanalytic situation. What you psychodramatists do is just the opposite. You reward the patient for the exhibition of his mental symptoms and thus become his accomplices in the formation and perpetuation of his neurotic defences.

A third flaw in your argument is well concealed from the eyes of the naive observer. You claim that you encourage acting out under the guidance of an observer who is able to "utilize the experience." I submit that this is a purely verbal maneuver. You do not explain in what way, if any, the psychodramatist is really able to do so. I believe he "utilizes" his experience on the basis of intuitively applied psychoanalytic principles without, however, owning up to them, or without even being aware that this is what he is doing. In fact I believe that no "utilization" of therapeutic experiences is possible unless it is derived from a thorough understanding of individual

and group dynamics as it was first outlined by Freud. Put in a capsule, the psychodramatist is either a psychoanalyst without wanting to be one—like Molière's *Medecin Malgré lui*—or he is just joining his patient in the staging of an unrehearsed and spontaneous neurosis—or of a folie-a-deux, a trois, a quatre, etc.—as the case may be. It is true that most psychodramatists are in effect much more analytically minded than they like to admit. They remind me of the Jewish worshiper who tried to sneak into a synagogue on the day of atonement without a ticket. When stopped by the usher he tried to explain to him that he only wanted to deliver to his uncle his forgotten prayer book. But the usher was unconvinced. "You cheater," he said, waving his index finger, "You cheater, don't you dare let me catch you praying in there."

Psychodramatist: I do hope that your digs and diatribes against psychodrama will eventually have a cathartic effect on you and your own peace of mind. They will thereby prove the validity of our method. Disregarding the digs, let me remind you that it is just the psychodramatic setting which provides the cathartic experience with its high emotional impact, far exceeding anything that can be achieved on the couch. Again, as far as the factor of insight is concerned, we too aim—to quote Mr. Enneis—at a "thorough evaluation of the interpersonal or human relations structure." We too seek "to bring into awareness those patterns of relationships which seem to perpetuate psychosis or neurosis." And it is needless to say, we too are against sin—that is, against *irrational* acting out.

Psychoanalyst: I am glad that you too are against "irrational" acting out and in favor of rational behavior in general. But here, again, I suspect that without the established principles of psychoanalytic theory you are at a loss in deciding what is "rational" or "irrational" behavior. Of course, you have evolved a useful sociometric method for the study of groups and group behavior. But your theoretical construct *tele* is merely a substitute for Freud's concept of aim-inhibited libidinal or aggressive ties, responsible for group cohesion. In a similar vein, you emphasize the importance of the existentialist *encounter*, here and now, between therapist and patient. But your frequent reiteration of the phrase is no substitute for the dynamic understanding of the processes of transference, counter-transference, identification and projection which it implies. You introduce the concept of the *social atom* for the dynamic patterns of early child-parent relationships; of *"phantoms"* for objects introjected into personality structure; you talk about *co-conscious* or *co-unconscious* states in preference of Freud's basic distinction between the primary and the secondary processes and their

diverse manifestations. But all this merely amounts to an esoteric, private nomenclature in order to establish your identity as a separate and distinct school of psychotherapeutic thought. The trouble is that as a result the principles of psychodrama like those of existential analysis, religious counseling, etc., remain outside our established scientific frame of reference and cannot be integrated with it. It is true that few would deny the merits of psychodrama as a practical procedure. But I submit that to the extent to which it actually achieves therapeutic results it is a form fruste of psychoanalysis projected from the couch on to the psychodramatic stage.

Ladies and Gentlemen, I think it is high time at this point to silence the imaginary psychoanalyst of my script and indeed to reprimand him for his insistence on one-sided, intemperate, partisan statements. Also, I should now give the word to the psychodramatist for his rebuttal. The psychodramatist might conceivably retort that psychoanalysis is in effect a forme fruste of psychodrama. He might refuse to accept science as the last court of appeal to judge the validity of his approach. He might quote Dr. Moreno's statement that psychodrama and group therapy in general derive their rationale from existential and not from scientific validation, and so on and so forth.

But let me try in conclusion to come in edge-wise with a few words of my own. Needless to say, that I am not surprised to see the *Psychodramatist* and the *Psychoanalyst* of my script hopelessly at odds and unable to come to terms on basic principles. The reason is that they are committed to two fundamentally conflicting philosophical positions. The psychoanalytic approach is essentially based on a materialistic, mechanistic, causal-deterministic scheme of things. It is concerned with instinctual drives, forces or energies. To the analyst the personality of man is nothing but an assemblage of mutually interchangeable and interdependent constituent parts or quanta of energy. The psychodramatist, by contrast, moves along essentially teleological, idealistic or existentialistic lines. Like the priestly healer, the religious reformer, the spiritual counselor, or the moral therapist of a past era, he sees man as a free agent, as the maker of decisions, as the fount and origin of purpose, meaning and value in an otherwise cold and inhospitable universe. No wonder that these contrasting positions seem to be virtually irreconcilable and mutually exclusive. But the striking fact is that both the materialistic, drive-oriented psychoanalyst and the value-oriented existential therapist, spiritual counselor, moral therapist or psychodramatist can find ample confirmation of their respective philosophies in their patients' responses therapeutic or otherwise. This is what I have

described as *doctrinal compliance.*[1] In fact, the representatives of both camps can claim to be the spokesmen of a self-sealing, perfectly consistent and even pragmatically verifiable system of thought. Taking as they do two widely divergent theoretical presuppositions as their points of departure they both seem to be right in their own right.

This is certainly a perplexing state of affairs and this is not the time nor the place to speculate as to its reasons. But let me remind you that seeming contradictions of this order are by no means confined to the field of psychology and psychotherapy. The history of theoretical physics is replete with similar examples. A classical case in point is the wave *versus* the particle concept of light, each permitting a set of perfectly valid interpretations and predictive statements. Yet the two respective physical theories are just as mutually exclusive and seemingly incompatible as the *energy* versus the *value* aspects of our psychic life. We are told that Niels Bohr's celebrated principle of complementarity holds the key for the reconciliation of these paradoxes. It may well be that a similar principle of *psychological complementarity* will help resolve the behavioral scientist's and especially the psychotherapist's dilemma. It will be for the psychotherapist to bring about a reconciliation of the two conflicting aspects *within his own personality* in the first place: the reconciliation of the conflict between causally determined instinctual drives on the one hand, and man's value oriented creative aspirations and quest for freedom and spontaneity on the other. I do not know whether it is altogether possible to attain such a goal. But I believe that whoever will come close to its consummation is not likely to be an orthodox follower of any one of the contemporary rival schools of psychotherapy, psychoanalytic or otherwise.

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[1] Doctrinal Compliance in Psychotherapy and Problems of Scientific Methodology. Progress in Psychotherapy, Vol. III.

MORENO'S DISCUSSION OF EHRENWALD'S DIALOGUE "PSYCHOANALYST VS. PSYCHODRAMATIST"

1. The brilliant and humorous author of this dialogue, Jan Ehrenwald, is in an awkward position: he has practiced psychoanalysis but he has never attended a psychodramatic session much less practiced it. He may play the part of the psychoanalyst but how can he play the part of the psychodramatist without bias? He is apparently well acquainted with psychonanalytic literature but he is poorly acquainted with psychodramatic writings. How can he make a fair historical comparison of the two positions?

2. Psychodrama in this *modern* format has no precedent in the history of psychotherapy. The format of psychodrama is the very opposite of the Greek tragedy. The Greek tragedy is a cultural conserve, the reenactment of a play written by a playwright, the psychodrama is a spontaneous creative production, presented in the Here and Now. Not only does it not turn the clock back but it starts a new future for psychotherapy on a realistic and scientific basis. The "psychoanalyst" is not aware that Moreno has systematically reevaluated Freud's concept of the unconscious. The unconscious dynamics as Freud has formulated it for individual analysis is difficult if not impossible to prove. Moreno has introduced instead *the concept of co-unconscious states*. Co-unconscious dynamics operate between individuals. It can be empirically validated. Acting out within a therapeutic setting is the therapeutic counterpart of living itself. It can not be substituted by any form of "interpretation" even if the therapist were God himself.

3. The "psychoanalyst" states that phrases like acting out and group dynamics have been explained and introduced by Freud. This is erroneous. "Acting out" is a term which Moreno has introduced into psychotherapeutic literature. (See Spontaneity Training of Children in "Impromptu versus Standardization," Moreno's Laboratories, New York, 1929, Psychodrama Volume I, page 140-45, Who Shall Survive?, *first* edition, 1934, page 325). Freud cannot have used the term. It is an Anglo-Saxon term for which there is no counterpart in German. But acting out defined as "acting from within" is a logical psychodramatic term. It has been borrowed by psychoanalysts but given a different meaning. Acting out is often an adequate response to the present situation and not neurotic. In psychodrama acting out is encouraged and permitted; in psychoanalysis it is forbidden. "We remember a feeble-minded girl whose desire to become a nurse took on fantastic forms. Although we knew she would never be able to become one, *we encouraged her to 'act out' this craving in training situations*. Finally she discovered her-

self that it was not suitable for her and asked to be trained for maid service." (See Sociometric Review, 1936, page 24). Obviously the same term "acting out" is used by psychodramatists and psychoanalysts for two different phenomena.

4. Psychodrama has been submitted in many of its phases to scientific validation. Moreno has pointed out however that "existential" validation plays an important part in every psychotherapeutic process.

The "psychoanalyst" points out that transference and projection have enriched the concept of "encounter." But he is in a characteristic psychoanalytic manner only concerned with the *pathology* of encounter. But what would encounter mean without its essential positive features—contact, communication, co-unconscious states, tele and role reversal?

5. The "psychoanalyst" wants the reader to believe that Moreno does not try to meet the requirements of scientific validation. The opposite is true for everyone who is acquainted with sociometry, group dynamics, group psychotherapy, psychodrama and role playing.

6. The psychoanalyst does not permit the patient to act out his fears or obsessions in the psychoanalytic office; were he to permit that he would turn into a psychodramatist. What he does is to interpret to the patient the meaning (as he, the analyst, sees it) of his wishes to act out. For the psychodramatist the acting out is part of his "fact finding" procedure and not an encouragement to the patient to "exhibit" himself. It is true, however, that many psychoanalysts of 1960 use psychodramatic techniques without admitting it. The "cheater" is therefore the psychoanalyst and not the psychodramatist.

7. Moreno followed Ehrenwald's intriguing dialogue with a dialogue between psychodramatist and psychoanalyst of his own. It has been type-recorded and is being transcribed and will be published in a subsequent issue of Group Psychotherapy.

USES OF MUSIC IN GROUP PSYCHOTHERAPY

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One dimension of the group psychotherapeutic process which can be constructively used by the group psychotherapist is that of music. When music is introduced into a therapy group, there is likely to be a modification of the group climate which may be important for the group's therapeutic progress.

