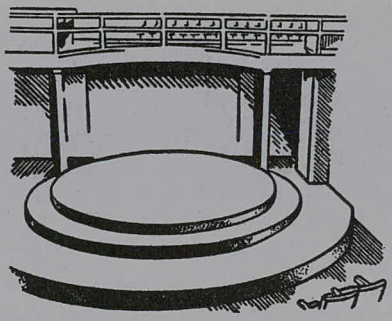
GROUP PSYCHOTHERAPY

A Quarterly



AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY
AND PSYCHODRAMA

Vol. XIV, Nos. 1-2, March-June, 1961

GROUP PSYCHOTHERAPY

Volume XIV March-June, 1961 Numbers 1-2

CONTENTS

FOUNDED BY J. L. MORENO, 1947

GROUP PSYCHOTHERAPY

Volume XIV March-June, 1961 Numbers 1-2

Beacon House, Inc.
Beacon, N.Y.

GROUP PSYCHOTHERAPY

Volume XIV | March-June, 1961 | Numbers 1-2

INTERNATIONAL SECTION

CONTRIBUTING EDITORS

Official Organ of the American Society of Group Psychotherapy and Psychodrama

Published by Beacon House Inc., 259 Wolcott Avenue, Beacon, N.Y.

Subscription $10.00 Yearly — Foreign Postage $1.00 Additional

Current Single Issues $3.00 — Double Current Issues $6.00

Single Back Copies $3.50 — Double Back Issues $7.00

Any issue is current until the following issue is off the press. Thereafter it becomes a back issue.

Membership dues in the American Society of Group Psychotherapy and Psychodrama: $9.00, including subscription to this journal.

NOTE TO AUTHORS:

Articles submitted are carefully considered by all members of the Editorial Committee. Editorial changes suggested by them are referred to the author for approval before being sent to press or, in the case of minor punctuation change for clarity, when galleys are sent to the author for correction.

No free reprints can be furnished. Use of cuts or drawings requiring special processing are at the expense of the author.

Prices for reprints of articles appearing in GROUP PSYCHOTHERAPY are based on printer's quotation, subject to change according to current costs. Authors are advised of printer's prices at time of paging.

Manuscripts and communications for the editors should be addressed to the Editorial Committee of GROUP PSYCHOTHERAPY, Beacon, N. Y., and *not to an individual.* Unsolicited manuscripts which are not accepted for publication will be returned if accompanied by a stamped, self addressed envelope. Manuscripts must be neatly typewritten and submitted in *duplicate.*

It is hereby understood that all articles are accepted for exclusive publication in this journal. Articles printed in GROUP PSYCHOTHERAPY become the property of Beacon House Inc.

For information concerning membership in the American Society of Group Psychotherapy and Psychodrama write to: Mary M. Angas, Linden Gate, Old Beach Rd., Apt. 2, Newport, R.I.

Second class privileges authorized at Beacon, N.Y., April 2, 1958.

AN EVALUATION OF A GOAL-DIRECTED GROUP PSYCHOTHERAPY WITH HOSPITALIZED PATIENTS[1]

FRANCIS F. VERNALLIS AND RAYMOND E. REINERT

VA Hospital, Topeka, Kansas

If a roster was made of all the writers on psychotherapy who recommend research concerning the effectiveness of psychotherapy, it would be a long and distinguished list. But the actual list of studies which have employed control groups is short. Knotty design problems such as patient selection or the measurement of behavioral change have forestalled investigation. We encountered a number of difficulties but we believe the fundamental aim—attempted evaluation of treatment—was maintained. Description of the treatment was the second aim of this study.

The goal-directed treatment approach is not a new treatment method but more an emphasis of an aspect of treatment. The therapist carefully and repeatedly defines for the patient what is to be done in the hospital and what the outcome of treatment is to be. As in most treatment methods, he also reflects and interprets the thoughts and feelings of the patient but in addition he defines procedures and goals. The general rationale of this approach is well stated by Hollingshead and Redlich. To quote them briefly, "When the role expectation on either side is uncertain, *goals are not clearly stated,* and the relationship is distant, both the therapist and the patient feel lost" (Italics ours) (1958, p. 346). Karl Menninger, too, wrote in his most recent book, "Surely the continued development of our knowledge will help us find quicker and less expensive ways of relieving symptoms and *rerouting misdirected travelers*" (Italics ours) (1958, p. xi). A goal-directed psychotherapy, (therefore), is hardly new, but a consistent, systematic emphasis of aims may be.

METHOD

General statement. A series of 30 treatment patients were individually matched with control cases. The two groups received the same standard hospital treatment program except for the addition of a goal-directed group psychotherapy for the experimental cases. Standard hospital care does not mean custodial care since this hospital has one of the highest staff-patient ratios together with the largest psychiatric residency program in the VA

[1] This study was an Individual Hospital Project of the Veterans Administration Psychiatric Evaluation Project which is directed by Dr. Richard L. Jenkins.

hospital system. Psychological tests were first used as the main outcome measure, but the tests were reluctantly given us. A corollary measure, time in the community, was substituted as the main measure of treatment effectiveness.

Selection of the patient sample. The patients were originally drawn from the three semi-open wards of what was known at Winter VA Hospital as the Acute and Intensive Treatment Section, Closed. The designation of the section as acute was partly inaccurate in that all the patients had had previous psychotic episodes. However, since they had recently required closed ward care and most had retained a clinically recognizable degree of reality testing and drive, transfer to a Continued Treatment Section was contraindicated. A patient was transferred to the Continued Treatment Section only after long term observation and careful assessment of his potentialities. The general accuracy of this judgment was demonstrated later. During the course of the study, the hospital moved to a group of modern, new buildings and it was reorganized into units and wards combining all types of patients. Some of the former Continued Treatment Section patients entered the sample through a change in the selection procedures which will be described later. They were too regressed, visibly so, to be integrated into the psychotherapy groups. Those matched pairs which involved the former Continued Treatment Section patients were droppd as a block, i.e., both members of the pair were dropped impartially to preserve the general homogeneity of the sample. Since the psychotherapy groups were open, only those patients who formerly were on the Acute Section or who were newly admitted to hospital and psychotic were added to the study sample. Moderately chronic psychotics probably would be a more accurate verbal description of the study patients. The majority of the patients were matched on only one measure, but Table 1 discloses their strong resemblance to each other as groups on seven descriptive, or background, variables. None of the factors differed statistically at a significant level.

Matching. In the original design, the Leary (1957) Interpersonal Check List (ICL), applied as a sociometric, was the basic matching measure. The ICL was completed independently by the patient's psychiatric resident and one other staff member, usually his ward nurse, for all who resided on the three semi-open wards of the Closed Acute Section, that is, all the patients on the wards were rated in a blanket manner. The ICL dominance and love scores for each patient were averaged and these new scores were used to plot his octant location. Th patients who had identical octants were paired and for the remaining patients, those closest in octant location were paired. After

the patients were matched, a coin was tossed to determine their treatment or control status.

When the patients and staff moved to the new facility and the consequent mixing of patient types occurred, the procedure for selecting study

TABLE 1

THE COMPARISON OF 30 TREATMENT CASES AND THEIR CONTROLS ON SEVEN BACKGROUND FACTORS

Variable	Treatment	Control
Age	M = 34.30	M = 33.79
	SD = 7.27	SD = 8.90
Education	M = 11.93	M = 11.73
	R = 8–19	R = 6–20
Months of Hospitalization		
Current	M = 13.03	M = 11.03
	R = 3–81	R = 2–96
Total	M = 28.00	M = 18.45
	SD = 29.33	SD = 19.67
	R = 4–131	R = 2–96
Occupation		
Mgr. & Prof.	5	5
Skilled	2	3
Non-skilled	23	22
Marital Status		
Married & Other	12	10
Single	18	20
Diagnoses		
Schizophrenic	22	24
Other	8	6
Race		
Negro	5	5
White	25	25

patients was changed. Psychiatric residents then nominated patients from any ward for group therapy rather than rating all patients on one particular ward in a blanket manner. This change produced former Continued Treatment Section patients as study cases; consequently all pairs involving these patients had to be dropped, as stated above. Replacements and additions were nominated by the psychiatric residents from former Closed Acute Section patients or newly admitted psychotic patients. Twelve pairs of patients were

secured by nomination. After nomination the patients were rated, matched, and a coin tossed in the previously stated manner.

Effectiveness of treatment measures. The ICL staff ratings were intended as the basic measures of change and corollary data were collected on discharges and returns. Identical and adjacent ICL octants were used for pair matching so the possible disagreements between raters ranged from zero to four. The intra-class correlation between raters was only .41. Nonetheless, it was decided to retain the ICL as the initial matching measure since it contributed somewhat toward the disclosure of patient similarity, and it provided a procedure for matching patients who were virtually unknown to the investigators.

Patient pairs were rated at the time of discharge from the hospital whenever either member of a pair left. The patient pairs who were not discharged were rated at the conclusion of treatment. As was expected from the low inter-rater agreement, the ratings did not disclose clinical changes.[2]

When the study had run about a year, a research social worker joined the hospital staff. He did not become an investigator for this study but he did plan to conduct an interview follow-up as an independent project. The investigators then decided to use time in the community as the outcome measure. Accurate information had been kept of discharges and returns, and the data were easily verified by hospital records. In point of fact, the therapist was quite concerned about discharges and returns to the hospital from the time the first study patient was released. Discharges occurred early in the project and they immediately became an important consideration in the treatment. The therapist had to keep in mind the possibility of premature release of patients. If he did not, he risked a higher return rate or, later, a greater number of treatment patients rated as poor on follow-up.

A discussion of time in the community as a treatment effectiveness measure is presented by Jenkins and Gurel (1959). The weight of their argument rests on the fact that return to the community is the stated aim of most mental hospitals. But the realization of this aim is valid, they add, only if a patient does not place too much stress on the community, particu-

[2] Self-administered psychometric tests were also used. Osgood's Semantic Differential and his Self-Concept Scale, as well as the ICL as a self-concept measure, were taken by the patients, but the tests did not disclose score changes between the groups. Many of the patients were too disorganized to respond to the tests in a rational manner. Other patients were missed for testing when they left the hospital and a few simply refused to take the tests.

larly in the form of alcoholism or lawbreaking. Liberal VA readmission policies provide a general safeguard against the possibility of patients suffering unreasonable tension as a consequence of discharge.

Treatment. Treatment covered 18 months. Meetings were an hour long and were held three times a week; the first named writer acted as therapist. Two groups met, and since the groups were open, their sizes varied from four to nine. Including both groups, the total number of sessions was 406 and the mean number of sessions attended per patient was 73, with a range of 12 to 217. Only when both the treatment and control cases remained in the hospital at least one month was the pair included in the sample.

The psychotherapy was characterized by clear-cut goal-direction. It was explicitly stated, first by the therapist and later by the older group members, that the patient role was a temporary one, ending in recovery and discharge. Thus, each member could check the extent of his progress, session by session. Although the group meetings were the focus of treatment, the therapist worked closely with each member's psychiatric resident to secure the best use of the hospital's facilities. This procedure, of course, confounded the contributions of group psychotherapy and administration to patient change. But talk alone did not appear to work as well when the patient's daily hospital experiences were not examined carefully. The extent of this interaction between therapist and administrator well exceeded standard practice at this hospital, but it seemed to be necessary for a goal-directed treatment method. The goal-directedness factor was not quantified in this study, but all psychiatric residents whose patients were group members, in addition to many other staff members, were well aware of its presence.

The therapist, of course, did not confine all his participation (nor even a majority of it) to defining goals or pointing out pivotal issues which impeded a group member's recovery. Instead, much of his interaction consisted of a discussion of conceptions concerning mental illness. That part of the humanistic tradition which deals with responsibility and freedom also was often a discussion topic.