The history of music in group psychotherapy is short but significant. An early experiment is Moreno's group improvisation at Carnegie Hall in New York, in which an ensemble of musicians each playing a different instrument cooperated in the creation of a musical theme. The conductor or the player of the first instrument suggested a tempo, then the leadership during the production migrated at intervals from one instrument to another. The change of leadership occurred intuitively (Moreno, 1931). The effect of spirituals and work songs of the southern negroes made life endurable under very difficult circumstances. (Altshuler, 1945). During World War II authorized experimental work in Music Therapy was initiated, through the *Office of the Air Surgeon, at the Fort Logan AAF Convalescent Hospital.* (McKay, 1945). A psychodramatic technique is used to treat creativity neurosis of musical performers. (Moreno, 1939). A combination of sound and movement in group psychotherapy is found helpful in the treatment of mental patients. (Branham, 1959).

A number of studies have experimentally established how music may influence group behavior. One study (Boernstein, 1936) demonstrated that the introduction of a "dark" sound (a D-Minor chord) had the same effect as a decrease in illumination on subjects' perception of a color wheel. Music instructors have traditionally described flats as dark and sharps as bright sounds.

One experimenter has demonstrated that music can lower the threshold of sensory perception (Disereus and Fine, 1939), and another has documented music's effect on the nervous system and emotions (Schoen, 1940). A study of 20,000 subjects found that various phonograph records produced a markedly uniform mood in a significant number of persons (Schoen, 1940). Dentists have found that music piped in to patients via earphones may take the place of anesthetics.

Most psychoanalysts regard music as being related to the earliest periods of psychological organization, when the ego cannot distinguish the boundaries between reality and the self (Coriat, 1945). Musicologists have said the same thing in non-psychological language (Hindemith, 1951). One psychoanalyst observed that music may release unconscious fantasies (Pfeifer, 1922). Nursery melodies have been used to penetrate patients' defenses against contact with reality (Antrim, 1944). Music has been formally used in group therapy (Altschuler, 1940), and the specific effect on psychiatric patients with various syndromes of various pieces of music has been documented (Capurso, 1952).

The Use of Records

On occasion it has been found that playing records of music quietly in the background during a therapy session helped some patients who had great difficulty in expressing emotion to do so. These patients had such defenses against others that voices did not stimulate them to respond, whereas music could.

There may be occasion when the group therapist may want to introduce some other kinds of musical expression because it will assist the group to express itself at a time when interpretations and other verbal insight-facilitating procedures are unproductive. On such occasions we have found that playing a phonograph record of a singer has had a powerful catalytic effect in helping to release emotional expression.

One group of adults had been meeting twice a week for eight months, and had been making good progress until it began to approach awareness of deeply buried unconscious fantasies about killing parents and siblings. The group members were approaching this material in a very gingerly way and were obviously having great difficulty in verbalizing their feelings. Some patients walked out of the room, some had spoken of leaving the group, and other expressions of avoidance had occurred.

At this point the therapist remarked that he would like to play a record which might be of interest to the group. It was "The Irish Ballade," by Tom Lehrer, a Harvard mathematician, who accompanies himself on the piano. The ballad deals with parenticide and fratricide.

The Irish Ballade[1]

A maid who in a fit of pique
Drowned her father in the creek

[1] Quoted by special permission of Mr. Tom Lehrer. Copyright, 1952, by Tom Lehrer.

The water tasted bad for a week
And we had to make do with gin.

Her mother she could never stand
And so a cyanide soup she planned
The mother died with a spoon in her hand
And her face in a hideous grin.

She set her sister's hair on fire
And as the smoke and flames rose higher
She danced around the funeral pyre. . . .

She weighted her brother down with stones
And sent him down to Davy Jones
All they ever found were some bones
And occasional pieces of skin.

One day she had nothing to do
She cut her baby brother in two
And served him up as an Irish stew
And invited the neighbors in.

And when at last the police came by
Her little pranks she did not deny
To do so she would have had to lie
And lying, she knew, was a sin.

The immediate reaction to this material was one of great anxiety and hostility. The group climate dissociated with the members falling back on secondary defenses, like joking and laughing, or tertiary defenses like rationalization and discussion of current events and various external matters. That a high status adult took such matters seriously enough to sing about them helped the group members to accept the extent to which such material had remained with and was influencing them and was not merely an early childhood fantasy. The mocking delivery of the record removed some of the initial sting of the content. The group members became more philosophical, more aware of themselves as participants in the human condition, and began discussing relevant myths, fairy tales, dreams, and religious matters.

After their initial defensive response, the patients responded in accordance with their individual character structures. One minister, who had been talking to the group about the essential goodness of men, was able for the first time to cope with the implications of a recurrent dream involving his

killing his wife. A very aggressive psychopath with a deep need to deny the expression of his hostility, objected to the record. "Why do you bring in this extraneous material?" A schizoid patient with a fertile imagination who had not been saying much, suddenly became alert and active when she realized that others shared her previously private language. A neurotic patient was helped to see how his response was not too different from that of the schizoid. A detached patient at first tried to disassociate himself from the content of the record as part of his general defense against others. An alienated woman who had difficulties in experiencing her own feeling range was helped to express herself by the record.

For two or three weeks the record and the material which it stimulated were the central themes of the group. Its playing had served to make it possible at an appropriate time for the group members to express buried and unpleasant ideas and feelings which might otherwise not have emerged so clearly and directly.

Use of a Piano

Some patients, usually schizoid or pseudoneurotic schizophrenics, have such trouble expressing themselves with words that they almost require some form of non-verbal communication like a record, music, or poetry, to make them feel that they can relate to themselves and to others. Mary was a 22-year-old and unmarried woman who lived with her widowed mother. She was in a group which had been meeting twice a week for a year.

When Mary was 11, her mother told her that her father, who had died three years earlier, was not her biological father, but that another man had been. One effect of this disclosure on Mary was to plant some unconscious doubt that her mother was her actual mother. Mary had been taking piano lessons from a male teacher and had been an enthusiastic student who practiced a great deal. After her mother's disclosure, Mary refused to read music as she projected her feelings about her "father" onto her hapless piano teacher. She began to lie to him about playing by reading notes. Although she previously had read music, she now began to play from memory. Mary played the piano throughout her adolescence almost compulsively, as her ability to communicate verbally gradually declined.

One day the therapist moved the group to a room which had a large grand piano. In the first room, Mary had been attentive to the group primarily in terms of ignoring it. As soon as the group moved to the room with the piano, Mary was drawn to it as if to a magnet. She would sit at the piano at the beginning of the session and play a piece which reflected

her mood and which usually caught the mood of the group. Like many schizoid persons, she was extremely sensitive to the group's moods. She encouraged the members of the group to ask her about each piece she played, and would delight in the group members' interest and in her discussion of the music. The group was tuned in to her moods by her playing and she served as a kind of mother-image for the members.

The music Mary played was often sad, harsh and lonely. As she and the group progressed, the music became less sad. The group looked forward to her playing briefly at the beginning of the session because the music helped the patients to respond on an affect level. Within a few months after the move to the room with the piano, Mary had progressed from saying nothing, but playing, through making comments like "The Moonlight Sonata is lonely," to the point at which she could discuss her feelings of loneliness and their meaning. She was gradually aided in achieving self-awareness and in understanding the role of the significant others in her life, and after several months no longer needed the piano to participate in the work of the group.

Therapist's Musical Intervention

Sometimes the therapist's direct musical intervention can help advance a group. Dorothy was a 29 year old housewife with two children. She was married to a salesman and had been in treatment for two years in a group which met twice a week. She was moody and suicidal and was unhappy that her move to the suburbs had not brought the happiness she expected. Dorothy had grown up in a tenement with three siblings, and had always felt herself the least favored of the four children. She had associated the slum environment with her rejection by her parents and hoped that the suburban environment would help her in relating to others, but her hopes were not fulfilled.

Dorothy had helped to create a relationship with her husband in which he was almost forced to reject her. She had no insight into the paranoid nature of her fantasies about him. For example, she telephoned him at home one evening and said that she was discussing music (she was a talented amateur musician) with a man friend at a bar. It was supper time, and her husband told her to come back promptly or not to come back at all. In order to "show him," she spent the night at a hotel by herself. Confronted by the reality of taking care of the children by himself, her husband did not back up his threat.

Her physician had been giving her tranquilizers and Vitamin B to

make her feel better, without much effect. One day she was complaining to the group of how nobody cared for her. Her voice and manner were becoming increasingly infantile. The therapist took his guitar and played Brahms' "Lullaby." Dorothy burst into tears and said, "This is the first nice thing anybody has ever done for me." She interpreted the therapist's playing the lullaby for her as a sign of his selecting her out of all her siblings in the group. It was important to her at that time to have the delusion that he preferred her, and she was able to discuss how neither her mother or father had payed much attention to her. The therapist's playing a guitar was a profound corrective emotional experience for Dorothy.

Like symbolic siblings, the group members complained that the therapist was favoring Dorothy and ignoring them. "You're taking the group's time to treat one member." They asked the therapist if he would make love to a group member who had a sex problem, just as he had taken the group's time to treat Dorothy's need for affection. When he said that he would not, the group members accused him of hypocrisy. The incident with the guitar sparked discussion for five sessions and the group overcame its initial negative reaction as it realized that whatever helped Dorothy also helped the group. It is of interest that a previous experimental study found the "Lullaby" to be "relaxing, meditative, soothing" (Capurso, 1952).

Some Uses of Recorded Classical Music

The overture to Wagner's "Parsifal" was used in another group, the members of which had been meeting for from two to three years. Most were ambulatory schizophrenics. Before the record of "Parsifal" was played, the therapist said: "I'd like to see how you like this." There was some discussion about whether the group really wanted to hear the record, or whether they felt partially coerced into doing so. Some expressed dislike of authoritarians, Germans, and Wagner. Finally, in an atmosphere of some expectant hostility, the overture was played.

After it was on for a few minutes, one patient began crying. When the record was finished, Tanya explained that she had had a vivid daydream as she heard the music.

Tanya was 25, and the wife of a minister. She had seen herself as a salamander in green slime in a kind of jungle ooze. The salamander had red eyes. In subsequent sessions this picture changed to that of a blonde girl with blue eyes. Tanya's unconscious identification with an animal and her feeling that she had been born before are, of course, sometimes found in

schizophrenics. She had so little identification with the human that she could readily believe that she had been an animal.

The five other patients all had profound responses to the record. Two became very tense. One patient had a daydream about being a medieval princess. One became extremely agitated and one became withdrawn. All the patients were able to express great hostility, which was mixd with a kind of near-religious feeling. They could express the hostility because of the threat posed by the therapist to their repressed fantasies by playing the overture. The mood created by Wagner, (who wrote the overture after spending a night in the Venice cathedral) is initially one of a kind of unshaped mystical engulfment which then becomes more structured. In the case of this group, it helped some members to put their unconscious fantasies into words, over a period of several sessions.

In another group, which had been meeting twice a week for two years, the last scene of Berlioz' "Faust" was played. It has a choral accompaniment which is relatively easy to follow. In this scene, the Devil tricks Faust by telling him that they are going to help Marguerite. Actually, he takes Faust to Hell and the music is concerned with Faust's increasing anxiety as he feels that he will soon be lost. Faust sees ghosts and other frightening sights. The music beautifully describes Marguerite's ascent to Heaven and Faust's descent to Hell. It particularly evokes responses in very depressed or guilty patients.

The final few minutes of the scene are affirmative and joyful. When played in the group, it provoked a number of profound fantasies and daydreams and helped several members of the group to communicate relatively deep rooted material. Different patients responded to various elements of the music. Some responded to the feeling of reality and escape from reality and some responded to Faust's conflict.