The therapist was strongly committed to each patient's improvement, and he was highly concerned with each patient's performance and morale. He attempted to establish a strong collaborative, man-to-man relationship with each individual member. For these reasons, a term suggested by Dr. R. L. Jenkins, "coaching" group psychotherapy, also discloses some of its features.

All the meetings were tape recorded and one meeting out of ten was

selected randomly for a Bales (1950) interaction process analysis. But of the tapes set aside, a number were inaudible so that a total of 29 sessions was analyzed.

Results

There were 14 treatment cases and 11 controls who were discharged from Topeka VA Hospital when treatment ended. By that time, a period covering 18 months, 7 discharged patients from the treatment group and 7 controls had returned to this hospital.

Mr. Elmer M. Straight, a Research Social Worker, conducted an independent follow-up study of the discharged patients. He has reported his results (1960) separately in this journal. His follow-up revealed one of the treatment cases had entered another VA Hospital where he remained three months before he was discharged. Of the 11 controls, one was found imprisoned and two others had been in other mental hospitals almost continuously. Mr. Straight also assessed the social adjustment of the discharged patients. He concluded the treatment cases adjusted at a level at least equal to the controls.

After taking into account the time spent in other institutions as disclosed by follow-up, the net time spent in the community by the treatment cases was 139 months as compared to 78 months by the controls, a difference of 61 months. The Wilcoxen Matched Pairs Signed Ranks Method showed the treatment cases had significantly more time in the community than the controls, .043 level by one-tailed test.

The Bales (1950) interaction process analysis scoring for the purpose of this study was quite reliable. Our purpose was determination of total category results rather than meeting by meeting developments. The first named investigator and another coder[3] counted 27,954 and 28,372 interactions respectively as the total number of units. They did not differ more than 3% on the number of interactions assigned to each category. Silences were deliberately and succesfully kept to a minimum since the tapes revealed they rarely exceeded a minute.

Figure 1 shows the proportion of the patients' and therapist's total interactions that fell in each category. A strong resemblance between the therapist's participation and that of the patients is disclosed by the figure. The earlier mentioned concepts concerning mental illness constituted much of the content of category five, the highest category. Since the ratio of the

[3] We wish to thank Miss Grace E. Thompson who served as one of the scorers for her conscientious attention to this task.

first three categories to the last three is approximately three to one, the ratio disclosed the therapist expressed more affiliative than hostile affect. The patients' frequent expressions of opinion indicated they felt relatively comfortable in the group. Too, their ready venting of hostility, category 12, a desirable turn for many of the patients, implied they did not feel threatened in the group.

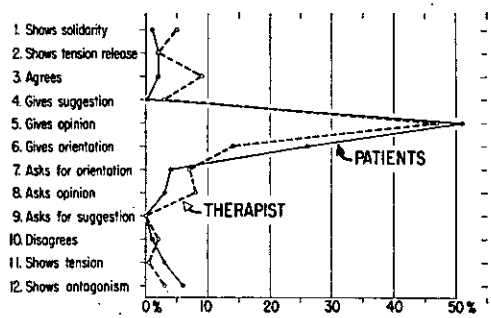


FIG. 1. INTERACTION PROFILE OF PATIENTS AND THERAPIST.

DISCUSSION

The finding that psychotherapeutic intervention with hospitalized patients produced a positive result is hardly implausible since many workers believe it does. But the point at issue is whether or not this exploratory study conforms sufficiently to commonly accepted research principles to support the findings. The initial matching of the patients was a crucial feature of the design. However, predominately homogeneous ward placement supplemented by the use of a sociometric technique evidently did result in satisfactory matching. The question of the suitability of time in the community as an outcome measure, of course, is a value judgment. But it serves as a relative measure of social recovery and it has the advantage of giving a longitudinal picture of patient movement as compared to a single cross-sectional evaluation date when many fluctuations can occur. However, when only one aspect of the problem is considered, that prolonged continuous hospitalization probably results in a lifetime patient, then whatever interrupts this pattern is a practical gain. But the attainment of this goal is valid only if discharge does not place too much stress on the patient, his family, or the community.

The Bales (1950) analysis made a contribution toward objective description of some aspects of the therapy. As an example, the investigators believed that a good bit of confrontation was a salient feature of the treat-

ment approach. Category 12, however, is too low to confirm this clinical impression; at least with respect to frequency.

SUMMARY

Thirty hospitalized, moderately chronic, mental patients were individually matched on one variable, personality organization, by the use of a sociometric technique and were found to be similar as groups on seven other variables. One group received group psychotherapy while the other served as a control group. All the psychotherapy sessions were tape recorded and a sample of sessions were analyzed by means of the Bales (1950) interaction process analysis method. The therapy covered a period of 18 months, it was a goal-directed, eclectic sort, and the therapist was active and involved. The treatment cases had significantly more time in the community than did the controls, .043 level by one-tailed test. An independent interview follow-up study disclosed the treatment cases were not discharged prematurely.

BIBLIOGRAPHY

Bales, R. F. (1950). Interaction process analysis. Cambridge: Addison Wesley Press.

Hollingshead, A. B. & Redlich, F. C. (1958). Social class and mental illness. New York: Wiley.

Jenkins, R. L. & Gurel, L. (1959). Predictive factors in early release. Ment. Hosp., **10**(11), 11-14.

Leary, T. F. (1957). Interpersonal diagnosis of personality. New York: Ronald.

Menninger, K. (1958). The theory of psychoanalytic technique. New York: Basic Books.

Moreno, J. L. (Editor, 1960). The Sociometry Reader, The Free Press, Glencoe, Ill. Straight, E. M. (1960). Evaluation of group psychotherapy by a follow-up of former hospitalized patients. Group Psychother., **13**, No. 2, 110-118.

INFLUENCE OF OPEN DOOR POLICY IN MENTAL HOSPITALS

JOHN J. PEARSE, M.D.

Willowbrook State School, Staten Island 14, N.Y.

About 1955 a meeting took place in London of members of the Association of Superintendents of Mental Hospitals with the purpose of exchanging information and experiences relating to the "open door" policy in mental hospitals. The "open door" at that time was already well established in most mental hospitals in Great Britain and in Scotland. It became apparent that there were two approaches to the problem, depending mainly on the basic temperament of the director of the particular hospital.

In one type of hospital, the "open door" was adopted fully and without reservation; even the most acute patients and the new admissions were left without protection of the closed door. The second approach was somewhat more conservative, accepting basically the open door for the entire hospital, leaving only one ward on the male side and one ward on the female side locked for the acutely disturbed patients. The second type of hospital introduced some modifications. There the door was open most of the time but could be locked and was locked when necessary.

The question of the "open door" was no longer under discussion, but which type would eventually be accepted was the main theme of discussion. All psychiatrists taking part in the conference agreed that the "open door" was a step in the right direction and certainly would be considered as a revolution in the basic concepts of the treatment of the hospital patients. No such dramatic change had occurred in hospital life since the time of Phillipe Pinel who unchained mental patients and elevated them from the level of dangerous animals to the dignity of human beings.

The first experiences with open doors in a hospital for the mentally sick happened by chance of war and thanks to a man who was on the spot and drew the right conclusions, these experiences were not wasted. This is how it happened.

In a town just outside London there was a large military aerodrome which was constantly a target for enemy bombardment. The mental hospital which was some distance from the aerodrome received a direct hit and many buildings were destroyed and patients killed. The buildings which escaped total destruction lost most of the windows and doors. The

medical superintendent was in despair. He knew that he could not have the damage repaired immediately as glass and timber were just not available and consequently would be unable to prevent the patients absconding from the hospital. As nothing could be done, he had to resign himself to do nothing. Any physician who gained his experience in mental hospitals must sympathize with the superintendent. The real or imaginary fears connected with an escaped patient are deeply engraved in any medical officer's mind. The medical superintendent visualized his patients running away and roaming the city and the countryside threatening the peace of normal citizens. But to his surprise, none of his fears materialized. The following morning the general check revealed that only one patient was missing and by lunch time, this patient came back and seated himself at his own place at the table. That mental hospital became, as far as I know, the first hospital which was forced to adopt the open door and open window policy not through a well considered psychiatric theory, but as a result of enemy action. The hospital was never the same and since that incident, remained without windows and without doors for a very long time. After the war, the windows and doors were replaced but the doors were never locked again.

The idea of the "open door" policy found extremely fertile ground and it did not take long for other hospitals to realize the advantages of the open door and to modify their attitude to mental patients. On the whole, it found very little opposition, even in the most conservative psychiatric circles.

There are many advantages of the "open door" policy and it has only a few disadvantages. I should like to emphasize now some of the advantages and for the present, ignore the disadvantages. The first advantage is more abstract and might be referred to as moral; the second is the therapeutic influence on the patients in the ward functioning as a group; thirdly, the influence on the nursing staff in charge of the patients as it is reflected in their behavior toward the patients.

Let me analyze the first and the third briefly and leave the second to the last as I am going to devote a little more time to the second. In my opinion, the reason why open door policy met with little opposition was, and this was confirmed by many of my colleagues, that they felt morally uneasy and suffered feelings of guilt to be forced to deprive another human being of his liberty and keep him under lock and key. Although this might sound somewhat farfetched, nevertheless, it seemed to have been a reality amongst the doctors. It is true that this was done in accordance

with the law and could be easily rationalized away. On a purely rational level depriving a mental patient of his liberty could be fully justified but on a less conscious level, guilt feelings could not be completely suppressed. Any outsider could observe how the more responsible physician sighed with relief when the open door policy was introduced in his hospital.

From the nursing point of view, there were several purely practical advantages and some less obvious advantages and on a more symbolic level. The practical side became obvious when the nurse became less preoccupied with opening and closing doors and worried less about the patient escaping. I need not go into details and describe the red tape procedure which had to be undertaken when a patient absconded. They show surprisingly little difference in Great Britain and the United States.

The influence on the patient which reflected on the nurse's duties was the fact that the less disturbed patient became less dependent on the nurse and often many such patients spontaneously took upon themselves the need to look after the more seriously ill patients. This was a great help during the post war years as nursing staffs were extremely scarce.

The nursing staff benefited from the lessening of emotional pressure and it should be added at this point that the patients were free to leave the wards and sit in the hospital grounds which gave the nursing staff the opportunity to complete their paper work undisturbed and arrange medication schedules for the following day.

On the more symbolic level, the nurse represented authority. She was both the rewarding and the punishing power. Whether aware of it or not, to a great extent, she carried the heavy burden of the positive and the negative transference. After the introduction of the "open door" the nurse became somewhat less important in the life of the patient, however, never losing completely her importance. In consequence, the emotional burden carried heretofore by the nurse became less heavy.

Each ward, and this is true of the sick and less sick patients, shows a particular and definite character. Sometimes it was easy to relate the tone of the group life to one individual, say the nurse in charge, a patient, or a group of patients. At other times the group character seems to have established itself without apparent rhyme or reason. The changes which occurred after the doors were opened were much more apparent in the wards for the more disturbed patients. At first there was no apparent difference in the behavior of the patients. Then one or two patients realized that the doors were opened and instead of taking advantage of the situation, the patient pointed out to the nurse that the door was open and it had better

be locked. One particular disturbed patient who had a record of many escapes from the hospital, lost interest when the door was opened and escape from the hospital became to him somewhat less of a challenge. There were many incidents in the life of the patients during the transition period but I shall not go into this problem deeper as it is irrelevant at present.

Once the patients realized that the doors were open and that they were free to come and go as they chose, the cohesion of the group started to lessen. As it has been mentioned before, the nurse in charge in most wards was, so to speak, on the top of the pyramid. Her favors from the point of view of the patients were worthwhile competing for. Tensions, jealousies and hatreds within the group could be directly traced back to the behavior of the nurse. Many frustrations resulted, agressive acts towards other members of the group or objects could be traced back to the nurse's ability to reward or withdraw the reward. Whether positive or negative emotions, love or hatred, all these were additional forces which basically added to the cohesion of the group. As it has been mentioned before, after the doors were opened, the nurse lost a great deal of her immediate importance to the emotional life of the patients. The patients were less confined to a restricted area and the physical proximity of other patients. Once the patients became less emotionally dependent on the nurse, the whole social structure of the ward collapsed only to be replaced by a different social structure. Different factors seemed to come into play. Instead of the pyramidal group structure, many little groups appeared within the larger group.