As the music expressed Faust's falling sensations, a 29 year old secretary cried out, "Oh, I remember a dream." Leslie was an ambulatory schizophrenic who had been married for six years. She had actually had the dream three months earlier, but the music triggered its recollection. In the dream she was in a therapy group telling the other patients of a dream she had had. The dream involved her engaging in homosexual wrestling with another woman, after she holds up a baby and tells her husband, "I'll kill the baby if you move." Her masculine self-concept, fantasies of murder, and sex problems, all emerged in this dream within a dream, which might not have been recalled were it not for the selection from "Faust." It had

been repressed for a long enough period so that there is reason to suspect that she might not have brought it to the surface without the music.

The problem of a group which had been meeting for about two years was not so much diffculty as ease in expressing hostility. Much self hate as well as mutual dislike was being expressed by members of the group. This blossomed forth at one session into shouted accusations. One male patient (Sidney) was insulting a female patient (Susan) very vigorously. She told him that she would have her husband, a policeman, "take care" of Sidney. When the therapist tried to say something, the patients would not let him do so and began saying "What kind of a doctor are you?" and "Give us our money back."

The therapist said, "You seem to be in a hateful mood. I'd like to play some Christian music." He put on a record of Debussy's "The Blessed Damozel," which is written around the theme of forgiveness. It has substantial parts for flutes and cymbals, and a very soothing quality.

The music had the effect of not only calming the group but also of helping to gear them into expressions of relatedness to each other. Susan explained that she was mad at her son, and had expressed this hostility toward Sidney. The music helped her and the other members of the group to express the feelings of relatedness which they had been repressing. They were able to be much more aware of why they had been so nasty to each other, and to express their desire to work with each other in the group.

A Patient's Musical Response

Musicians' choice of their vocation is usually a function of dynamic forces of which they are, of course, seldom aware. One use of music in a group involved a professional musician's loss of his ability to play.

A 35 year old married patient in a group which had been meeting for about six months was a trumpeter. When his wife asked Philip for a divorce, he lost his ability to play the trumpet, almost overnight. The other patients asked him to bring his trumpet for the group sessions to see if he could play in the group. Philip tried, but he could not make any sounds. He was not able to move his lips on the instrument's mouthpiece and his lips trembled when they approached the trumpet. The group began to call him "Quivering Lip Phil."

His wife was very disturbed about Philip's deterioration and asked the therapist for permission to come to a group session and tell her side of the story. The patients, after some discussion, decided to let her come. Phyllis was a former schoolteacher with considerable intellectual pretensions who

thought of her husband as a "sex machine" and an animal who was not up to her intellectual level. She told the group how her husband had become impotent and repeatedly tried cunnilingus, much to her disgust. She said that she kept telling him "you're no man."

The group helped Philip to see, at subsequent sessions, how he had projected his wife's vagina onto his trumpet. By the time his wife asked for a divorce, Philip could no longer even get his lips on the trumpet's mouthpiece. Shortly after his wife's visit to the group, he reported a dream in which he was sitting on the toilet bowl and frantically calling his wife for help, which she was refusing to give. The following week he had a dream in which he was twelve years old and his mother was beating him for not practicing on the trumpet. His lips began quivering and he bit the mouthpiece in defiance of her. These two dreams which the group helped Philip to understand, made visible his dependency needs, his regression, and the coercion associated in his mind with playing the trumpet, as well as helping to clarify the interrelationships among his wife, his mother, and the trumpet.

In spite of these insights, working through his problem was difficult and he could only bring himself to play again very gradually. He brought his trumpet to the group sessions and derived a great deal from being able to play in the group. He had to retrace all of the steps through which he had gone in playing the trumpet, first playing scales, then marches, and finally standard pieces. Were it not for the group interest in his struggle and permitting him to play in the group, his progress would have been very questionable. After about a year he overcame his musical amnesia and was able once again to work as a musician, as he became more aware of music's meaning for him. Philip and his wife established a much healthier relationship generally coterminous with his reestablishing himself as a musician, after his wife joined another therapy group and began to achieve some insight herself.

There is much folk lore about the embouchure, or the lip and mouth muscles involved in playing a wind instrument. It is of interest that part of the folklore of modern jazz is the story of the famous trumpeter who prepares for a performance by engaging in extended cunnilingus. In some magical way he is presumed to be able to play the trumpet better as a result. Philip had not mentioned this story, which was referred to by other musician patients, but symbolically he responded as if he knew the story, and he may have heard it at one time and repressed it. Of all jazz instruments, the trumpet is generally regarded as the most aggressive, and it is certainly the loudest as well as the most physically taxing for the performer.

Discussion

In each of these cases, the introduction of some form of music into the therapy group advanced the progress of the group. In every case the music was introduced when it appeared to be an organic outgrowth of the group situation. There was some discussion by the therapist of the music to be introduced and an indication of what it would be. There was some group resistance to the music in each case, but this was not unexpected. Music is seen by some patients as a kind of mysterious force of which they may be afraid.

The specific kinds of music used varied with the situation and the group's therapeutic progress. There is a differential sensitivity to dimensions of music like rhythm, tonality, theme and dissonance. The more disturbed the patients, the more likely are they to respond to these elements of the music. Jazz music was not found to be productive, because the themes of suffering (the "blues") and sex of most modern jazz represent areas that patients have little difficulty in verbalizing.

The patients in the groups reported on were largely composed of borderline cases, or ambulatory schizophrenics, who were being seen in a private practice situation. It is possible that less disturbed patients in other treatment settings might respond differently. Work is currently under way on the use of music in a variety of other treatment contexts.

Relatively contemporary composers like Mahler and Stravinsky, who use a sophisticated awareness of the psychological components inherent in music, are actually composing music in terms of their expectations of specific audience perceptions. This may lead to more precise employment of music in group psychotherapy as more composers verbalize the themes of their music. The profundity of therapy groups' reaction to music underlines the importance of employing this potentially valuable tool with maximum advance planning and care.

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GROUP PSYCHOTHERAPY AND ROLE PLAYING IN LABOR RELATIONS: A CASE STUDY

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INTRODUCTION

Generated by a kind of "social conscience" industrial management has accorded increasing attention to that area euphemistically referred to as Human Relations; and, it has even seen fit to venture into fields of endeavor which it formerly considered to be foreign to its interests and needs. From its technological and mechanical orientation industrial management's emphasis has been slowly channeled into a bio-social awareness of the importance of the personal equation; that the individual and his work group are permanent and inexorable sources of both pain and pleasure in industrial life. A most interesting aspect, incidentally, about this awakening of management to the need for "humanizing" its organization along predetermined lines (paralleling technologic improvements of its operations), which can be classified as psychengineering, is the abject failure of the social organization to comprehend the nature and complexity of the problems of management. In effect, the formal organization claims the informal organization suffers from a form of "intellectual myopia," i.e., an inability to perceive the long range issues because of a limited frame of reference. On the other hand, the informal organization charges the formal organization engages in sundry acts of mental masturbation.

As a consequence neither management nor employees have found a way to successfully bridge their misunderstandings and develop an empathic response aimed at reducing conflicts and tensions. With the advent of unionism the efforts to understand one another and work in harmony has not been noticeably narrowed; and with each passing year more ways and means for formalizing the avenues of understanding and communication have arisen. And, with each new need or demand a new method, technique or procedure had to be evolved to assist both management and the union in the pursuance of their efforts to more effectively deal with one another; the individual demand has given way to collective bargaining; the informal understanding is now a written contract; the personal gripe becomes a formal grievance, *ad infinitum*.

As a direct result of union-management relations the grievance has assumed overriding importance as a powerful instrument in labor relations. Unfortunately, it has also become a means whereby it has been used both injudiciously and with malice as often as not. With an increase in the volume of grievances, concomitantly management has had to increase its labor relations staff as well as continually train them in the fine art of effectively disposing of grievances.

There are an estimated 100,000 collective bargaining agreements in force today (1). These agreements, with their built-in due process machinery—the grievance procedure and arbitration—protect the personal rights of each worker just as the due process clause and the other articles of the Constitution of the United States protect the personal rights of every citizen. Since a grievance can generally be defined in terms of anything related to the job situation which an employee thinks or feels is wrong—be it either real or imaginary—the grievance machinery is essentially designed to answer problems once they have occurred (6).

Case Background

A large steel company with a long history of labor unrest—work stoppages, work slowdowns, and strikes—found itself facing an increasing number of grievances with each passing year since the war. The past year was an especially turbulent one which eventually culminated in a two week strike because the union claimed over 1000 of their grievances were not satisfactorily disposed of. (Actually, some 600 grievances had been resolved, albeit not to the complete satisfaction of all union officers, with another 400 grievances being in the various steps of the grievance machinery. Nevertheless, 400 grievances is a sizable number to cope with particularly in view of the fact a sister company with the same labor force had less than one-tenth of that number over the same time span.)

Over the previous four years top management had been changed three times in an effort to find an effective team which could make plant operations profitable and straighten out its labor problems simultaneously. Also, during this period the Labor Relations Director and his staff of ten supervisors conscientiously sought to improve their skills by undertaking both formal and informal means of self and group improvement. Apparently, in spite of all efforts, labor-management relations deteriorated steadily and the labor relations supervisors were being "swamped" with grievances. Each labor relations supervisor was assigned to a given mill and he was fully responsible

for handling all grievances which arose in his bailiwick. The work load became unbearable; it stretched from a 5-day work week into six, and from 40 hours to 60 hours per work week.

Operational Procedures and Methods

A meeting with the industrial relations executives led to a decision that a new, radically different approach was needed to assist the labor relations staff out of their dilemma. It was determined we had to work with the attitudes and psychodynamics of each supervisor's *modus operandi* rather than concentrating on the mechanical aspects. Such a course of action necessitated two operational procedures being applied: (1) initially setting up a non-directive, permissive climate of self-examination and self-evaluation, and (2) moving into a more directed, critique-centered direction geared toward re-orienting each supervisor's skills and capabilities. Inherent in these procedures is an application which pertains to education as well as other fields of endeavor: there is a need to build and build upon a solid foundation. If the foundation is solid the superstructure will be secure; if it is weak it cannot adequately support the structure built onto it.

One of the essential tasks therefore is to acquaint the supervisors with the manner in which they think, feel and behave; then, by means of group discussion and evaluation, to develop insights and awareness into what they do and how they do it so they can take corrective or remedial steps to alter (and improve) their own methods in handling grievances. Once this foundation of how they feel, perceive and react to persons, places, and situations is examined and evaluated the next step is to move in the direction of strengthening the mechanics of how to both effectively and efficiently operate in handling grievances.

The central problem to be faced here is one of having a person learn about himself not as he sees his action but as others do. We do not see things as THEY are but as WE are! This usually involves having the person unlearn something and training or retraining him before a difference in behavior comes about. Furthermore, it is felt a more expeditious and beneficial therapeutic effect would be evidenced if one's peers acted as the primary agents in propagating change rather than an outsider.

Two weeks prior to the first meeting the Labor Relations Director informed the ten Labor Relations supervisors that a new series of special meetings was to begin and that each man was to come prepared to fully present and discuss a current grievance or one which he has recently handled and is still in the process of being adjudicated. These meetings were to be

of two hours duration, after regular working hours, and to be preceded by a dinner in the company dining room.

At the initial meeting the author explained the aims and purposes of the forthcoming series of meetings, together with outlining a general description of some of the techniques and procedures to be utilized during the course of the meetings. The group was asked for permission to tape record each meeting so each could be used to review and evaluate the entire meeting after which the tape would be erased. The training group normally consisted of the Labor Relations Director, the ten supervisors, and the two heads of the Industrial Relations Department.

Basically, a less intensive form of group therapy than is conducted in a normal clinical session was called for inasmuch as these supervisors were not disturbed or neurotic. The primary aim of these meetings was to critically examine the skills and capacities these supervisors used in the normal conduct of their affairs, and to suggest remedial and corrective measures which will make the supervisors personally more effective. Such a scope of applications in an industrial environment is almost a rare happenstance as a search of the literature will reveal (2, 3, 4, 5).

After the initial briefing then the author arbitrarily called upon one of the Labor Relations supervisors to stand before the group near a chartpad (which could be used to provide visual assistance in whatever manner the supervisor saw fit), and make his presentation. The room arrangement was such that all participants were seated in a semi-circle with the person making the presentation at the open end of the semi-circle. The time it took to make a complete presentation of the facts behind a grievance together with the supportive evidence, which included records, statements from the principals, work samples, etc., varied with the nature of the grievance, but the mean time was 45 minutes.

After the presentation was concluded each participant was allowed, in turn, to first ask questions and second suggest alternative courses of action, procedures or methods to be employed. (It was agreed by all participants no interruptions would be permitted during a presentation, but a question could be asked which served to clarify or explain an obscure, unusual or involved point.) Questions were asked of the supervisor making the presentation in order to obtain information or raise questions pertaining to: (1) unanswered or unclear problems or statements germane to the handling of the grievance; (2) new interpretations or ways of looking at the grievance and what is involved in it; and (3) tieing up loose ends or flaws which require additional attention and/or consideration.

After each participant had asked his questions the next step centered about suggesting different methods or means for handling this particular grievance. If any differences occurred in this step, role-playing was utilized in an effort to secure a more realistic understanding rather than a mere recital of one's convictions or hunches.

The following phase in the procedure was one of extreme importance because it aimed at crystallizing the entire presentation and discussion into three salient problem areas which were to be answered on the basis of the accumulated fund of information: (1) what are the key issues involved in this grievance and why? (2) what is or should be management's position with respect to these issues and why? and (3) what does the union expect to gain by this grievance, and what implications does it hold for management? In most instances little disagreement was evidenced in conjunction with the first two problem areas, but the third one oftentimes proved difficult to answer. It was at this juncture that one's empathic ability was truly tested by a series of role-playing scenes (7). Those role-playing experiences proved most enlightening and valuable from two standpoints: (1) it revealed the inflexible, obdurate orientation of some of the supervisors, and (2) it opened up some supervisor's eyes to the covert purposes which often underlie the filing of grievances under various sections of the labor contract. (Another interesting finding which was uncovered and which paralleled what actually occurred in grievance hearings was the withholding of facts at the first step by the union.)

Up to this point the entire proceeding has been problem-centered with little attention paid to the personality dynamics of the supervisor making the presentation. Therefore, the next order of business was to view the presentation in terms of the personal make-up of the supervisor, and to relate his actions or inactions against a background of his intellectual, emotional and behavioral traits. Here the entire group discussed and evaluated the presentation as to the soundness of the investigation, validity of the evidence, reliability of the witnesses, the feelings and attitudes of the labor relations supervisor, and the like.

From this sort of a personal evaluation a constructive list of the shortcomings of the supervisor and the way he handled the grievance was made, together with follow-up action to be taken, corrective action to be made in view of one's personality failings, and a follow-up report on the nature of improvement made. Finally, the entire meeting was summarized by the author with special attention being devoted to the assessment of both the

supervisor's strengths and weaknesses relative to the grievance and his own psychodynamics.

Before the next scheduled meeting the tape recording of the previous meeting was played back by the author and reviewed. This proved to be a most helpful procedure because these playbacks often led to the isolation and identification of other personality and mechanical shortcomings in the presentation. The presentation of Supervisor Einer provides an excellent illustration. A careful study of his recorded presentation revealed the following findings which were missed by the group, and which were "news" to the supervisor himself: (1) of the 39 questions which were directed at him, he never allowed any of the supervisors to complete their questions before he began to answer back; (2) he invariably reacted to certain key words with alacrity, e.g., "you didn't find out . . . ," "shouldn't you have . . . ," (3) he referred to the union or union representatives with the adjective "damned," e.g., "that damned steward," or "this damned union"; (4) his manner in dealing with line employees was always deprecatory and sardonic; and (5) in response to asked questions, he often times allowed his answer to be both discursive and desultory, seldom getting at the crux of the matter.

Conclusion

The use of group therapy approach and the utilization of role playing in the attempt to understand the relationship between one's personality dynamics and the manner in which he wrestles with job related problems is finding a gradual acceptance in industry. Inherent in this acceptance is the belief that a problem situation can not be parcelled out from the person(s) involved in it. This rationale was tested in a series of meetings with labor relations supervisors in an attempt to cut through a heavy work load of grievances, and after a half year training program the personal effectiveness of supervisors was increased as measured by the rate of grievance disposition which was nearly doubled over an eight-month period.

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THE CASE FOR THE "OPEN" PSYCHODRAMATIC SESSION A DIALOGUE

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"Hey, what's this I hear about you directing psychodramas that are "open" to the public? I should think that a person who is as much concerned with ethical issues as you are would be dead against such sessions. Don't you realize the great harm that can be done in exposing people before the eyes of others with whom they must live? I'm really surprised at you!"

"Just a minute. You have your facts wrong. First of all, I have not been directing "psychodrama" sessions in public. The dramas that I have been leading were specifically designated as "sociodramas" and during them, great care was taken to keep the focus on larger social issues and away from those which would be of personal concern only to particular individuals. Secondly, the sessions were not presented to the public. They were done on the request of an organized group in the community which felt that it could achieve its own aims by having us conduct a series of sociodramas concerning subjects that were of particular concern to it. However, it is true that we have been seriously considering the possibility of changing from sociodramas to psychodramas and making the sessions available to the general public."

"Well, perhaps it was not your aim up to now to have full-fledged psychodramas, but I have it on the authority of someone who has attended several of your sessions that from time to time you have become involved in the personal lives and problems of individuals in the course of dramatic presentations. Will you deny that this is true?"

"No, I won't deny it, but, as you may know, such involvement is an important part of the experience. The very nature of the sociodrama is to explore general social problems, or at least problems that are of concern to the group within which they are produced, and usually the raw material for such a drama is drawn from the experiences of the people who are participating. It is this use of real experiences that gives the performance its reality and indeed, its effectiveness."

"But how can you condone the exposing of personal material before large groups of people, many of whom do not know or care for the individuals

on the stage? Don't you feel that all of us have the right to respect for our privacy; the right to keep secret our weaknesses and inadequacies?"

"Of course I do, and I would never think of forcing a person to be a participant in a psychodrama or a sociodrama against his will. All of our actors are volunteer subjects. They are willing to participate in the dramas for they feel that there is much more to be gained than lost by so doing. As long as they participate knowing the nature of the technique and of their own free will, I can see nothing unethical about these activities."

"Yes, but do the people who act in your dramas fully comprehend the nature of what they are doing before they become involved? It seems to me that a person cannot understand what the sociodrama involves until he has actually been a participant. How then can a person be aware of what it involves before he has experienced participation in one?"

"You have a good point there. However, it is my opinion that it is a prime responsibility of the director to indicate to potential participants the nature of the activity, to mention that there may be some revelation of personal material and to leave it up to the individual concerned whether or not he desires to take part. Indeed, I believe that it is the responsibility of the director to orient the entire audience to the significance of what may take place and to inform them that anyone who remains once the session has begun may become personally involved in the drama. I do believe it would be wrong for an individual to be invited to participate, indeed, even to attend a session, without first having been given an orientation which would enable him to decide whether or not he wants to become involved in such an experience. It may be true that one cannot comprehend the full impact of the drama except through personal participation, nevertheless, I feel that a competent orientation on the part of the director can accomplish a great deal in preventing people from becoming involved unawares."

"You say that when people chose to participate, they feel that more can be gained than lost from the experience. I wish you would explain just what it is that would prompt people to get involved in what seems to me to be quite a risky activity."

"Well, as I have already said, the psycho- or sociodrama is an activity which enables people to explore areas of personal or group concern which are significant to them. If anything is wrong in our culture it is a belief in secretiveness; that each person must live in his own cave, scrupulously hiding the crises of his life from the vision of his neighbors. The psychodramatic method stands as the facilitator of communication par excellence. It provides participants with a new look at the reality of human relations, a

view which enables them to realize that others have the same kinds of problems as their own; moreover, it enables them to look more clearly at their own lives and to perceive relationships of which they were formerly unaware. The psychodramatic experience enables the subject to break through his fears and other barriers to communication and shows him that the world does not necessarily consist of hostile aggressors but rather of other human beings who share his difficulties and who have unmeasured stores of acceptance, sympathy and respect for his problems."

"Well, I may agree that people are much too secretive and that a lot of the pain of mankind may be directly attributed to people's fears and their inability to communicate with themselves and others, but accepting the real world in which we live, it would seem somewhat dangerous to attempt a public unfolding of human problems by the use of the open-to-the-public psychodrama. People have constructed psychological defenses because of real threats that they may have experienced during their lives. Who are we to tear away such defenses before we are first able to guarantee a world free from threat; something that we are not prepared to do, at least at this time?"

"I don't agree! Many of the so-called threats that you refer to are imagined, not real at all. It is only as people dare to openly view themselves and others that they can overcome the barriers to communication and discover that many of their fears are really unfounded."

"This may all be true on a theoretical level, but practically speaking, I just can't see how it can be done. You expose people before their friends and associates and you will never be forgiven. Circumstances being what they are, you just can't get away with it. The average person is just waiting for some morsel of gossip to be uncovered so that he can toss it around among his friends. People can be irreparably hurt by the indiscriminate exposure of themselves that is inherent in these dramatic methods. Perhaps in a closed group where feelings of confidentiality and intimacy have been established, such unveiling can be tolerable, but in an open session, in the presence of an unscreened, untrained and not necessarily sympathetic audience, such exposure might well be dangerous."

"You certainly have a good point there, one which is hard to refute. Indeed, this is perhaps the fundamental reason why so many people are critical of open sessions. They simply don't wish to risk the possibility of anyone being hurt through his participation.

"Let me try to explore this point in the following manner. First, it should be noted that the sociodrama and indeed, the psychodrama are group techniques. Such dramas are functions of the concerns of the people on the

stage; but even more so, they are functions of the groups which give rise to them. There is no drama at all until a group is formed and a problem is identified within and by the group. The action on the stage develops out of and is relevant to the group itself, and in my experience, there is little that can be carried out on the stage to which the group itself does not give its sanction. Because the drama has emerged from the group, the group shares the responsibility for what happens during the course of the drama. The director serves as a catalyst to bring into action on the stage the content inherent in the problems that are being presented by the group members.