It is difficult to avoid seeing certain similarities between experiments with animals and the behavior of patients after the doors were opened. These experiments show that animals when exposed to a stress situation in a confined space, react with neuroticism, whereas the same animals, removed into a less restricted area, lose their neurotic trends. We must, at the same time, keep in mind all the pitfalls and shortcomings when we are attempting to translate experiments on animals' behavior into human behavior.

The structure of the smaller groups varied a great deal. In some groups a "natural leader" took charge and the rest of the patients adhered to him. Other groups, which could be called "voluntary workers groups" consisted of two kinds of patients: the "givers" and the "receivers." Some patients spontaneously started to care and look after the more helpless patients. It was not necessarily the physically stronger of the mentally better preserved who belonged to the "givers" and vice versa. In other

groups some common interest seemed to be the focal point in the crystallization of the group. On the whole, only the most deteriorated patients could not or would not function as the social being.

The natural re-grouping after the doors were opened decreased to a great measure the feelings of frustration in the patients. Emotional charges were withdrawn from the nurse or other patients and seemed to find direction and expression in physical activities, walks and other pursuits. The result could be measured in less fist fights among the patients, less abusive quarrels and less broken windows.

It is true that the open doors were a new event in the monotonous life of the patients in a mental hospital and certainly some of the improvements could be directly attributed to that fact. Professor Eugene Bleuler was well aware of the beneficial influence of a change of environment on the patient. He went so far as to arrange an exchange of his patients with those in other hospitals in order to give them the benefit of change of environment. It must be said at this point that the scheme did not last very long for reasons other than medical. The patient suffering from schizophrenic illness was no exception in that respect. The external stimulus seemed to make a sufficient impact on him to get him out of his autistic state and make it possible for him to come in communion with reality.

It has been noticed that many secondary psychiatric disturbances improved. It would not be too farfetched if we compared that with states achieved after hours of group psychotherapy. However, after many months there was a certain degree of regression but the patients never went back to their starting points.

There is a hope that the "institutionalized character" of the patient is a phenomenon of the past.

Needless to say, the stages described during the transitional period are somewhat idealized and this is done only for the purpose of clarity and they are basically correct. The advantages of the open doors are without dispute. It is only to be regretted that certain hospitals are unfortunately situated (in the centers of big cities) where the "open door" policy could not be readily adopted. It is certainly easier if the hospital is situated in the country. How the community can participate in helping to open the doors in mental hospitals could be a subject for further discussion and would certainly be rewarding.

THE "OPEN DOOR" POLICY IN MENTAL HOSPITALS vs. THE "CLOSED DOOR" POLICY IN THE COMMUNITY

Discussion of Dr. Pearse's Paper

J. L. MORENO, M.D.

Moreno Institute, Beacon, N.Y.

The open door policy in mental hospitals and prisons has been advocated and practiced in the United States long before it became a vogue in Great Britain and was re-introduced across the Atlantic Ocean. Dr. William A. White said in the course of acting as Moderator of the Round Table Conference on The Application of the Group Method to the Classification of Prisoners held during the annual meeting of the American Psychiatric Association on May 31, 1932 in Philadelphia: "I remember visiting, a few years ago, a prison in the East with about one thousand inmates. It had no walls and only a few cells. The dormitory system, similar to that in schools, was in use. On the first occasion I found no men in the solitary cells and on the second occasion only one. The men were free to conduct themselves and the warden was clever enough to handle the men so that they felt comfortable. They did not run away nor did they commit acts which would have made the running of the prison impossible." . . ."Some years ago Congress made an appropriation for a prison in Washington, D.C. . . . A prison was erected without walls and with no cells. It still functions successfully."*

Why the open door became an easily acceptable dictum in 1955, whereas it was an exception in the 1930's can be understood if one takes into consideration the influence of group dynamics, sociometry and the psychotherapy movement. All these have contributed to the thinking of the hospital administrator and his staff. The open door doctrines of the 1950's know that there are therapeutic forces within the group upon which they can rely, and which will assist in the maintenance of a high degree of control. The idea of the mental hospital population as an "irrational mass" has been replaced by the idea that the patient groups have a therapeutic structure and that "one man can operate as a therapeutic agent to the other." The open door policy rests safely upon the fact that every mental hospital is a group psychotherapy project in situ. It is a therapeutic milieu in which "all hospital employees must participate. In fact, group psycho-

* *Group Psychotherapy, A Symposium*, pp. 19 and 23, Beacon House, 1945.

therapy in its present form is the preliminary effort to the complete mobilization of all the persons of the institution who are oriented to serving the mental patient. Group Psychotherapy is the beginning and terminal force in the therapeutic society of the total hospital situation which includes all the other general and specific therapies."**

In viewing this open door of the mental hospital, let us not overlook the other end of the process. If the hospital has opened the doors, but the doors in the community remain "closed" to him, we have increased the anxiety of the patient instead of alleviating it. If we should seriously aspire to the hospital as a therapeutic community, we should simultaneously aspire to transforming the open community into a therapeutic community. The entire problem means that the community at large should work towards the ideal of a therapeutic society.

** "Presentation of Moreno's Psychodrama at the Third Mental Hospital Institute," Dr. Hilding A. Bengs, *Group Psychotherapy*, Vol. 4, 1951, p. 213.

GROUP TECHNIQUES WITH TEEN-AGE EMOTIONALLY DISTURBED GIRLS

MARGUERITE M. PARRISH, M.S.W.

Catholic Social Services of Washtenaw County, Ann Arbor, Michigan

Group Psychotherapy is currently being added to the traditional treatment methods that have long been used by social agencies. The Catholic Social Services of Washtenaw County in line with this trend uses group methods and psychodrama as well as the long established individual case work interview methods in its work with clients.

The Catholic Social Services of Washtenaw County is a family and children's agency supported by the Roman Catholic Church and devoted to healthy family living. The services of the agency are available free of charge to any adult or child living in Washtenaw County, irrespective of racial, nationality, religious, social or economic background. Washtenaw County is located in Michigan within forty miles of Metropolitan Detroit. It's chief center of population is Ann Arbor which is the home of the Unversity of Michigan.

During 1961 the agency served 829 families or 1662 individuals. 204 of the individuals served were under 18 years of age and a large percentage of this group fell into the teen age category. Most of these children were worked with individually, but group techniques were for the second consecutive year used with a small number of teen age girls who came to the agency as disturbed adolescents, who were once disturbed children and who were certain to become disturbed adults if adequate help were not received. All of the girls included in the group had been traumatized by unwholesome, neurotic relationships with their parents and had been reared in a consistent state of emotional impoverishment and extreme tension. All of the girls in the group needed help years before it was made available to them, but the parents did not recognize the need for help and resented suggestions on the part of the school officials. This factor in itself indicates the nature of the parent-client relationship and points out for us the difficulty involved in treating the girls by focusing on improving the relationship with the parents. For some of the girls included in the group physical separation seemed to be a necessary part of treatment but this could not in all such instances be arranged. In such instances as school placement was possible feelings of guilt on the part of the parents and children had to be worked through prior to placement.

History material revealed that all of the girls had temper tantrums

prior to starting school and had difficulty in school from the time when they started in the first grade. Most of the girls had been moved from school to school as the parents blamed the school for the problems. All of the girls come from economically sound families, but emotionally they had suffered very early in life severe rejection as well as frustration of their basic affectional needs. The girls felt rejected and unloved and at the same time had an inordinate need for primary affectional needs. They tried to defend against these needs by isolation. One of the girls expressed herself by saying, "I am the happiest when in bed with my cat beside me".

In the home the girls were difficult to live with, argumentative and moody. They had either few friends or no friends. They had either failed or were near failures in school, could not get along with teachers or classmates, had frequently truanted from school and spent all their free time day dreaming. A number of the girls had been asked to leave school as the result of their behavior problems. Difficulty involving the community varied in seriousness and extent but existed in each case. The girls had without exception become sex conscious at an early age and were anxious to establish their independence. Another factor the girls had in common was problems in the area of establishment of individual identity. Psychological testing showed that the girls who had the least trouble in the community apparently had the least amount of ego strength and were so to speak making no effort to solve the problems facing them. The girls having the most difficulty in the community had considerable more ego strength and were trying to solve their problems. They were trying to solve them by seeking allies among adolescents facing similar problems. The various members of these groups who were referred to by the schools as difficult problems bolstered one another in their desire for independence and manifested this independence in a display of antisocial behavior. The girls relinquished their individuality to the group. The group in turn gave them a sense of self worth which they gained through having their dress, speech and actions sanctioned by the group members. The fact that these girls could become members of a group led to the decision to try group therapy.

The girls making up this group were accepted for group treatment as individual treatment had either failed or been of limited value. Without exception the girls had over the years been treated individually by visiting teachers, social workers and psychiatrists but the pattern of difficulty continued to grow rather than decrease. Psychiatric care was in several instances terminated as the parents were resistive to having a member of the family seen by a psychiatrist.

The girls ranging in age from 15 yrs. to 17 yrs. met for the first time in the group meeting. Sessions were held once a week, June through August, and were a combination of interview group therapy, activity group therapy and psychodrama.

The group was a closed group in that all of the girls started with the first session and continued until the last session. A room approximately 18 feet by 22 feet in size was used for the sessions. The room was equipped with a table and chairs for each member of the group. The seating arrangement was informal; a semicircular arrangement of the chairs with the therapist as a part of the group was the usual arrangement. Refreshments were served during the meeting, and this gratification of oral needs definitely helped some of the girls to be more at ease.

The hope that group therapy might provide some help for this group of adolescents was as previously stated based on the recognition that many of them in spite of their poor relationship with their teachers, families and therapists had been able to enter into relationships with other adolescents. Four of the eight girls in the group had been able to enter into such relationships. Since therapeutic results in group therapy is dependent upon interaction between the members of the group this factor seemed to be of importance. This type of treatment also seemed to be the method of choice as the orignal traumatization had occurred in a group, the family, and it was felt that group interaction could be utilized to help the girls live out some of their early emotional fixation.

The girls readily related to one another and freely expressed themselves within the confines of the group. Of tremendous importance to the girls was the security of belonging. In the group they for the first time experience healthy acceptance rather than rejection and the dynamic interplay which resulted provided an effective starting point for therapy.

During the first session the girls found common ground which proved to be a bond between them. This resulted in a universalization of problems which it would have been difficult to accomplish in a one to one relationship and made it easier for the girls to face themselves and accept their problems. Before the end of the first session remarks, such as "you know my parents", "I know exactly what you mean" and "you can't win" were being passed around. The first common ground was disinterest on the part of parents and discord in the home.

As a general picture of the home life and parents of these girls was disclosed psychodrama was initiated. Through the psychodramatic scenes the real picture rapidly emerged. It seemed that the parents of these girls

were invariably poles apart in their thinking. Even in instances where the parents showed the same internal conflict they invariably expressed opposite sides of the conflict. It also developed that the parents were disappointed in their marriages, thought about their marital partners in negative terms and in some instances verbalized the advantages of being married to someone else. Divorce was used as a threat. Periodic explosions of hostility and physical separation completed the picture. The separation was brought about by the father having extra jobs, the mother constantly being at club meetings and the mother working even though financial need did not exist. The hours were invariably such that the marital partners had very little time together. Even when the parents were at home together physical separation was managed. This was done by the husband having a special province, such as the library, garage or basement, where he stayed while the wife stayed in a sewing room or somewhere else in the house. The parents were also rigidly separated with respect to their roles. Each had a specific responsibility and there was no sharing of responsibilities, opinions or ideas. The girls realized the situation that existed between their respective parents but had not reached the point of understanding or accepting the situation. Which ever parent they sided with the ultimate result was guilt over the negative feelings which resulted around the other parent.