It is obvious, of course, that the director assumes a great deal of responsibility in producing a drama. It is his task to help the drama unfold; but it is also his task, and a demanding one at that, to protect the actors on the stage and indeed, the group itself from getting into situations that are too intense for them to handle. It is a large part of the skill of the competent director to be able to gauge the depth to which the drama has gone and to keep the action at a tolerable level of intensity. It is also his responsibility to keep the group discussions before, during and after the stage performance so focused that they remain at a level which is profitable to the group.

Now, you talk about the 'unscreened, untrained and not necessarily sympathetic audience' before which the exposure of personal material may be dangerous. My answer is that a drama that is properly conducted, one which grows out of the needs and the concerns of the group and one which through competent direction is kept within the bounds set for it by the group, will be a function of the group and of every member of that group. In a sense, the people on the stage become the personal representatives of the people in the audience and are concerned with the working out of problems that are of real concern to both parties, the actors and the persons in the audience. It is only in the case of dramas that are prematurely forced onto the stage, dramas which are not really a function of the group present, that the audience or at least certain members of the audience may take on the role of spectators rather than that of participants; and in looking on as spectators, may become tale-bearers and gossips. The degree to which the drama succeeds in capturing the minds and the hearts of the audience is of course, in large measure a function of the skill, experience and sensitivity of the director. I would have to agree that in the hands of an unskilled director, some unpleasant situations might develop. Another safeguard then, rests in the ability of the director to keep control of the dramatic action and the group discussion and to guide them into productive rather than destructive channels.

It may be true that some audience members may have come to the session motivated by curiosity or even out of malice, but even these individuals, with the guidance of a skilled director, may soon find themselves a part of the group working out personally significant problems. There seems to be something about the technique which affects even the most callous. My guess is that there are few people who can remain untouched by the human material that is revealed in the psychodrama. Those few who might initially be unaffected, might well be those who are in the greatest need of having the experience of participating with others. Indeed, it is one of the strengths of the psychodrama that it reaches out from the stage into the emotions of the members of the audience, arousing feelings of strong identification and sympathy which few other media are able to produce.

Now let me return to a question that was implicit in your first remarks. You ask why a person who is concerned with professional ethics would risk conducting open sessions. I think this matter bears some real consideration. Although we have so far confined ourselves to sociodramas, this question relates similarly to open sessions of psychodrama.

You are, no doubt, concerned with the matter of confidentiality; that is, whether the producing of open sessions may not violate professional ethics in the sense that private material is made public. I admit that I have as yet not been able to fully resolve this rather sensitive issue, however, I would like to forward the hypothesis that directing open sessions is not a violation of one's professional responsibilities. It seems to me that if the director is fully qualified and if various safeguards are observed, little if any harm should come to participants.

I have already indicated that I consider it to be necessary for potential participants to be properly oriented to the method and allowed freedom of choice as to whether or not they desire to take part. In addition, it has been suggested that it is the director's task to keep the session at an appropriate depth, one at which the group is able to handle whatever may be exposed. The danger that you fear would possibly occur when, in spite of these safeguards, an individual, in the course of a drama, reveals material that he either did not want to reveal or that he was not aware would be revealed. In other words, although the individual may have volunteered to take part knowing that something of himself might be exposed, he may find after the drama is over, that material has emerged which puts him in a rather awkward and exposed position. Indeed, the very nature of the drama is such that it may tend to pull the subject deeper into personal material than he had at first intended.

Although this might indeed be an unpleasant position, I feel that a person involved in psychodrama must always risk such revelation. As I have said, the chances are, and of this the participants must be convinced, that there is more to be gained than lost by opening up one's inner world.

Now, as to the person who has something real to conceal, for one reason or another, the only absolute safeguard is for him to refrain from participating in the psychodramatic session. If he does choose to take part, he must be prepared to face the consequences. In this sense, the psychodrama is like any other investigative technique. If one were to voluntarily submit to the public administration of a lie detecting test or certain 'truth' drugs or any other searching type of device, he would have to be prepared to accept whatever might be disclosed. The nature of the psychodrama is the portrayal of truth and the subject must be ready to accept the truth."

"Accepting what you have said, how would you handle the person who chooses to take part in a drama and then, in the course of it, discloses a problem of great personal import and urgency? You certainly are not in a position to provide the necessary therapy in a single session. Isn't it possible that you may start a process of revelation that cannot be left dangling, one that must be immediately followed up by professional efforts if the person is not going to suffer?"

"It is true that in a single open session, there may be no provision for following up problems which may be unfolded on the stage. But the psychodramatic experience may well serve to prompt individuals to actively seek means outside of the group which can help them to resolve their problems. And of course, there is nothing to prevent the trained personnel present at the sessions from attempting to guide such individuals into the proper channels. Indeed, it might be the ethical responsibility of the professional persons to suggest to such subjects their need for professional help. In this way, the open session might serve to start troubled members of the community on their way to the resolution of their difficulties under the guidance of professional help."

"Before we close, I have one other question: I have heard that at some of the hospitals where psychodrama is employed as a therapeutic device, therapeutic sessions have been opened to anyone who might be interested. Don't you think that this is going a little too far?"

"I'm afraid my answer has to be the same as it was regarding public sessions outside of the hospital setting. I believe it is incumbent upon the director to orient potential members of the audience concerning the nature

of the process and of the possibility that they too, by virtue of their presence, may become participants, either as observers or as actors on the stage.

I believe that it is part of the code of psychodrama that those present during a drama should be prepared and willing to participate in the action itself if the course of the drama seems to require it. Indeed, I feel that this is perhaps the only basis upon which people should be admitted to psychodramas, either in the hospital setting or elsewhere. I am very strongly against the practice in some institutions, where people are allowed to observe psychodramatic sessions through a one-way vision screen. Either such persons should be physically present in the room where the others may call upon them to be participants or, at least, to share their reactions during or after the session, or they should be completely excluded. Psychodrama, in my estimation, should not be made into an incidental amusement. It is a tool of psychological analysis in which all in attendance should be prepared to give as well as to receive as equals. No observer, in my estimation, has the ethical right to be present, unless he is at the same time prepared to assume the obligations of participating and sharing his own reactions."

CHANGES IN PERCEPTION AND INTERACTION IN GROUP THERAPY

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Group therapy for nurses was initiated at Brockton VA Hospital in 1955 when the Chief Nurse, from whom several of the staff nurses had been seeking guidance about their personal problems, suggested that they form a therapy group. The group was organized on a voluntary basis with the senior author as group leader. Sessions were scheduled weekly for periods of an hour and a quarter. Twelve nurses joined the first year and met every week from October until the end of May. This procedure continued for the past four years. Membership varied from year to year with some drop-outs and some new members applying each year.

The basic agreement, set forth by the group leader at the beginning of the year, included the usual stipulations about confidentiality of material, regular attendance, and responsibility to participate in the group work. Psychology trainees acted as observer-recorders, but the group members themselves were responsible for providing continuity by reviewing the events of the previous session as each session began. At the end of one hour the regular sessions were concluded. During the next fifteen minutes the therapist polled the group in round-robin fashion asking each member to comment on his impressions of what had been going on during the past hour. This was followed by the group leader's summary of the session.

One objective of these sessions was to create a group atmosphere in which members would feel free enough to discuss their current feelings and reactions. Content involved relationships at work, at home, in social situations, or in the group setting itself. Since the latter provided the one situation in which all members had an opportunity to share an immediate experience, the leader tended to emphasize the importance of the group setting for fruitful discussion. From time to time the leader or one of the members would note a similarity between a situation outside the group which was being discussed and situations which occurred within the group. It was felt that maximum therapeutic value would be obtained from exploring on-going

[1] Acknowledgment is made to Dr. Aaron S. Mason, Director, Professional Services; Miss Alice P. Mooney, Area Chief, Nursing Service; and Mr. Francis Flood, Chief, Nursing Service, whose vision and cooperation made this project possible.

feelings and behavior and from attempting to understand them in the light of previous events in the history of the individual and of the group. It was felt that the group therapeutic process would be helpful in developing more realistic images of self and others by providing the members with opportunities to distinguish more clearly between the demands of reality and their perception of these demands in the light of their individual needs.

During the first three years of this group's history subjective post-evaluations of the progress of the group and its individual members were made by the group leader and the trainee-recorder. However, it was felt that a more definitive investigation into the areas of process and progress should be made. When the social psychology training program was established at this hospital, an opportunity was provided to utilize some of the techniques for analysis of small-group behavior. Two social psychology trainees were assigned to act as observer and recorder. Several hypotheses were formulated and appropriate instrumentation was developed to test these out.

Previous studies (1, 3) have emphasized changes in the perception of self and relief of distress resulting from psychotherapy. We were interested in the effects of this type of psychotherapy upon changes in perception of others as well as of self and in the relationships between perception and interaction.

It was hypothesized that comparisons between data from the beginning sessions and subsequent sessions would show the following changes:

1. Self-ratings will become more positive.
2. Perceptions of self and other group members which are discrepant will correspond more closely: i.e., deviations between self-ratings and ratings of other group members by each subject will become smaller.
3. Positive sociometric choices will be made primarily among the high contributors and negative choices primarily among the low contributors to group progress. (4, 5)
4. Interactions will be directed predominantly toward those members who are most active and who contribute most to the group's progress.

The experimental subjects were ten nurses who volunteered to attend weekly group therapy sessions. Four of these were male and six female. Controls were seven female nurses who worked in one building of the hospital.

After the fourth, fourteenth, twenty-fourth and thirty-fourth sessions, members of both therapy and control groups were given two types of rating forms to be filled out. One of these was a modification of the Semantic

Differential (1) consisting of nine seven-point scales representing the areas of Evaluation, Activity and Potency as follows:

Evaluation: Bad-Good; Worthwhile-Worthless; Pleasant-Unpleasant.
Activity: Passive-Active; Fast-Slow; Cold-Warm.
Potency: Strong-Weak; Soft-Hard; Rugged-Delicate.

Each group member was requested to rate himself, his mother, his father and every other group member on these scales.

The second rating form was a Sociometric Questionnaire containing eight pairs of items. Each member was asked to designate the group members with whom he felt most comfortable and least comfortable; those who seemed to have the most friendly feelings toward him and those who had the least friendly feelings; those who understood him most and those who understood him least; those toward whom he had the most friendly feelings and those toward whom he felt least friendly; those whom he thought he understood most and least; those who most helped him and those who least helped him to express himself; those toward whom he felt the group leader had the most friendly feelings and those toward whom the leader seemed to be least friendly; the members whom the leader seemed to understand best and the ones he seemed to understand least.

All group members were independently rated by the therapist, observer and recorder on a three-point scale according to a subjective estimate of their contribution to the group and their own progress, i.e., High, Medium and Low. The three judges rated the ten members identically with the exception of one member whose estimate varied by only one scale point for one judge. The pseudonyms for the members in the three groups are:

High: Bert, Ted and Alice.
Medium: Ed, Dinah, Bud and Donna.
Low: Dora, Cathy and Lenore.

In education and in professional status the High and Medium groups were homogeneous with the Low group somewhat lower. The members of the three groups were randomly distributed with respect to age. In regularity of attendance the Highs were least frequently absent and the Lows most. Two of the three High members were male; two of the four Medium members were male; the three Low members were female. The therapy and control groups did not differ significantly in age, education or hospital status.

Synopses of the four group sessions under study follow:

4th Session

Present: Highs—Ted and Alice; Medium—Donna; Lows—Dora and Cathy. Donna complained about her relationships with authority and with subordinate figures as well. She was supported by Cathy and was questioned by Ted and Alice who attempted to relate these situations to what was going on in the group. Ted also attempted to relate his current feelings to experiences in his own personal history.

14th Session

Present: Highs—Alice, Bert, Ted; Mediums—Bud, Ed; Lows—Dora, Lenore, Cathy.

First Dora, then Ed attacked Alice, Bert and Ted who were sitting at the upper end of the table near the leader for excluding them from the discussion. The High members banded together and defended themselves, attacking Ed as being imperceptive. Dora blamed herself while Ed accused Alice of being a phony.

24th Session

Present: Highs—Ted, Bert, Alice; Mediums—Dinah, Donna, Bud, Ed; Lows—Lenore.

Dinah reluctantly presented a problem regarding change of job but stated that the group was too analytical, referring the Highs. Ed and Donna partially supported the value of insight while Bert was ambivalent. Alice and Ted combined with Donna to discuss Dinah's problem. Ed finally asked the group to leave off playing with Dinah's feelings.

34th Session

Present: Highs—Ted, Bert, Alice; Medium: Ed, Dinah, Bud and Donna. Lenore, Dora.

Ed let the group know he doesn't trust it. Bert and Ted agreed that trust is an important problem related to authority figures. They raised the question of promotions and ratings—how can you be honest? Alice criticized the leader for stopping an attack on Donna—Bert agreed. Ed introspected, helped by Bert's gentle probing. Bud discussed dependency needs. Ted wished he could be more open with his superior. Bert and Alice engaged in free-associations to the mystification of the others. Alice talked about difficulties in communication and understanding.

RESULTS

I. Semantic Differential Data

1. The ratings of four control group members, all female, were available for comparison between the first and third testings (4th and 24th weeks). Their difference-scores for these testings were compared with those of the four female members of the therapy group which were available for the same testings. The deviations between self-ratings and ratings of others were summed for each subject on both testings. The difference between a subject's total self-other discrepancy score on the first testing and the score on the second testing was interpreted as indicating greater or less perceived distance between self and others over time. A larger total discrepancy score for any subject on the third testing than on the first testing indicated greater perceived distance while a smaller discrepancy score on the third testing than on the first indicated less perceived distance.

The therapy group members showed a greater decrease in self-other discrepancy than did the control group on the Activity ($p < .10$) and Potency ($p < .10$) factors but not on the Evaluation factor.[2]

2. Self-ratings of five therapy group members were available for comparison between the first and fourth testings (4th and 34th weeks). Table 1 shows a significant downgrading of Self in Potency with all other distributions falling short of significant change. However, the trend is evident for less positive ratings of Self (10 out of 15 ratings being lower and one higher), Mother (7 out of 15 lower and 3 higher), and Father (7 out of 12 lower and 4 higher) as compared with ratings of the group leader (7 higher, 6 lower).

TABLE 1

CHANGES IN RATINGS BY THERAPY GROUP MEMBERS FROM FOURTH TO THIRTY-FOURTH WEEKS

	Self (N = 5)			Mother (N = 5)			Father (N = 4)			Group Leader (N = 5)		
	+	0	—	+	0	—	+	0	—	+	0	—
Evaluation	1	2	2	1	2	2	1	1	2	2	1	2
Activity	0	2	3	1	3	1	2	0	2	3	0	2
Potency	0	0	5*	1	0	4	1	0	3	2	1	2

* Significant at .06 level according to binomial test.

[2] Mann-Whitney U-Test.

The general downgrading tendency after thirty-four weeks of group therapy is surprising unless it is interpreted as reflecting greater freedom to be critical of self and of those most intimately related to self (Mother and Father), to be less defensive with less need to idealize. On this basis, it might be hoped that a sounder basis for enhanced self-esteem could be achieved through continued exposure to therapy. The trend toward less distance between Self, Mother and Father may also indicate a beginning of greater acceptance and integration of qualities previously rejected as parental rather than one's own. It is apparent that in this group there was as yet little transference of such perceptions to the group leader as a substitute parent.

The fact that High and Low as well as Medium contributors to group progress made their negative sociometric choices most frequently among the Mediums possibly resulted from a feeling of ambivalence about the Mediums. The other two groups appear to have been more definite in their behavior while the middle group vacillated from one role to the other. This vacillation and uncertainty conceivably could have produced feelings of discomfort in the others as well as in themselves. No such clear-cut pattern was observed with respect to positive choices.

The shift of direction of negative affect statements from negative sociometric choices to positive choices again seems to reflect a growing feeling that positive choices would accept such negative expressions of feeling. This was vividly illustrated in a session in which one member characterized another as a "snot" and a "no-good bum" whose needling had upset him some time prior to the meeting when he had not been feeling too well anyway. The second member responded rather sharply that this needling was probably due to the fact that his accuser had disappointed him in something he had promised to do and neglected. They concluded by agreeing that they could talk to each other in this way only because they knew it was safe in that basically they had positive feelings about each other.

SUMMARY

A therapy group of "normal" subjects interested in help with their personal problems was studied by means of self-ratings, sociometric choices and interaction patterns.

Ratings of self and of other members of their own group by a therapy and control group were compared. Ratings of self and others including Mother and Father by therapy group members after the fourth and thirty-fourth sessions were compared. Changes over time in sociometric choices and in interaction among therapy group members was described.

Results were interpreted as supporting the hypothesis that after a number of weeks in a therapy group, members would tend to feel less distance between themselves and other group members. Therapy group members also felt less distance between themselves and both parents. At the same time the tendency of members to rate themselves and their parents less favorably than they had at the beginning of therapy was thought to indicate a diminution of defensiveness.

While total interactions were directed primarily to the most active contributors to group progress, as predicted, negative affects were directed not to the low contributors but to the mediums. This was discussed in terms of the effects of role vacillation. No clear-cut pattern of direction of positively toned acts was observed.

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EVALUATION OF GROUP PSYCHOTHERAPY BY FOLLOW-UP STUDY OF FORMERLY HOSPITALIZED PATIENTS*

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During the last four decades, but especially in the most recent one, psychologists, psychiatrists, sociologists, and social workers have evidenced mutual interest in developing a standardized method of measuring the effectiveness of their therapeutic efforts. This fact is attested to by the numerous studies reported in the literature in which representatives of two or more of these professions participated in the development and execution of the research plan. The present study follows the precedent of the interdisciplinary trend by adding a follow-up evaluation by a social worker to the attempts by a psychologist and psychiatrist to measure the effectiveness of group psychotherapy with hospitalized patients.

The group psychotherapy study utilizing a "goal direction" (4) approach with F. F. Vernallis, psychologist, as therapist and R. E. Reinert, psychiatrist, as co-investigator, ran for 18 months, terminating August 22, 1959. A series of 30 treatment patients were individually matched on one variable (personality organization) and found to be similar on seven other variables (age, education, months of hospitalization both prior to and during the psychotherapy study, occupation, marital status, diagnosis, and race) with 30 control cases. The two groups received the same standard hospital treatment program except for the addition of group psychotherapy for the treatment cases. During the group psychotherapy study, 19 treatment and 16 control subjects were released from the hospital. However, seven subjects from each group had to return to the hospital for continuation of treatment. Of the 14 subjects who returned to the hospital, two treatment and one control subject had re-entered the community by the termination date of the psychotherapy study. Thus, there were 14 treatment and 10 control subjects living in the community by the termination date of the group psychotherapy study. In their report, Vernallis and Reinert used release from the hospital and length of time in the community as their principal criteria of improvement. They found that the treatment group had 61 more months in the community than the control group. The

* This study is an individual research project under the auspices of the VA Psychiatric Evaluation Project, Richard L. Jenkins, Director.

Wilcoxen Matched Pairs Signed Ranks Method (3) showed that the treatment cases had significantly more time in the community than the controls, .043 level by one-tailed test.

Although discharge and length of absence from a hospital are frequently used in reporting treatment effectiveness, clinicians and researchers alike are aware of the shortcomings of these criteria as a conclusive measure. For example, Freeman and Simmons (2) have reported that the higher expectation of a wife or tolerance of behavioral deviance by parents may have a decided influence on whether a former patient returns to a hospital or remains in the community, regardless of his psycho-social performance level. Clausen (1) noted that discharged psychiatric patients ranged from those who functioned "normally" to many who were as emotionally disorganized as hospitalized patients. As these views indicate, discharge and time out of the hospital are not sufficient criteria in themselves for evaluating therapeutic effectiveness.

Purpose

The general purpose of the present follow-up study was to further evaluate the treatment effectiveness of the Vernallis-Reinert group psychotherapy study by an assessment of the subjects' level of social adjustment in their community environment.

The specific purposes were: (1) to determine whether the control subjects' social adjustment had a more disruptive effect on their environment than did that of the treatment subjects; (2) to illustrate one approach to the problem of measuring effectiveness of a therapeutic technique.

Sample

Description of subjects. The 24 subjects[1] included in this follow-up study were male veterans ranging in age from 22 to 61 years, who had been hospitalized either for treatment of functional psychosis or severe neurosis. Fourteen of the subjects had been treatment and 10 had been control subjects in the Vernallis-Reinert Study. Each of these subjects had been released prior to and were not receiving any form of psychiatric treatment from the hospital on August 22, 1959, the termination date of the group psychotherapy study. All subjects had been in the community at least 90 days prior to commencement of the follow-up study.

[1] In the Vernallis-Reinert study, 25 subjects were reported to have been released from the hospital. One subject was directly transferred to a prison and did not spend any time in the community. Therefore, he did not meet the criteria for the present study.

Description of informants. Informants, for this study, were relatives such as a wife, parent, sibling, or a close associate who had frequent contact with the subject.

METHOD

Follow-up procedure. In preparation for the follow-up interviews with the subject and his informant, a brief questionnaire was mailed to each subject. The intent of the questionnaire was to obtain factual knowledge about the subject's social functioning and to verify his location. All 24 subjects replied to the questionnaires. Their replies also provided names of informants to be contacted in addition to the subject. With this information, a travel schedule was prepared by the project secretary, with consideration of geographic location. Interview dates were preassigned for each subject, equally distributing insofar as possible the treatment and control subjects throughout the three month follow-up period.

The rationale of preassigning interview dates was to avoid possible contamination; e.g., interviewing one group during an unfavorable employment season. Furthermore, a preassigned interview date provided a cutoff point for the interviews. Flexibility of at least one week was allowed for unavoidable changes. Any subject who was hospitalized for psychiatric treatment on his preassigned interview date was arbitrarily included in the poor adjustment group.

The collection of data commenced November 1, 1959, and ended February 1, 1960. During this period, 13 treatment and 10 control subjects and their informants were interviewed privately, in their homes. One treatment subject could not be located due to the migratory nature of his employment. In this case, only factual information was obtained from a relative and will be reported accordingly in the results.