Through psychodrama the girls developed a more understanding attitude toward their parents and were also able to experiment with various ways of handling the home situation. In short the sessions resulted in a discharge of tension or catharsis, new insights, a changed concept of parents and self and a newly developed ability to handle home difficulties. Finding themselves and their families accepted after exposing the home in its real light was also a therapeutic experience. At first the girls found it difficult to believe that others could have tolerance and respect for them and for their parents after really knowing them and knowing their parents.

Following this phase the girls moved into school experiences, anti social behavior and plans for the future. During this phase as well as during the previous phase of treatment both real life and "make believe" situations were acted out. By "make believe" I mean a situation which was the product of the imagination of the therapist or one of the group members rather than a reality situation in which one of the group had been involved. By using these two types of situations in proper proportion it was possible to develop in the group members a feeling of ease, and it was possible to temper the anxiety and hold the group from one meeting to the next. This is important when meetings can be held only once each week. Ideally such

meetings should be held two or three times per week. Make believe scenes bring about more ready participation and a greater degree of spontaneity. Such scenes afford group members who are as yet insecure regarding expressing themselves the security of anonymity and at such point as they feel able they can say "That is my story", "That is what my home is like". The majority of the girls rapidly moved from "make believe" scenes to reality scenes.

Throughout the summer catharsis continued to be an important part of each session. Within the group the girls had found a safe place to express their feelings and without the need for considering consequences in the sense that they had to in everyday living. The girls were able to become violently angry, express hostility toward authority, pass judgements, mete out rewards and punishments and enjoy their repressed desires for power. They were also safely able to give way to fears, be infantile, abusive and even destructive. All of this was easily possible as they realized the situation would remain a part of the psychodrama and that the consequences would also be "an act" even though closely paralleling real life. As the situation would end when the drama would end they felt safe in relaxing inhibitions and discharging tensions.

By the tenth week the girls seemed to have adequately expressed their problems regarding the home, the school and authority in general and were able to face their loneliness and their inability to make friends. The security resulting from the group relationship and their new insights made it much easier for them to reveal themselves in this area than it would otherwise have been. The girls acted out various ways of making friends and meeting social situations. Constructive criticism was encouraged not only as a learning experience but on the grounds that persons so criticised become less sensitive. Relationships with the opposite sex were an important part of this phase of treatment.

During sessions the group members combined and recombined themselves into various groupings, and attention was at various times given to various persons. During early sessions the girls were drawn toward the most hostile and verbal member of the group, but as sessions progressed movement was toward the healthier group members. While remaining as passive as possible the group leader or therapist helped each girl to express herself and also helped the group as a whole to persist toward its goal of individual advancement.

The roles the individual group members were encouraged to act out were also a carefully thought out part of the treatment process. When a

girl seemed to be particularly in need of ego building she was cast as an important and well liked individual looked up to in the community and important to the community. On the other hand some of the group members were unconsciously seeking punishment, and these individuals were cast in roles where these needs could be met. At the same time an effort was made to determine why these needs existed and help the individuals overcome this unhealthy emotional situation. During this phase of treatment the meetings frequently flowed from interview methods to psychodrama and back to interview methods.

Whenever possible the therapist made use of the group members who were able to handle situations unusually well and encouraged them to be active in situations where they could demonstrate their ability. Not only is this technique ego building for the individual group member, but it is very helpful to other group members.

The group experience obviously did not cure these girls. It succeeded, however, in drastically altering, at a critical point in their lives the way they related to authority. Boarding school would undoubtedly have been a negative rather than a positive experience if this change in feeling had not been affected. It also drastically altered each girl's image of herself and her family and the result was a new sense of value with regard to self and family and a new feeling of security.

The girls were also able to accept solutions that were arrived at by the group. It is not felt that this could as easily have happened in individual treatment. Coming from the group such solutions were more acceptable as they seemed less arbitrary and grew out of a vital process that went on between themselves and their contemporaries.

Individual treatment was hampered with these girls because of broken appointments and new outbursts of anti social behavior. In the group the girls did not seem to find it necessary to run into difficulty in order to escape treatment. The saying "In unity there is strength" applies to individuals with problems.

Two of the eight girls are in boarding school and six returned to the schools they had previously attended. Six of the eight girls have been able to continue in school without new serious conflicts developing, have shown themselves better able to socialize and are making a fairly adequate adjustment within the family circle. Ideally treatment should have continued for a longer period of time, but the short group experience was fruitful in that it helped each group member develop her potential for both independence and interdependence which is the ultimate goal of treatment.

PSYCHODRAMA AND AUTOGENIC RELAXATION

GERTRUD ROTHMAN, M.D.
San Francisco, Calif.

Through the past centuries man was busy investigating what the world was like around him. All other species adapted themselves to nature. Man is the only species that modified nature according to his own needs—inventing tools and machines. Only recently has he had time to look into himself and to see what was going on in himself. Since psychology is a relatively young science, it would be arrogant to assume that our present knowledge is so complete that no further development is possible. In my experience as a practicing psychiatrist stretching over twenty-five years I came to look at psychology as a house to which new rooms, windows, doors and passageways have been added gradually.

During the development of psychodrama-techniques various forms of expression, such as psycho-music and psycho-dance were used to great advantage; even hypnosis was occasionally combined with psychodrama. When encouraged by Moreno to apply psychodramatic methods in working with a group of students, I found autogenic relaxation a valuable adjuvant to psychodrama. The method, as first described by Schultz in Germany thirty years ago can be considered as a form of self-hypnosis, and the prejudice prevailing against hypnosis accounts for the fact that it has been hardly used in America. Only recently, after we had acquired a better understanding of the mechanism of suggestion, was hypnosis recognized by the medical profession as a scientific method of therapy.

Suggestion is due to a primitive mental process which determined the acceptance of simple ideas in the evolutionary period, before man had acquired the ability of logical thinking. The human infant still responds easily to suggestion, imitating adults in his environment, and it is conditioned through obedience to uncritical acceptance of ideas. Only later in life this is superseded by reason. But even in adult life the critical faculties of our mind are often temporarily suspended: being exposed to environment influences, propaganda, radio, newspapers, we are continuously accepting suggestions.

Autogenic relaxation, as described by Schultz, and then called autogenic training, required extensive preparation; it led to a state of deep hypnosis, sometimes to somnambulism. The subject became insensitive to pain, minor operations could be performed and pregnant women gave birth without

anesthetic. Such deep hypnotic state is not desirable when autogenic relaxation is combined with psychodrama. A slight trance is all that is required. We often drift into such trance-like states in our every-day life, e.g. when day-dreaming or driving on a monotonous highway. Our mind functions then on a more primitive level. When we focus our attention upon something interesting, other stimuli are not registered; bodily pain is hardly perceived or may be minimized when our attention is absorbed. Our thinking process is reduced to mono-ideism—the mind is centered upon only one idea, all other distractions are excluded. In the modified autogenic relaxation combined with concentration such a state of mind is intentionally produced by the subject himself. The kind of suggestions to be used are selected according to the personality of the partient, taking into consideration the specific conflict or symptom.

This procedure is distinctly different from hypnosis: hypnosis is always a parent-child relationship—either an authoritative approach is used to make the patient submit, or he is lured into abandoning critical intellectual evaluation and drifts into a more primitive suggestible state. A sudden startling approach, administration of drugs, or confusion techniques may have an adverse effect: hostility or ambivalence may be evoked especially in patients who harbored resentment against an authoritative father, but also feared a domineering mother—the woman with the penis—the woman with power. One has also to consider that the doctor-patient relationship has drastically changed during recent years: formerly the patient had an almost childlike faith and submitted to the doctor's judgment. The average patient nowadays is better educated and wants to understand the procedure. By fully informing him before starting therapy, doubts, fears and suspicions he may possibly have, are dissipated and his full cooperation is gained. A positive therapeutic relationship gives him sufficient security to abandon critical intellectual activity and to drift into a state of heightened suggestibility.

In accordance with the rôle of the director in psychodrama, no ruthless approach is used, but as dispassionate, non-domineering, sympathetic, and unobtrusively guiding attitude is assumed.

The modified Schultz method can no more be regarded as 'training' but autogenic 'relaxation'—a "do it yourself" method. It is not considered as a static mental condition in which the subjugated patient automatically accepts suggestions, but as a highly dynamic state in which ordinary psychological mechanisms are functioning, but they are fluctuating in depth. For these reasons sleep, as used in hypnosis, is avoided—everything is directed towards movement.

Autogenic relaxation facilitates the ultilization of psychodrama-techniques—self-presentation, soliloquy, projection, rôle—reversal, and is helpful to better remembrance and presentation of a dream on the stage.

When applied by the protagonist, it enables him to break through the barriers of comunications, to overcome the initial resistance and possible stage fright in the warming-up process; an anxious, timid or self-conscious individual gets started easier by throwing body and mind into motion.

Although motivated by the distress of his conflict, the patient may not be able to act spontaneously on account of an unconscious defense; there may be underlying guilt, shame, or fear of humiliation. Therefore he is afraid to lose control. In such cases autogenic training can be helpful in overcoming a still existing unconcious resistance.

The auxiliary ego finds it easier, in autogenic relaxation, to identify with the protagonist, to experience the world of the patient and understand his problem. A smaller number of auxiliary egos is required which is a definite practical advantage.

An audience in autogenic relaxation has a greater capacity for empathy.

Whereas the Schultz method was directed towards treatment of circulatory disturbances and the patient was lead to train himself in controlling heart- and vasomotoric system, autogenic relaxation combined with psychodrama has a much wider range of application:

Children respond easily and very favorably to the method: they are not yet as far removed as adults are from uncritical thinking. Spontaneous acting is natural to them. In their games they concentrate upon various rôles, e.g. pretending to be a policeman, or a train conductor. Autogenic relaxation combined with psychodrama has been very rewarding in the treatment of symptoms such as nailbiting, tics, enuresis, which often persist after long having been outgrown. The objection that such a treatment be merely symptomatic, is not justified. When freed from a symptom a patient is often able to get out of a vicious circle. The objection that it may weaken the willpower of the subject, is equally unjustified. By enabling the patient to acquire self-discipline it even strengthens his willpower. Mothers can be instructed to make use of autogenic relaxation for catharsis. Children act out conflicts in the family situation with toys, dolls, spontaneously, not needing much assistance, in natural play; mothers can learn to convert natural sleep into autogenic relaxation and the depth of sleep can be regulated similar to the method of fractioned hypnosis, e.g. in cases of enuresis when it is desirable that the child awake by himself at certain intervals during the night.

Schultz considered autogenic training as a diagnostic tool in the differential diagnosis of epilepsy in children, which, he states, is psychogenic more often than we assume: if we can produce a fit by appropriate suggestion, we can be almost certain that it is not genuine epilepsy but the nature of the fits is functional. Many cases of psychic origin diagnosed as pseudo-epilepsy can be cured with autogenic relaxation and psychodrama.

The method proved to be valuable in family problems, especially marriage conflicts, and in the rehabilitation of the handicapped. Of the great variety of indications I like to emphasize weight-control and insomnia.

In the treatment of psychosis it is almost indispensable: whereas special precautions had to be taken with latent schizophrenics in order not to precipitate a psychosis, this danger is almost non-existent when autogenic relaxation is used with psychodrama: Not only can anxiety be controlled better, but the therapist can not so easily be involved in the patient's network of paranoid ideas of reference; the patient can not imagine to be 'influenced' by the therapist because in autogenic relaxation he definitely "does it himself".

SUMMARY

Autogenic Training, as described by Schultz in Germany, was modified and used in combination with Psychodrama by Rothman in America. This form of autogenic relaxation is not carried as far as to lead into a state of deep trance, hypnosis or sleep, but is now used as a relaxant, facilitating the warm up in psychodramatic techniques. The mechanism of action is explained and diagnostic, differential-diagnostic, and therapeutic values are discussed.

AN ALTERNATIVE TO MORE AND LARGER PRISONS; A ROLE TRAINING PROGRAM FOR SOCIAL RECONNECTION*

MARTIN R. HASKELL, PH.D.

The City College of New York

Mr. J. Edgar Hoover recently announced that in 1960 crime rates in the United States had increased 12%. The Police Commissioner of the City of New York responding to the rise in the crime rate in New York City announced that he had hired some 1,300 additional policemen. The Commissioner of Correction of New York City noted the increase in crime and pointed out that the number of persons committed to correctional institutions in New York City had risen substantially. She stated that additional prisons would be required. Administrators dealing with the crime problem can only suggest additional police or additional penal institutions depending on which area they are administering. The author of this paper takes the view that it is a function of the social scientist not only to study or analyze existing conditions but to propose change when sociological theory and current research indicate that change is necessary.

Rehabilitation programs at our prisons and the quality of the personnel administering them have greatly improved over the years. Parole programs have been expanded and developed. While there is still room for considerable improvement both in residential correctional treatment programs and in parole treatment programs whatever change that has taken place has been in a positive direction. Nevertheless, recidivist rates remain extremely high. What has been totally neglected is the transition from the status of inmate to that of free citizen. It is the contention of the author in this paper that to successfully accomplish this transition, which we shall refer to as social reconnection, will greatly reduce recidivism and at the same time make it unnecessary to construct the additional maximum and medium confinement facilities otherwise made necessary by the rise in crime rates. Based on the experiences of the British in the social reconnection of World War II Prisoners of War, the author's experiment in role training as preparation for release on parole from a city penitentiary and his experiences in administering an after-care program for adolescent delinquent boys, the author has prepared a tentative role training program for social reconnection.

---

* Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, New York, March 25, 1961.

Most inmates prior to their incarceration are members of delinquent groups with sub-cultures deviating materially from that of the dominant culture in our society. Other inmates, while at prison, are subjected to a continuous acculteration and assimilation of the criminal value system. They tend to develop a vocabulary that reflects attitudes, beliefs, opinions and orientations different from and often opposing those of the conventional person, if they did not have such attitudes when they arrived at the prison. The roles played by the inmate of a prison and the roles he is required to play upon his release are vastly different in most important aspects. This is obviously true of the important family roles. The inmate is living apart from his wife, his parents, or any other relatives with whom he normally resides. What often passes unnoticed is that he is also away from his community roles and normal occupational role. In spite of the fact that most inmates do some work while in prison, the attitudes attached to the role of worker differ materially from the attitudes required for a satisfactory achievement in a work situation on the outside. Workers in the prison labor system are encouraged to be non-productive, dilatory and contentious. Prison developed attitudes affect the individual's concept of the role of the job seeker. In prison the inmate does not have to seek a job. It is considered to be the duty of the officials to provide him with work and the inmate comes to feel that he has a right to a job. Foremen in the prison are content with a limited amount of productivity, the standards being far lower than that set by foremen and employers outside the prison. Far more cooperation than the inmate is accustomed to give is expected of him by fellow workers, foremen and employers when he works on the outside (4).

Moreno first developed role playing in occupational, family and community roles at the Hudson Training School for Girls to prepare delinquent girls to face life situations. He called this spontaneity training because his emphasis was on training of individuals for conduct in possibly arising situations, in a variety of roles and functions they may have to assume towards a variety of persons in the possible roles they may assume (6). Haskell developed a more structured form of role playing in which the emphasis was on experience in past situations as preparation for future action. He called this role training. Techniques developed by Moreno for use in psychodrama were applied (5). His role training program was designed to help the inmate know the rights he acquired as the occupant of a status, the rights of all others involved in the situations he might have to face, his obligations and the obligations of all of the significant

others in his family, on his job, and in his community. Since most of the inmates of a correctional institution do not have experience during their period of incarceration in roles in which they are required to function on the outside, role training was used to help them adjust to future roles (2) (3).

British "Civil Resettlement Scheme" (7)

At the conclusion of World War II the British found that a substantial number of prisoners of war returning to England had been "desocialized". Because of the absence of the normal social structure, these military men, while prisoners of war had few normal societal roles available to them. Failure to take normal social roles proved to be one criteria of desocialization. Failure to obtain normal social relationships because of the social structure in which they found themselves, resulted in failure to sustain social relationships, and this provided a second criteria of desocialization. They returned to the community lacking resources to make the restorations necessary and the resilence to resume abandoned activities. The result was that desocialization was induced in repatriated prisoners of war despite the degree of structural equalibrium in post war Britain. While in the army and particularly while prisoners of war, the men ceased to function as husbands and fathers. Their families readjusted in their absence. When they returned a disequalibrium was caused comparable with that created by their departure. Outside the family, his associates had similar difficulty in accepting the repatriate into the milieu they had established without him. Such experiences led men to feel that they were rejected by their families and friends. They also found on their return that there were no jobs for them, that they did not know where to begin looking for jobs, and that they had no idea of what jobs they were qualified for. Industrial life had gone on without them for several years and they had been replaced.

The British set up resettlement camps intended to gradually prepare the former prisoner of war to assume his various roles. Length of stay in a resettlement camp averaged four or five weeks. The individual passed through four phases, 1, learning about and testing out the unit, 2, establishing himself within it, 3, orienting himself to the surrounding industrial and social community and 4, making and reality testing personal plans. These were all phases calculated to accomplish social reconnection with the home society. The socialized adult usually belongs to a family group, a work group and an informal group of leisure time friends. Repatriates were prepared to assume roles in prototypes of these groups.

The first few days were spent in adjusting the individual to his dormitory, meals and to the group with whom he was to stay in the resettlement camp. On Saturday morning, he selected civilian clothes which he wore home, weekends being spent at home to avoid damage to new social roots in the home environment and to keep alive problems related to future planning. Thus, he was introduced to his family roles on weekends, in a relatively ideal setting. At these times he had no anxiety about his work situation and was fairly secure in knowing that he had a place to return to and could face these family roles without anxieties. After one week the individual was taken to an employment exchange and then to a factory. During this first week the men were occupied inside the unit attending workshops and informational discussions. They took part in the social life which included dances attended by civilians, particularly girls from the neighborhood who did much to diminish exaggerated fears of women. By the second week they were visiting factory shops, training centers and social organizations in small groups. During the third and fourth week assignments became more individual. Men undertook job rehearsals, spending several days acquiring the feel of the job, without the burden of responsibility. Personal problems were discussed with the specialist staff, the vocational anxieties being usually brought out before those concerned with family relations. Many of these latter anxieties first appeared in the guise of job problems. As Civil Resettlement units matured they passed generally from being employment dominant to becoming family dominant and wives and families were more fully brought into activities and discussions. Although no role training was given in family, community, or occupational roles, each individual was introduced to these roles one at a time, and furthermore was given an opportunity to discuss the roles in groups with trained psychologists and psychiatrists. A group of persons treated at Civil Resettlement units, when compared with a control group showed significant differences in family, occupational, and community adjustment.

A Role Training Program as Preparation for Release on Parole (3)

While there may be many personality and character differences between repatriated prisoners of war and men released from correctional institutions, problems relating to social reconnection are essentially similar. Hypothesizing that the administration of a Role Training Program to inmates of a prison would result in certain attitudinal and behavioral changes, Haskell undertook to study the effect of such a program. In 1956, he conducted

an experiment at Riker's Island Penitentiary in New York City during which he directed, as preparation for release on parole, fifteen role training sessions in occupational, family and community roles. When compared with a control group it was found that the group receiving the training showed significant improvement in role playing ability, a measure of social skill which probably includes creativity, spontaneity, and empathy, as well as in attitudes toward conformity to general social values. The program was administered in the prison although ideally it should have been administered in a half-way house outside the prison so that the inmate could face his new roles and meet the demands of new situations one at a time.

From July 1957 until July 1960, the author as Placement Director of Berkshire Farm for Boys, administered an after-care program which emphasized role training, job placement, and help with family and community relationships. Those not going to school were role trained in occupational roles and given assistance in finding jobs. Quarters were found for those who could not live with their families and all were provided role training in family and community roles. Of the seventy boys involved in this program ten were recommitted by courts during the three year period. The recidivist rate attained is considered low by those who work in the field of corrections and can be in part attributed to the role training program. A social reconnection center, however, by providing a sheltered environment, would have made the transition from full residence to community life much safer (1).

A Role Training Program for Social Reconnection

In the United States no large scale effort of social reconnection for inmates of correctional institutions has yet been attempted. Ideally, a building in a city should be designated a social reconnection center for persons returning from correctional institutions. After a few days of indoctrination, the individuals could be introduced into occupational roles. Role training would be furnished in the roles of job-applicant, fellow-worker, worker-foreman, worker-employer, and worker-union and the individual would then be sent out to seek employment. As soon as he found employment, he would have an opportunity to continue his role training in occupational roles until he was satisfied that he understood all of the relationships on his job. He could then be introduced to the significant family roles in role training sessions. Simultaneously with the role training he could resume meetings with members of his family, either by visits or at social functions. The individual without family ties could benefit by role training

in family roles and could be introduced to more normal social relationships with others, including members of the opposite sex. This could be accomplished at social functions at the social reconnection center. While the individual was working he would continue to live at the center getting training in family roles and community roles until he would be eventually re-introduced into the community. For those with families the transition would probably be to the family home. For those without families, the transition would be to rented quarters. In each case, the transition to normal community roles, family roles and occupational roles would be a gradual one and role training would accompany each change. Role enactment would clarify each problem as it arose.

It is anticipated that a very large percentage would have found work by the twentieth day of the program and would actually have worked for two weeks while at the reconnection center. Thus, these people would return to their families as employed persons with an income. They would also have been role trained in family, community and occupational roles over a period of time. This would have afforded them an opportunity to learn each role and act in each role with a minimum of stress. Thus, persons who were poorly adjusted to society prior to going to prison as well as those persons who had become desocialized at such an institution would have an opportunity for social reconnection. While it is possible that some resocialization may take place within the prison walls most prison administrators would agree that the roles in which the inmate function are so vastly different from the roles in which he is required to function in a competitive society that some transitional stage is essential if the individual is to succeed outside the prison.

A social reconnection program provides a bridge between institutionalization and the free competitive society. It is essential. What is amazing is that it has been so long neglected. The role training program that has been outlined above has been tried experimentally in a correctional institution. It has also been tried with persons outside a correctional institution. Inmates and parolees accept it, participate in it and learn in the course of it. The experiment at Riker's Island demonstrated that there was a significant amount of learning taking place, tests showing significant increase in role playing ability and in attitudes favoring conformity to general social values. If we are to release people to the community and expect them to function in social roles we should provide them training in those roles and the ideal place to provide this training is in a social reconnection center where men can meet each role one at a time and be prepared for future roles in role train-

ing sessions. The cost of maintaining a social reconnection center in any city would be a fraction of the amount required to build and maintain another minimum or maximum security installation. Furthermore, the therapeutic effect of a maximum or medium security installation must be supplemented by an effective program of social reconnection, if recidivism is to be reduced.