Fifteen of the subjects resided within a 200 mile radius of Topeka VA Hospital[2] and were interviewed by the writer. VA Regional Office social workers located nearest the residences of the remaining nine subjects were requested to interview these subjects. Standardized instructions and the appropriate interviewing schedules, which will be described later, were sent to each VA Regional Office social worker.

Interviews were semi-structured and designed to obtain both longitudinal and cross-sectional information pertaining to the subject's social adjustment. The interviewer was required to evaluate the reliability of the

[2] Travel area covered by the social worker of the Topeka VA contingent of the Psychiatric Evaluation Project.

information obtained from the subject and the informants. If the data were considered to be of poor reliability by the interviewer, he was instructed to contact other informants to clarify discrepancies. The writer and the nine other social workers who conducted the follow-up interviews all followed the same interview procedure. None knew whether the subject was a control or treatment subject of the group psychotherapy study at the time of the follow-up interview. No direct attempt to elicit this knowledge was made by the interviewers. Each interviewer recorded a narrative description and an objective, factual report of the subject's social adjustment.

Social Adjustment Scale. When all interviews were completed, the writer rated each subject without knowledge of his identity as a treatment or control subject on a four point scale known as Report of Social Adjustment (ROSA).[3] This scale was constructed to describe the social adjustment of a subject in the form of a profile of the separate scores for each of the following major areas: occupational, school, family, interpersonal, and community. The information from which these ratings were made was obtained from 56 factually-oriented items and narrative descriptions of each of the five areas of social functioning. However, since none of the subjects in the follow-up study were attending school, this area will be eliminated in further discussion of social adjustment.

The ROSA was used as a semi-structured interviewing guide to obtain both cross-sectional and longitudinal data about the subjects' social functioning. Since the ROSA was designed for a larger research project, all of its items were not reported in the present study. Some longitudinal data will be reported. However, the ratings on the four point scale were based on a cross-sectional view of the subjects' adjustment. In order to make a cross-sectional appraisal that would be representative of the subject's adjustment, it was necessary to collect information about his behavior over a fixed period of time preceding the follow-up interview. For this purpose, an arbitrary time period of 30 days preceding the follow-up date was used.

Social adjustment, as defined for instrumental use of the ROSA, is evaluated in terms of the degree to which the subject is meeting social requirements in his various roles. Individuals differ in accordance to the expected role performance; the differences are a product of their group affiliations and the positions assigned to them by members of that group.

[3] Developed by Mr. Seymour Slovik, Research Social Worker, Montrose VA Hospital. The scale is used by the Psychiatric Evaluation Project for evaluation of social adjustment of veterans formerly hospitalized in one of the 12 participating VA hospitals.

"Social requirements" refer to the performance and attitudes that are normally expected from a person with certain rights and obligations, irrespective of the person's status as an expatient.

The final result of the ROSA is a profile of the subject's adjustment in each of the four areas mentioned above: occupational, family, interpersonal and community. The basis for a four point classification of functioning in each of these areas is derived from the following criteria:

1. Good: Meeting standards of expected behavior. Activities reflect appropriate concern with his own material and economical enhancement as well as with community requirements.
2. Fair: Meeting minimal expectations. Emotional investment while sufficient to maintain membership in group is weak. Major energies directed toward holding the line and/or simulating a productive orientation. Little energy available for self-fulfillment and status improvement.
3. Marginal: Functioning is borderline. Behavior includes elements that satisfy community standards. Evidence of dysfunction, however, suggests that status is clearly tied to amount of stress encountered in day to day activities.
4. Poor: Behavior is clearly discrepant with prevailing community standards. Requires a degree of help or control not normally accorded to persons with equivalent social-economic cultural background.

Results

Data were obtained on all 14 treatment subjects regarding employment. Six subjects were employed 35 or more hours a week. Of these six, five were earning enough money to support themselves without aid from governmental sources or relatives. The other was self-employed but not earning enough money to support himself independently. One treatment subject was employed part-time (18 hours a week). Seven were unemployed. Of these seven, three had been gainfully employed for a brief period, not exceeding 30 days, since their release from the hospital, but were not employed at the time of the interview. All but one who were employed either full or part-time indicated that their employment was satisfying to them.

Of the ten control subjects, six were employed 35 or more hours a week. Of these six, four were earning enough money to support themselves without aid from governmental sources or relatives. Two were self-employed, but not earning money to support themselves independently. Four were unem-

ployed. All employed subjects indicated that their employment was satisfying to them.

Table 1 presents a tabular description of the distribution of the treatment and control subjects according to marital status and residence at the time of the follow-up interview.

TABLE 1
RESIDENCE AND MARITAL STATUS ON RELEASE FROM HOSPITAL

	Residence													
	Parents		Wife		Sib-lings		Friend		Alone		Insti-tution		Total	
Marital Status	T	C	T	C	T	C	T	C	T	C	T	C	T	C
Never Married	5				1	1		1				1	6	3
Married			1	4									1	4
Divorced					1		1	1	2				4	1
Separated	1								1	1	1		3	1
Widowed												1	0	1
Total	6		1	4	2	1	1	2	3	1	1	2	14	10

As revealed by Table 1, six of the treatment subjects were living with their parents while none of the control subjects were. Only one treatment subject was living with his wife in contrast to the four control subjects. It is of interest to note that of the seven treatment subjects who were divorced or separated, only two lived with relatives, either parents or siblings. On the other hand, among the control subjects, except for the four who were married, only one subject lived with a relative. Due to the small sample, no meaningful pattern could be detected in regard to any possible influence the relationship with the persons with whom the subject was residing might have, on his level of social functioning.

Informants of ten of the treatment subjects reported that they were satisfied with the subject's relationship to them. The informants of the remaining four subjects reported their relationship as less than satisfying.

Informants of five of the control subjects reported that they were satisfied with the subject's relationship to them, and informants of the remaining five reported their relationship as less than satisfying.

Recreational activity was defined as leaving the home to participate in: solitary medias, such as movies, spectator sports; social activities, such as card games, dominoes, visiting friends; active sports, such as hunting, fishing. These data were categorized in the following three classifications:

frequently, at least once weekly; occasionally, at least once monthly; rarely or never, less than once a month.

Information was obtained on only 13 treatment subjects in regard to frequency of recreational activities. Three participated in recreational activities frequently, four occasionally, and six, rarely or never.

Of the 10 control subjects, four participated in recreational activities frequently, one occasionally, and five, rarely or never.

Two items, excessive drinking and difficulty with the police, seemed to reflect the amount of stress imposed by the subject upon his immediate family as well as the community. Excessive drinking was evaluated in terms of the accepted norms of the family and community. Difficulty with the police was defined as any attention of the police toward the subject's behavior except minor violations such as over-parking, unless their repetition became a problem.

Of the treatment cases, one subject was reported as drinking excessively and one was reported to the police for fighting with a neighbor, but was not arrested.

Of the control subjects, three were reported as drinking excessively. Three had had difficulty with the police, ranging from window peeping to intoxication and street brawling. Two of these three were arrested and served terms of one and four months in a county jail.

Table 2 describes the subjects' level of social adjustment. Criteria for these ratings were defined in the description of the ROSA.

TABLE 2

COMPARISON OF SOCIAL ADJUSTMENT BETWEEN 13 TREATMENT* AND 10 CONTROL SUBJECTS

	Occupational		Family		Interpersonal		Community	
	T	C	T	C	T	C	T	C
Good	2	3	5	3	2	4	2	3
Fair	4	0	4	2	5	1	5	1
Marginal	0	3	1	1	3	3	3	3
Poor	7	4	3	4	3	2	3	3

* Because only factual data were obtained on one treatment subject, his over-all social adjustment was not rated.

As Table 2 indicates, the social functioning of the treatment subjects as a group was not found to be better at a statistically significant level than that of the control subjects. However, by inspection, it is evident that proportionately more of the treatment group were operating on either a "good" or "fair" level than the control group.

Discussion

This present study was carried out for the general purpose of providing a further measurement of treatment effectiveness of a group psychotherapy study by a posthospital evaluation of the subjects' level of social adjustment. One of the specific aims of the present study was to see whether the control subjects' social adjustment had a more disruptive effect on their environment than did that of the treatment subjects. Also, this study was an effort to demonstrate one plan of follow-up evaluation of social adjustment as an additional dimension in measuring effectiveness of a therapeutic technique. The results of this study failed to provide a statistically significant indication that the treatment subjects, as a group, functioned at a higher social adjustment level than the control subjects. However, by inspection, it is apparent that more of the control subjects than treatment subjects evidenced disruptive behavior such as excessive drinking and difficulty with the police. It is important to note, also, that the treatment subjects as indicated in Table 2 were functioning on a higher level, by inspection. This point is of importance since in the Vernallis-Reinert study it was reported that the treatment group had significantly more time in the community than the control subjects. Therefore, it seems apparent that this advantage was not gained merely by administrative manipulation by the therapist to push his treatment subjects into the community, irrespective of their readiness to make the necessary adjustment.

In regard to the second purpose of this study, many methodological weaknesses are apparent. However, a careful survey of the literature reveals that very few follow-up studies employing an objective methodological scheme have been reported. It stands to reason that such reports whether yielding conclusive results or not should be reported because of the guide lines such reports can provide for clinicians and researchers who are seeking a solution to the complex problem of measuring treatment effectiveness objectively.

Summary

Twenty-four formerly hospitalized patients, 14 treatment and 10 control subjects, of a group psychotherapy study who had been released from the hospital by that study's termination date were followed into the community for evaluation of the level of their social functioning.

A comparison of their social adjustment as seen by profiles of their functioning in four areas (occupational, family, interpersonal, and community) indicated a slight inspectional difference between the two groups.

Among the treatment subjects, there was evidence of proportionately less excessive drinking, difficulty with the police and proportionately more of the treatment subjects functioning on either a "good" or "fair" level.

Despite the limitations of the present study (e.g., the relatively small number of cases) the nature of the findings that, by inspection, slightly more of the treatment group were doing better than the control group gives evidence that can be embellished by replication or further investigation along similar lines of methodology.

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3. SIEGEL, SIDNEY. Nonparametric Statistics for the Behavioral Sciences (New York: McGraw Hill Book Co., 1956), pp. 75-83.
4. VERNALLIS, FRANCIS F. & REINERT, R. E. "An Evaluation of a Goal-Directed Group Psychotherapy with Hospitalized Patients." Submitted for publication.

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.

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—"transperceptions.") 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

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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.

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.

J. L. Moreno, M. D.,
Beacon, N. Y.

ACADEMY OF PSYCHODRAMA AND GROUP PSYCHOTHERAPY

Certification

The Academy of Psychodrama and Group Psychotherapy (APGP) located in Beacon, N.Y. is the central Institute, being the oldest in existence, upon which all other Institutes as they develop in the course of the years will depend for guidance. It was founded in 1937 and was the main source of inspiration in the teaching and training of sociometry, group psychotherapy, group dynamics, psychodrama and role playing.

The Academy issues Certificates of Attendance, Training, Associates, Directors and Diplomates.

Certification of Directors

Director's Certificates have been granted to date to the following:

Robert Boguslaw, Ph.D (Los Angeles, 1950)
Eya F. Branham (Santa Monica, 1948)
Anna Brind, Ph.D. (Los Angeles, 1951)
Anthony Brunse, M.D. (Los Angeles, 1949)
Gertrude Harrow-Clemens, Ph.D. (Los Angeles, 1945)
Robert S. Drews, M.D. (Detroit, 1952)
Arnold Dreyer, Jr., M.A. (St. Louis, 1955)
James Enneis, M.A. (Washington, D.C., 1947)
Ernest Fantel, M.D. (Los Angeles, 1938)
Leon Fine, M.A. (St. Louis, 1958)
Robert B. Haas, Ph.D. (Los Angeles, 1945)
Margaret Hagan, M.S.W. (Washington, D.C., 1939)
Martin R. Haskell, Ph.D. (New York City, 1952)
Helen H. Jennings, Ph.D. (New York, 1930)
Rosemary Lippitt, Ph.D. (Ann Arbor, 1943)
Zerka Toeman Moreno (Beacon, 1941)
Neville Murray, M.D. (San Antonio, 1960)
Abel G. Ossorio, Ph.D (St. Louis, 1959)
Marguerite M. Parrish, M.S.W. (Pontiac, 1950)
Frisso Potts, M.D. (Havana, 1960)
Frances Herriott-Sargent (Washington, D.C., 1940)
Anne Ancelin-Schützenberger, M.A. (Paris, 1950)
Adaline Starr (Chicago, 1947)
Hannah B. Weiner, M.A. (New York City, 1952)
Lewis Yablonsky, Ph.D. (Amherst, 1950)

Certification of Diplomates

Diplomates are certified upon the joint approval of the Academy of Psychodrama and Group Psychotherapy and the American Society of Group Psychotherapy and Psychodrama.

Certification of Corresponding Members

The Board of the Academy has designated the following as Corresponding Members:

Didier Anzieu, Ph.D. (France)
Jose A. Bustamante, M.D. (Cuba)
Juliette Favez-Boutonier, M.D. (France)
A. Friedemann, M.D. (Switzerland)
Henrik Infield, Ph.D. (Israel)
Nurettin Kösemihal, Ph.D. (Turkey)
H. A. Kreitler, Ph.D. (Israel)
Serge Lebovici, M.D. (France)
J. L. Marti-Tusquets, M.D. (Spain)
Gosaku Naruse, Ph.D. (Japan)
Andreas Petö, M. D. (Hungary)
A. Potamianou, Ph.D. (Greece)
Frisso Potts, M.D. (Cuba)
Pandharinath Prabhu, Ph.D. (India)
Raoul Schindler, M.D. (Austria)
Ragnar Schulze, Ph.D. (Sweden)
Anne Ancelin-Schützenberger, M.A. (France)
H. R. Teirich, M.D. (Germany)

Teaching and Training Centers

The Academy of Psychodrama and Group Psychotherapy (of the Moreno Institute) *recognizes* the following three organizations as training and teaching centers: Psychodramatic Institute (1937), Beacon, N.Y.; Psychodrama Department, St. Elizabeth's Hospital (1940), Washington, D.C.; and the New York Psychodrama Institute (1942), 236 West 78 Street (corner Broadway), formerly at 101 Park Avenue.

In addition there are *affiliated* Institutes in Paris, France; Detroit, Michigan; St. Louis, Missouri; Los Angeles, California; San Antonio, Texas; and others which may achieve full recognition in the course of time.

Training Institutes are certified upon the joint approval of the Academy of Psychodrama and Group Psychotherapy and the American Society of Group Psychotherapy and Psychodrama.

The Committee of Minimum Standards of the Academy of Psychodrama and Group Psychotherapy (Chairman, Zerka T. Moreno) and the Committee for Accreditation and Training of the American Society of Group Psychotherapy and Psychodrama (Chairman, James Enneis) have each formulated minimum professional standards for sociometrists, group psychotherapists and psychodramatists. The recommendations will be published in the next issue of the journal.

Future Programs of the Academy, Beacon, N.Y.

During the August 1960 Academy a conference on future programs was held on August 17th and 18th. Participants were: Dr. J. L. Moreno, Zerka T. Moreno, Wallis and Adrienne Wohlking, Barbara Seabourne, Anne Schützenberger, Dr. Abel Ossorio, Dr. Ida Gelber, Nancy J. Mehl, Hannah B. Weiner and Dr. and Mrs. Frisso J. Potts. The conference led to the following recommendations: 1. Preparing a four-page announcement of the program of the Academy to be sent to all prospective participants; 2. three academic lectures to be delivered by J. L. Moreno or anyone whom he names

as substitute. The first academic lecture to be on sociometry; the second on group dynamics and group psychotherapy and the third on psychodrama and role playing.

The lecture on sociometry will be delivered soon after the sociogram of the group has been made. The lecture on group dynamics and group psychotherapy will be delivered after a session on group dynamics and group psychotherapy has taken place. The lecture on psychodrama and role playing will take place soon after the psychodramatic session has been given.

The first three session demonstrations should be, if in any way possible, conducted by J. L. Moreno personally. The three academic lectures should be registered on a tape recorder and be placed after the sessions in the library room so as to provide the students the opportunity to hear them by playback.

A bulletin on sociometric group and psychodramatic techniques should be prepared and distributed among the participants before or during the Academy. It should contain an essential bibliography of the field.

Every third day of the Academy a question and answer period of at least one hour should be reserved. A library room should be available on the premises for reading of the essential texts and journals in the field.

The board of directors (consisting of ten persons) decide on full or part certification of the delegates. The Academy issues four types of certificates: attendance, training, associate and director.

It is understood that every participant who applies for an Academy certificate should submit himself a) to a session as a protagonist; b) a session as a director; c) an oral examination answering three fundamental questions dealing with the field—one on sociometry, one on group dynamics and group psychotherapy and one on psychodrama. The questions are to be answered before the group. A preliminary evaluation of the performance is made by the group. It will be used supplementing the final decision on the certification.

The results of certification are published in the two journals, Group Psychotherapy and the International Journal of Sociometry and Sociatry.

A Committee on Programs of the Academy was formed consisting of Abel G. Ossorio, Wallis Wohlking and Hannah B. Weiner.

Training Certificates

The following have received Training Certificates: Drs. Max Ackerman, Sylvia Ackerman, Betty Murray, Teresa Potts, Reika Fine, Hillel Bardin, Francois Baxais, John Hoffman, Glenn E. Kane, Mary Angas, Laurie Mae

Carter, Margaret May, Rolf Krojanker, Joseph Meiers, Wallace Wohlking, Jim Thomas, Barbara Seabourne, Jim Sacks, Alexander Van West, Jim Randolph, Joseph Mann, Clarissa Jacobson, Edna Rainey, Ida Gelber, Samuel Greenberg, Rose Garlock, Adrienne Wohlking, Jack Ward, Simon Marcus Blajan, Gretel Leutz, Dorothy Miazza and Walter Klavun.

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

New Members and Applications for Membership

Dr. Samuel B. Broder
Nettie Drexel
Dr. Jan Ehrenwald
Jean Jacques Fombeur
Dr. Walter J. Garre
John R. Jehle, Sr.
Sister M. Julia
Dr. Jack J. Leedy
Dr. Sol Levine
Dr. Neville Murray
Jack H. Oster
Mrs. Betty Murray
Dr. Fernando J. Cabrera
Rose Garlock
Dr. Charles Sutch
Mrs. Sam W. Pearl
Dr. Matthew D. Parrish
Dr. John J. Pearse
Dr. Erving Polster
Teresa Potts
J. Randolph
Dr. James M. Sacks
Jay Sanford
Dr. Leonard K. Supple
James B. Thomas
Dr. Alexander Van West
Natalie Van West
Shirley Mae Burghard
John E. McManus
Dr. Joseph Gagliardo
Jaime Blasquez
Randolph Cautley

New Fellows

Martha Steinmetz, M.S.W.
Martin Haskell, Ph.D
Cecilia Wells, M.A.

Membership Campaign

Members of the various chapters are now being contacted and offered membership in the national Society. There are numerous members of the various local chapters who are not yet members of the national Society. Write to Zerka T. Moreno, P.O. Box 311, Beacon, N.Y.

Annual Meeting

The twentieth annual meeting of the American Society of Group Psychotherapy and Psychodrama will be held at the Barbizon Plaza Hotel in New York City on March 24th, 25th and 26th, 1961. Papers should be sent to Zerka T. Moreno, P.O. Box 311, Beacon, N.Y.

ANNOUNCEMENTS

New Headquarters of the Moreno Institute, New York City

The Moreno Institute purchased a building in New York City at 236 West 78 Street near Broadway corner. The building will be open to the public on November 20th. It is easily accessible, being one block from 79th Street West Side Subway; two blocks from Riverside Drive and near the Crosstown Busses on 79th Street connecting the West Side with the East Side of Manhattan.

There will be a daily program of activities—mornings, afternoons and evenings. A special pamphlet describing the daily schedule is now in preparation. This pamphlet is available at the Moreno Institute, 259 Wolcott Avenue, Beacon, N.Y. Lecture-demonstrations open to the public will be conducted as usual, on Friday evenings, from 8:30-10:30. Special sessions dealing with particular problems may be arranged on any evening for interested groups. In addition, an enlarged program of daily activities will be offered: a psychological clinic, group and individual consultations and treatment, psychodrama and role playing, group psychotherapy and group dynamics, family therapy, and training courses in industry and affiliated subjects.

A staff of psychiatrists, psychologists, sociologists and educators will be available for research, therapy and training. The new headquarters will contain a theatre of psychodrama. It will also contain a reading room and a bookshop.

New Centers of Psychodrama and Group Psychotherapy

Psychological Laboratory, Harvard University, Cambridge, Mass.

University Hospital of Havana, Cuba; Director—Dr. Jose A. Bustamante.

The Murray Clinic, San Antonio, Texas; Director—Dr. Neville Murray.

Ypsilanti State Hospital, Ypsilanti, Michigan.

State Hospital, Logansport, Indiana; Director—Adaline Starr.

Seminar on Group Psychotherapy in Oslo, Norway

Upon the invitation of the Norwegian Association for Medical Child Psychology Dr. George R. Bach of Beverly Hills, California, presented a three day Seminar in Oslo, Norway on August 20, 21 and 22, 1960.

Music Therapy

An International Symposium "Die Music in der Medizin" by Dr. H. Teirich (Freiburg i. Br., Germany) in Die Heilkunst, München, May 1960.

Erratum

The author of "Group Action in the Rehabilitation of the Mentally Retarded" in Group Psychotherapy, Volume XIII No. 1, James McDaniel, holds an M.S. Degree and not a Ph.D., as was erroneously published.

Progress in Psychotherapy, Vol. VI, 1961, Edited by J. L. Moreno, M.D.

The internationally known series PROGRESS IN PSYCHOTHERAPY has been taken over by Beacon House beginning with Volume VI. The first five volumes have been published annually by Grune & Stratton from 1956-1960. Each volume was dedicated to a special theme, Vol. I to "The Third Psychiatric Revolution"; Vol. II to "Anxiety and Therapy"; Vol. III to "Techniques of Psychotherapy"; Vol. IV to "Social Psychotherapy"; Vol. V to "Review and Integrations."

Volume VI is now in preparation; title and theme to be announced. Publication date is *May 1961. For further information, write:* J. L. Moreno, M.D., Editor, P.O. Box 311, Beacon, N.Y.