BIBLIOGRAPHY

1. HASKELL, MARTIN R., Role Training and Job Placement of Adolescent Delinquents: The Berkshire Farm After-Care Program *Group Psychotherapy*, September 1959.
2. HASKELL, MARTIN R., The Relationship of Changes in Role Playing Ability to Changes in Certain Social Values. Unpublished Ph.D. Thesis, *New York University*, 1957.
3. HASKELL, MARTIN R. AND H. ASHLEY WEEKS, Role Training as Preparation for Release from a Correctional Institution. *The Journal of Criminal Law, Criminology and Police Science,* January 1960.
4. OHLIN, LLOYD E., *Sociology and the Field of Corrections,* Russell Sage Foundation, New York 1956.
5. MORENO, J. L., *Psychodrama Vol. I, 1946 and Psychodrama Vol. II, 1958,* Beacon House, Beacon, N. Y.
6. MORENO, J. L., *"Who Shall Survive?",* 1953, Beacon House, Beacon, N. Y.
7. WILSON, A. T. M., E. L. TRIST, AND ADAM CURLE, Transitional Communities and Social Reconnection: A Study of the Civil Resettlement of British Prisoners of War. in Swanson, Guy E., Theodore M. Newcomb and Eugene L. Hartley (Editors); *Readings in Social Psychology.* New York, Henry Holt and Company, *1952.*

A THIRTY DAY ROLE TRAINING PROGRAM AT A SOCIAL RECONNECTION CENTER

Day	A.M.	P.M.	Evening
1. Wednesday	Orientation Tour Get Acquainted Time	Room Assignments Based on Sociometric Choice	Session Introduction to Role Training
2. Thursday	Housekeeping*	Role Training in Role of Job Seeker	Group Discussion
3. Friday	Housekeeping	Role Training in Meeting Family	Social Dance (Relatives may be invited)
4. Saturday	Housekeeping	Role Training in Meeting Family and Friends	Social Activity with Visiting Friends, Family
5. Sunday	Church (Voluntarily)	Visitors Invited	Film
6. Monday	Housekeeping	Role Training in Role of Job Applicant	Group Discussion
7. Tuesday	Housekeeping	Role Training in Worker-Foreman Relationships	Group Discussion
8. Wednesday	Housekeeping	Role Training in Worker-Worker Relationships	Recreation
9. Thursday	Housekeeping	Role Training in Worker-Employer Relationships and Job Applicant	Group Discussion
10. Friday	Housekeeping	Rule Training in Family Roles	Weekend Home
11. Saturday 12. Sunday	Weekend Home		

* Since most of the housekeeping at the reconnection center would be performed by the residents, the group would be divided into morning and afternoon housekeeping groups. Role training sessions would be given in the morning or afternoon in coordination with housekeeping assignments.

A THIRTY DAY ROLE TRAINING PROGRAM AT A SOCIAL RECONNECTION CENTER (*Continued*)

	Day	A.M.	P.M.	Evening
13.	Monday	Housekeeping	Role Training in Occupational Roles	Sociometric Choice of Roommate (Move)
14.	Tuesday	New York State Employment		Role Training in Occupational Roles
15.	Wednesday	New York State Employment		Role Training in Occupational Roles
16.	Thursday	New York State Employment		Role Training in Occupational Roles
17.	Friday	New York State Employment		Weekend Home
18.	Saturday	Weekend Home		
19.	Sunday			Weekend Home
20.	Monday	Employment Seeking		Role Training in Family Roles
21.	Tuesday	Employment Seeking		Role Training in Family Roles
22.	Wednesday	Employment Seeking		Recreational Program
23.	Thursday	Employment Seeking		Role Training in Family Roles
24.	Friday	Employment Seeking		Weekend Home
25.	Saturday	Weekend Home		
26.	Sunday			Weekend Home
27.	Monday	Employment Seeking		Role Training in Community Roles (Education)
28.	Tuesday	Employment Seeking		Role Training in Community Roles (Parole Officer)
29.	Wednesday	Employment Seeking		Role Training in Community Roles
30.	Thursday	Employment Seeking		Role Training in Community Roles
31.	Friday	Discharge date for those who were employed and had a place to live.		

IDEOLOGY AND SOCIOMETRIC POSITION*

HILARY A. GOLD, PH.D.
Teachers College, Columbia University

The Problem

A recent investigation has attempted to discover whether the ideology of classroom teachers—of children's classroom leaders—and of children in classroom situations—evidences a relationship that is sociometrically discernable.[1] Ideology is hereby defined as "an organization of opinions, attitudes, and values—a way of thinking about man and society,"[2] that an individual possesses. The research referred to, specifically studied the ideology of the formal classroom leader, the teacher, in an effort to determine whether his ideological frame of reference—measured on a continuum ranging from socially integrative to dominative patterns of thinking—is a variable in the determination of leaders and isolates within classroom settings.

This research, furthermore, studied the ideology of those individual children comprising the classroom group, and compared their ways of thinking with the predominant ideology of the teacher—in an effort to discover whether the psychological environment fostered by the classroom teacher is related to (1) the selection of leaders by the children; and (2) the isolates . . . the number of children with whom the class as a whole indicated they did not wish to associate.

Area of Investigation

The responses of the fifth grade children and teachers of a school district, located in a suburban community on the outskirts of New York City, comprised the basic data of this investigation. Thus, a total of 919 children, together with their 30 classroom teachers, distributed in seven, separate school buildings, participated in this study.

It is important to observe, at the outset, that the school district housing this project has what is generally considered "a good school program." Academic results as measured by achievement tests are relatively high; the

---

* Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, New York, March 24, 1961.

[1] Hilary A. Gold, "Ideology, Leadership and Isolation in Classroom Situations," doctoral dissertation, Teachers College, Columbia University, 1960.

[2] T. W. Adorno, *et al., The Authoritarian Personality* (New York: Harper & Brothers, 1950), p. 2.

total district, as evaluated in a Metropolitan School Study Council research, is also superior.

Instruments

The instrument used to obtain a measure of the predominant pattern of thinking of the individual classroom teachers was Adorno's F Scale.[3] Responses to the F Scale indicated that the thirty classroom teachers studied, scored within a range of 1.53-5.36, with a mean score of 3.23. In addition a standard deviation of .94 was obtained. This, it is felt, compares favorably to the range of 1.4-3.9 and standard deviation of .90 received by Adorno and his colleagues when studying a larger group of 449 individuals.

The children participating in this study completed a series of sociometric questions intended to give an indication of their roles in the classroom, and a questionnaire designed to provide a measure of their predominant pattern of thinking-along a continuum ranging from socially integrative to dominative ideologies.

A series of five sociograms was decided upon as the instrument to locate the children who are the children's classroom leaders. By including questions referring to the children's social desires this instrument was able to locate, in addition, those children who may be considered as isolates within the classroom group. The importance of this approach, in the writer's opinion is that the children in each classroom group are able to express themselves in terms of their own wishes for leadership and association; indirectly, therefore, their needs and values may be inferred.

The three children placing at the highest extreme of the combined rankings resulting from the sociometric questions—which were scored by assigning differential weights according to the order of choice preference —were selected as the leaders of their particular classroom. Thus, in an attempt to recognize that leadership is a relative process, those children who are more often than not selected by their peers for positions of group responsibility were defined as the children's classroom leaders. Those children who did not receive any choices indicating a desire for positive association—whose total score on the combined rankings was zero—were regarded as the classroom isolates. The term isolate, therefore, is used to connote the statue given by the members of the classroom group, as a whole, to those individuals with whom they do not choose to associate. It in no way indicates that these "unchosen" children are isolated of their own accord.

---

[3] *Ibid.*, pp. 255-257.

Findings

Ideology and leadership. A clear cut, statistically significant,[4] relationship was discovered between the ideological pattern possessed by those children selected by their peers for leadership roles within the classroom, and the fifth grade faculty of an individual school building. In contrast to this, however, no significant relationships were evidenced at the individual classroom level. In other words, whereas the normative ideology of a representative sampling of the faculty in an individual school building was shown to be related to the sociometric position of children's classroom leaders—the ideology of an individual classroom teacher was not shown to be related to the sociometric position of the leaders in his own classroom unit.

This is not so surprising when one considers the unique tone or climate that is often recognizable within a school building. Similarly, the responses of the faculty in the seven school buildings studied, revealed distinctive, and sometimes vastly different, patterns of thinking from school building to school building. The recent research of Jacob on changing values in college offers a related and interesting perspective to these findings.[5] Jacob found that with few, individual, exceptions the impact of college instructors—even in courses in social science—was negative, in terms of changing student patterns of value during college. He did find, however, that a combination of factors observable by looking at whole colleges, rather than at educational influences in isolation, could produce a distinctive institutional atmosphere—a climate of values—in which students were decidedly influenced. This finding, furthermore, appears related to Newcomb's study on attitude development at Bennington.[6] Here Newcomb states that in "a membership group in which certain attitudes are approved (i.e., held by majorities, and conspicuously so by leaders), individuals acquire the approved attitudes to the extent that the membership group (particularly as symbolized by leaders and dominant sub-groups) serves as a positive point of reference."[7]

The data previously presented appear to indicate that, in the population studied, those children selected by their peers for leadership roles within the

[4] A coefficient of correlation of .82, statistically significant at the .01 level was evidenced.

[5] Philip E. Jacob, *Changing Values in College* (New York: Harper & Brothers, 1957), 174 pp.

[6] Theodore M. Newcomb, "Attitude Development as a Function of Reference Groups: The Bennington Study," in Eleanor E. Maccoby, Theodore M. Newcomb, and Eugene L. Hartley, eds., *Readings in Social Psychology* (New York: Henry Holt And Company, 1958), pp. 265-275.

[7] *Ibid.*, p. 265.

classroom, may hold the pattern of thinking possessed by the building faculty as a reference criterion: therefore, sociometric position is, to some extent, influenced by the prevailing normative ideology of a school building.

An additional factor of possible influence in the sociometric position of children selected for leadership roles was also revealed. A comparison of the patterns of thinking possessed by the leaders with the patterns of thinking possessed by the other pupils in their classroom units, indicated that the leaders possessed ideologies that were more socially-integrative than their peers. Thus, the data indicate that children with ideological predispositions towards socially-integrative behavior were generally found to be the leaders in their classroom groups. As Jennings has previously said: "Leadership appears to reside in the inter-personal contribution of which the individual becomes capable in a specific setting eliciting such contribution from him."[8]

Ideology and Isolation. I now come, to what is, in my own mind, the most significant finding with reference to ideology and sociometric position in classroom situations: the relationship between the ideology of classroom teachers and the percentage of children in an individual classroom who are isolates.

Through the sociometric techniques previously described, it was discovered that of the 919 children participating in this study, 72 were isolates. Percentages of children who were isolates in an individual classroom ranged from zero per cent to 19 per cent. This, in itself, is both revealing and disheartening.

Data, statistically significant at the .0005 level, support the conclusion that the relative number of isolates within a classroom group is theoretically increased when the ideology of the classroom teacher is predominantly dominative. In other words, when the individual teacher scores on the F Scale were ranked and arranged on a continuum ranging from socially integrative to dominative ideological patterns of thinking, it was readily apparent that those teachers whose scores on the F Scale were above the median of the group studied—had the greatest percentage of isolates within their classrooms.

It should be noted, also, that of the thirty classroom units studied, only two did not evidence any children who may be termed isolates. In both of these cases the classroom teachers scored below the first quartile of the ranked teacher scores resulting from the administration of the F Scale.

In discussing the relationship of ideology and leadership, it was previ-

[8] Helen Hall Jennings, *Leadership And Isolation* (New York: Longmans, Green and Co., 2nd Edit., 1950), p. 205.

ously mentioned that those children chosen by their peers for positions of classroom leadership were more socially-integrative in their thinking than their classmates. The converse of this was discovered with reference to the ideological frame of reference of the isolate. Thus, 79 per cent of the isolates located in this research were found to possess more dominative—or in other words—less socially-integrative—patterns of thinking than their peers. It is important to recognize, however, that the isolates, as the leaders, do not differ markedly from the ideological pattern exhibited by the pupils in their classrooms. In no cases did the isolates, nor the leaders, score more than two standard deviations above or below the mean score of the pupils in their classrooms.

Summary and Conclusions

To summarize the relationships evidenced between ideology and sociometric position in classroom situations, data from one investigation indicate that such a relationship does exist—to a statistically significant degree. This paper has breifly described how data indicating that children with ideological predispositions towards socially-integrative behavior were generally found to be the leaders in their classroom groups. In addition, an ideological similarity between these leaders and representatives of a school building faculty—providing a specific setting eliciting leadership contribution from them—was observable.

The data obtained with reference to ideology and isolation within classroom situations appear to indicate that the classroom teacher possessing a dominative ideology, fosters isolation. In addition, evidence supportive of Jennings' finding that isolation appears as the opposite extreme to leadership on "the continuum of inter-personal sensitivity between the members of the group and the individual"[9] was found.

It may be assumed that the classroom teacher fosters a psychological climate within the classroom setting. This climate, in the case of teachers possessing dominative ideological patterns of thinking, appears not conducive to: (1) eliciting the interpersonal contributions of those children possessing relatively less socially integrative patterns of thinking than their peers, and (2) developing the interpersonal relationships which the members of the classroom group are capable of making with one another.

Thus, I offer for your consideration, that ideology, the predominant pattern of thinking with which children and teachers veiw their world, is an additional dimension to be considered in observing, evaluating, and interpreting, sociometric position in classroom situations.

[9] *Ibid.*

ROLE-PLAYING

A Useful Tool in Understanding the Impact of Industrial Automation on the Displaced Worker

Jerry M. Rosenberg

Mayor's Conference on Youth Employment, New York City

The number of jobless in February, 1961, reached 5,700,000. It is the highest rate and number of workers in this category since unemployment insurance started in 1938.

As an example of a depressed state, we might cite the case of West Virginia. Though its population dropped 7.9 per cent in the last decade to 1,800,000, there are 70,000 receiving unemployment compensation and many more have exhausted their benefits. About 15 per cent of West Virginia's population is receiving surplus food from the Federal Government. The Kanawha County is an example of how automation has taken jobs from mines, where a fifty per cent drop in mine employment meant a production loss of only 1.5 per cent.

It may be true that technological improvements are most likely to be introduced when the economic atmosphere is at least able to provide for the adjustments made necessary by change. Consequently, during a period of stable employment, the worker's ability to resist changes may be high, thus slowing up or postponing the introduction of new machines.

During a period of high unemployment, as we experience today, management may be more successful in the introduction of automated equipment. One reason for this is that unions are weaker during this period of adjustment. Thus, we should realize, not only that automation creates special problems in our labor market today, but also that the high rate of unemployment should encourage its further development.

In the past, role-playing has been successful in various areas of industrial rehabilitation. The literature reveals how worthy this tool has been in union-management strife, employee conflicts, and reactions to threats of displacement.

Any technique, to be of lasting value, must adjust to the social requirements of the community. Various approaches since the first of February, 1961, have been considered to help reduce the high unemployment statistic. Acknowledging the progress in Congress to relieve the tension among the jobless, the followers of role-playing can join the ranks of the researchers and be of service to help ease the plight of the displaced.

Those who are experienced in using this approach might seriously

consider how it can be applied to explore the various ways to get the worker off the "bread line" and back on the job.

The Kennedy Administration attacks the problem of chronic depression on four main fronts:

a. it would double the distribution of surplus food,
b. it would provide about $400 million in grants and low interest loans to communities to build new plants,
c. it would provide funds to extend unemployment compensation for those who have exhausted their benefits under state law, and
d. it would set up a program of public works to create new jobs.

These proposals have been suggested as an economic precaution to increased displacement. Might it not be as important to look at the social-psychological aspects of technological unemployment and evaluate using role-playing, potential methods to get the employee back to his machine, taking into account individual needs, frustrations, and aspirations? Displaced workers can release their feelings before teams composed of their fellow-workers, union officials, members of management and government agencies, and vice versa. Realistic responses may pave the way towards an eventual program of rehabilitation for all concerned. How each person reacts to a suggested way of helping the displaced is as important as the solution itself.

The concept "role-playing" is a simple one. It provides the participant with an insight into another person's point of view by having the player act out the other person's part.

Even though this technique will not get the worker back on the job, it will serve as a means for the jobless and the employed to explore the present situation and examine individual and group reaction towards the methods of solution. In addition to the proposals before Congress, it is necessary to witness how people will react to other alternative solutions, which are more individual in nature.

For each approach stated below, role-playing can be employed in several ways:

1. With the aid of private or public funds, teams of high officials from the government, unions, and industry are organized. These participants should be involved with the problems of automation on the workforce. A situation might be created whereby a displaced worker is standing on a line for his monthly supply of surplus food. A discussion emerges with other displaced workers. In the role-playing techinique, representatives

from management, the unions, and government can act out the part of the displaced, expressing their feelings towards their plight and what might be done to help them. Each of the approaches along with those of the Kennedy Administration can be discussed and disputed.

2. On a smaller scale, a group of unemployed workers, representatives from business, union leaders or government officials could independently role-play expressing each viewpoint as they change character.

Once the groups experience the problems of the unemployed, a clearer appreciation of what to do might be available. Approaches that were at first thought sound, might require changes.

Below are eight guides that can be examined, using the technique of role-playing, as additional approaches to getting the jobless on a work schedule.

1. *Retraining*—You equip old employees working on obsolete equipment to run the new equipment.

This may be easier stated than accomplished. What of interests and skills? Are the displaced able to be retrained? What about the age factor in readjusting to a schoolboy situation? Should it be "in" or "out" department training?

As important, what do we retrain for? We must be careful not to retrain for positions that will soon become obsolute.

2. *Transfer*—You move employees to other departments or to different operations.

There are additional problems to be discussed. Group structure may change. The level of job satisfaction may be greatly altered. A new operation may imply a new way of life.

3. *Placement outside the company*—In some cases, personnel departments have been able to arrange for neighboring companies to take on their displaced personnel.

Reaction to this might focus itself towards the problems created by movement from one region of the country to another.

4. *Job re-assignment*—By a rather extensive re-education and retraining program, displaced workers are suited for completely different jobs from those previously held.

Similar to the *Retraining* approach, this requires a complete alteration in work habits. For some, they may look upon this as a chance to get interested in a form of work never before experienced. For others, such a drastic change may be very threatening.

5. *Placement in newly developed fields*—Specialized equipment will not only change the patterns of the existing jobs, but will usher in entirely new fields of work.

Additional problems will warrant consideration. Will these new jobs require a higher level of skill? Will those displaced be called upon to fill these positions or will workers be called in to take over these new openings in sales, programming and operating automatic equipment.

6. *Jobs created by new products*—The age of automation and nucleonics will lead to the development of entirely new products and thus result in increased employment.

Just as synthetics and plastics became a billion dollar business, additional products will emerge as a result of automation.

Once again the concern is, who will be employed, new persons or the displaced? What will the reaction be of the jobless towards a shift in style and tempo of work.

7. *Accelerated retirement*—By lowering the age requirement for a pension, older workers may be content to retire.

This is not new for role-playing. The perennial question—Does a man retire to life or from life? What of the workers who have spent 35 years in a factory? Now he is told to go out and enjoy himself. What to do is the problem for many.

8. *Shorter working periods*—By reducing the working period, more workers will be needed to keep production going at its former rate.

In addition to the problems this produces by way of reducing our rate of production, how will the unemployed react to this alternative? Will they be overjoyed with the possibilities of increased leisure or will they react to this by seeking a second job to supplement their weekly income?

Mechanization has resulted in a new way of life, replete with its destructive and constructive functions. With each unemployed worker, industry undoes the good and gains of technological progress. The solution over the years is not free food. It is work. Work based on a national plan to restore our economy. Work based on individual needs.

The technique of role-playing can serve in this area by working with the jobless and helping management, unions and the government understand what internal changes unemployment creates for the worker. Similarly, it may indicate how the displaced will cope with any future plans for getting off the bread line and back on the wage earning line.

NOTE ON A PROJECTIVE TECHNIQUE FOR STUDYING GROUP DYNAMICS

WILLIAM W. MICHAUX

Veterans Administration, Washington, D.C.

The technique to be described is a modified sentence completion method which yields material for the diagnostic study of groups rather than of individuals. In effect, the group both composes and takes its own chain sentence completion test; each member contributes one completion and then composes a stem to be completed by another member. Although validation studies are yet to be done, the technique in its present state appears promising as a tool for research in group dynamics.

The materials needed are enough sheets of paper to accommodate one written sentence per group member. The sheets are stapled together in booklet or tablet format with a face sheet bearing the following instructions:

"1. Complete the last sentence below.

"2. Immediately following that, write the beginning, but not the ending, of another sentence. Leave the ending blank so that the next person can fill it in.

"3. Then pass the paper on to anyone else who has not already had it.

"4. After each person in the group has had a turn, the last person to get the paper should return it to the examiner."

In starting the paper on its rounds, the examiner must single out one member and ask him to write the opening stem. (If focus on some particular topic is wanted, the examiner may anounce the chosen subject matter and supply the first stem himself.) While the test is under way, the group may, if desired, keep busy with some other non-distracting task such as written work or silent study. The stem written by the last member participating may be completed by the writer of the opening stem, or if preferable may simply be deleted. The sequence in which members participate can be controlled by a prearranged order if this is needed for experimental purposes. To obtain longer protocols (e.g. from smaller groups), the entire round robin may be repeated, giving each member two or more turns.

The technique is adaptable also to "unassembled" groups such as social cliques or patients on a hospital ward. For such situations the instructions and administration should be modified to suit the circumstances. For example, a list of members' names may be included in the form of a routing scheme,

so that each member, after taking his turn, crosses out his name and passes the paper on to another participant.

The obtained response material will be subject to whatever kind of analysis is called for by the nature of the research problem and the design of the experiment. In general, the most plausible analytic methods will probably be either psycholinguistic or projective. Conceivably, after thorough trial in research, the technique may prove useful in both diagnostic and therapeutic work with groups. In a group psychotherapy setting, the material could be fed back to the group either orally or in writing (one copy to each member).

Considered as a potential projective test, the technique appears to encourage candid expression by permitting considerable relaxation of surface defenses. No one contributor need feel personally accountable for a complete statement because no single individual actually produces one. The following sample is excerpted from the protocol given by a large mental hygiene clinic's professional staff:

"Getting back to the subject of the clinic, in it there is an interesting subculture in which/the foibles of the human race are laid bare. Yet we can see a definite/trend towards improvement. Since that is the case,/should we not do whatever is necessary to keep our foibles bare? For we are/as barren a group as ever assembled, and who would know better/than we? However, being aware of this barrenness, we are in a position/to pick each others' brains without fear of stealing anything. There remains the possibility, however, that the brains of our patients/are already stolen. If we cannot steal the unstealable then we must/find some more fruitful occupation. Or perhaps we could go on to/a more productive phase governed by the method of task orientation and the goal might be the patients' benefit. In order to accomplish only a little of that we/must proceed with concentrated effort. It would seem that unless we do,/we will fade away into the twilight of interpersonal decadence."

OUTLINE OF GROUP PSYCHOTHERAPY FOR JUVENILE DELINQUENTS AND CRIMINAL OFFENDERS*

Robert P. Odenwald, M.D.

Catholic University of America, Washington, D.C.

The theory of punishment popularly accepted in our society is that the wrongdoer is punished; (1) to reform or rehabilitate him; (2) to protect society; and (3) for the purpose of deterring the person involved or others from engaging in similar criminal activity.

The first element of this theory is tested by the question, does punishment in the form of confinement really help criminals to reform or to be rehabilitated? Do they come out of confinement after serving their terms as better persons? It is indeed doubtful whether this purpose is ever achieved.

As regards the protection of society, I am ready to admit that society is entitled to live in peace and tranquility and to be protected from those who have committed asocial or antisocial acts, and who are likely to do so again. But, in my view, society receives better protection if the criminal is confined where he can receive psychiatric treatment leading to the improvement or cure of the condition or state that helped to make him an offender in the in the first place.

As for the element of deterring the evil-doers statistics show that two-thirds of all those confined in penal institutions are repeaters and chronic offenders. And one needs but put the question as to whether crime is dying out—to have the answer.

In summary, then, we have statistical evidence to prove that our present-day forms of punishment for crime simply do not achieve the purposes for which they ostensibly exist. Such punishments were never effective for the purpose of rehabilitation. The psychiatrist's concern, and his only concern, is to deal preventively, diagnostically and remedially with the behavior of human beings which reflects any malfunction of their mental or emotional life.

Group psychotherapy seems to be an excellent medium of helping juvenile delinquents and criminal offenders to be rehabilitated. As these subjects—generally speaking—attack society or a group, the advantage of group psychotherapy is evident.

---

* Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, New York, March 25, 1961.

In this short paper, I just want to mention, that juvenile delinquency exists—I don't want to underestimate its impact on society, or society's impact on it. I maintain that much delinquency, if it is recognized early and adequately treated, whether by the psychologist, the psychiatric social worker, or the psychiatrist, can be cured. Let us bear in mind that adolescence is the age of delinquency par excellence, the period of anti-social acts, major or minor. Most youngsters and teenagers live through this daring age, when running away from a cop is exciting fun, without any serious implications. They may desire to steal for the thrill, perhaps an apple from the fruit stand, or a trinket, or a little cash from parents or friends. As a young teenager, he may not be held responsible; punishment for his wrong-doing may be left to the parents. However, if the offense is more serious or the parents inadequate, society "punishes" the adolescent by sending him to a reformatory.

But as I have already pointed out any lasting reform from such a "reformatory," is more than doubtful. More likely it is that the boy will be discharged even worse than he was before; in the institution, his environment may have consisted of seasoned criminally-minded juveniles who served as leaders.

Group psychotherapy for reformatories should have first place in penal therapy. Knowing the unfortunate fact of inadequate funds and a lack of psychiatric personnel, let me modestly suggest that there should be a team of a psychiatrist, a psychologist and a psychiatric social worker for at least 100 juveniles in a reformatory home. They could be divided in groups of 10 to 20 inhabitants, according to age and I mean here not only chronological, but mental and emotional age. They could be seen 3 times weekly by a psychiatrist and his team—one day by the social worker, one day by the psychologist or psychiatrist. The rest of the time could be used for psychological tests—by social work study and by personal psychiatric evaluation.

I am well aware of the shortcomings of this plan, but it would be at least a beginning.

Viewed from the basis of mental health or illness, criminals are classified into four groups: (1) the psychotic; (2) the psychopathic; (3) psychoneurotic, and (4) the so-called "normal" criminal. What should be done with them depends on the group to which they belong.

About the psychotic wrong-doer, there is not much to say. He is seriously ill, and requires incarceration, not in a prison for a specific term, but in an institution for psychiatric treatment as long as this is indicated.

The psychopathic group is probably the one most difficult to under-

stand. The question has even been raised whether this group properly belongs in the category of mental disease. It is a group not easy to define, and such various terms have been used to designate the conditions as: moral insanity, psychopathic inferiority, or sociopathy. The psychopath is in a constant struggle against his environment, much as a trapped animal struggles to escape from the cage or trap that confines him.

Psychoneurotics may suffer from maladjustments, anxieties, shyness, phobias, compulsions, or obsessions. Their condition may bring on such functional disorders as disturbances of vision, speech, or hearing, respiratory ailments, stomach and intestinal disorders, convulsions. Kleptomaniacs and pyromaniacs fall within this group.

Sexual offenders are a special class of wrong-doers among psychoneurotics, who owe their criminality to a specific kind of personality. It is well known that a sexual offender may get a jail term of six months for his sexual wrong-doing, and that that will not prevent him from committing the same or a similar crime later on; more and more judges are today asking that minor sex offenders, such as exhibitionists and homosexuals, on a first offense, should undergo psychiatric treatment instead of being sentenced to jail.

Many of those who commit serious sex crimes are very sick people, whom the layman may well regard as "degenerates." With no control over their strong sexual impulses, these sexual psychopaths commit the same serious crime time and time again if they are let loose in society.

In this class of psychoneurotics belong also the alcoholics, people who, in my opinion, are mentally sick. Yet the law, in classifying intoxication as a legal offense, has, to a certain extent, removed the alcoholic from treatment by the physician.

Of most interest, however, is that vast army of wrong-doers who do not fit into any of the above-mentioned groups—they cannot be considered psychotic, psychopathic or psychoneurotic.

If we examine the past history of any one of these wrong-doers, we are apt to come upon hereditary factors which point only to the individual's capacity to commit a lawless act under certain circumstances. Today hereditary factors are regarded as being of minor importance in the causation of crime. It would appear that the environment is of far greater importance. Thus, we find bad childhood influences, disturbed family conditions, broken homes, drunken parents, immoral behavior, parents who emotionally reject their children although they may not go as far as sending their children to foster homes or institutions, as some do. Generally, although not always,

there is a poor economic background; in the immediate background there may be prostitutes, gamblers, professional criminals and underworld figures of one sort or another.

The protection of society is indeed a worthy objective. Here is a young first offender, tried, sentenced to jail, let us say for six months. The chances are that he comes out, only to return to further wrong-doing. Had the need for psychiatric group treatment been understood, he might have been committed to a mental institution on an indefinite basis. Perhaps his treatment would last from 2 to 4 years until he could be regarded as rehabilitated and ready to return to society. Is this not a better way to protect society than to prescribe "punishment" at the end of which, with every likelihood, he will return to commit the same crime, or an even worse one?

Instead of penalty, let us have rehabilitation, let us have psychiatric treatment, let us have group psychotherapy.

A group of a psychiatric team—a psychiatrist, psychologist and psychiatric social worker for 250 inmates of a penal institution could be of enormous help and value. Such a team could save the state and society enormous sums of money, rehabilitate valuable personalities and contribute to the humanitarian and sociological aspects of the United States.

I do not wish to imply that the work of psychiatrists with offenders will be a panacea for every criminal. But I am confident it will reduce repetition of crimes by fully one-half or more. I further believe that even greater success would be achieved by psychiatric group treatment of juvenile delinquents in the early stages of their delinquency.

The psychiatrist who functions in the penal institution is rather a new undertaking, but in my opinion, has already so well proved his worth that I consider it unfortunate that there are not more psychiatrists in such places. The prison official and the psychiatrist appear at times to interfere with the efficiency of each other. Wrong-doers in the past have been primarily punished by loss of freedom. The new idea is to reform them by educational, religious, social work and psychiatric methods. With the use of these newer professional workers and such techniques as group psychotherapy, the notion that punishment alone is the remedy of crime, fortunately is losing ground.

NOTE ON PSYCHODRAMA OF THE BLIND

J. L. MORENO, M.D.

Moreno Institute, Beacon, N.Y.

The question has been raised whether psychodrama of the blind is possible, due to the lack of physical mobility on the part of the blind. Therefore, a technique has to be invented which gives the imagination of the blind, physically and mentally, full rein. The "seeing eye" of a dog is commonly used by the blind for walking in the direction needed to cross streets or to enter doors. In psychodrama, an auxiliary ego should be assigned to every blind person; this auxiliary ego has to hold the blind by the hand and move into space with him as if they would be one. Physical contact is important as a psychological binder. The auxiliary ego accompanies the blind in all his actions, doubling and interacting with him. The auxiliary ego fulfills in this manner the function of the "seeing eye" on the psychological level; at the same time, an auxiliary ego "seeing eye" sits in the audience and reports to the group of blind patients what is happening before them, acting as their seeing eye. Thus, the various techniques such as the double, mirror, role reversal, etc., can be employed whenever required, enabling the blind to take full advantage of the psychodramatic method.

TRAINING STATE HOSPITAL PERSONNEL THROUGH PSYCHODRAMA AND SOCIOMETRY

ADALINE STARR AND ERNEST FOGEL, M.D.

Logansport State Hospital, Logansport, Ind.

When we think of a psychiatric hospital as a therapeutic community, we visualize ideally all the members of the staff as therapeutic agents to the patients and the patients as auxiliary egos to each other. This concept of rehabilitation has been a developing philosophy at our hospital for the past few years.

To establish this social climate requires considerable and constant communication: a wide variety of interpersonal contacts must meet and work cooperatively with each other in one way or another. In order to activate this program, we decided upon the plan of training the general hospital staff in the management of groups. Our principle objective is to give ward personnel a realistic and therapeutic role in patient care. There is, however, a hopeful expectancy that all the personnel of the hospital, industrial and recreational therapists, nurses and attendants, add new role-relationships to the patient and to each other as group director, group leader or group therapist, depending upon previous qualifications and talent.

The purpose of this paper is to outline a training program and briefly describe some of the sociometric processes and psychodramatic techniques used in a staff development program. This experience covers a years' work which began with six weekly workshops and continues to meet once a month.

As the staff moves from custodial to humanistic roles, guidance and training must be made available to them. It was felt that merely verbalizing the value of new attitudes and perceptions were not enough; the staff needed a chance to practice the handling of typical and unusual conflicts or ward problems and to select key situations which seem a requisite for understanding their role in the hospital. Psychodrama was selected as the method which potentially offered both action and analytic processes necessary to develop these skills. Sociometry formalizes a perception of group structure; according to Moreno "the lower the sociometric status of individuals, the more they are exposed to injury from powerful members and cliques of the group."* In effect then, we seek to help raise the sociometric score, not only of the patients, but also of the staff.

* J. L. Moreno, *Who Shall Survive?*, 1953, p. 763.

We began by inviting a psychodrama consultant to head this program. The general form of the six workshops was as follows: all the services of the hospital were invited to attend; the day was broken into four phases, namely a morning lecture, followed by a demonstration with patients; an afternoon demonstration with a group of patients, followed by role-playing with the staff audience. Usually an audience analyst was asked to use his own cues and perceptions to summarize the events of the patient-group demonstration. The attendance was high—about one hundred and sixty, with visitors from other state institutions present. The monthly workshop is restricted to existing and newly-formed patient groups and the ward personnel interested in the group. The goals of the program:

1. To provide a significant group experience for the ward personnel
2. To acquaint them with role-playing and sociometric techniques
3. To have them develop some skill in its application
4. To provide an opportunity to apply these skills in leading patient groups
5. As a result of this experience, it is to be hoped, that communication and interaction between staff members and patients will become more meaningful.

Sample procedure

The morning lecture dealt briefly with theoretical problems and a description of simple techniques: the spontaneity of the group, warming-up processes, sociometric testing, action analysis and production.

First Meeting — Orientation to Group Structure

The task at such a meeting was to discover the line-up of the staff toward participating in a group-oriented probram. A verbal sociometric test effectively revealed the following: the chief of nursing services had, since 1952, been managing groups of patients and had captured the interest of several nurses to carry out his program. The other nurses felt lacking in skill or training or time to join him. The head of AA enthusiastically welcomed the method for his group. The industrial therapist planned to utilize sociometric and psychodramatic techniques with his adolescent group. Others on the staff had experienced failure in group work and were discouraged with the process. One therapist felt psychoanalytically-oriented group therapy was of value, but had reservations about psychodrama. The superintendent hoped to alter and improve the staff's skill through process. The rest of the audience had not made a decision about the program. The director pointed out the attraction-repulsion-indifference pattern existing in the group in respect to this project.

At this point, the temptation is to draw a plot from the audience, but as will be indicated later, it is better to show the method with a group of patients. So the director points out the advantages of disclosing the group structure and suggests that with a patient group simple diagnostic tests can be made at the beginning of each session which are helpful in deciding on new patients to be invited into or eliminated from the group; the kinds of discussions which can be of value to them as well as patients problems and their relationship to hospital personnel. The demonstration with patients begins:

The objectives of the morning demonstration with a patient group were to present the staff with an experience of patient interaction in which each member of the audience could study the pattern of behavior as it was unfolding and to respond spontaneously to the protrayal of the action.

Demonstration With Adolescent Group

Twelve adolescents sit in a semi-circle as a front row of the audience. The director faces the group, and briefly describes group therapy and psychodrama, enlisting their aid in giving a demonstration. "Let's begin by introducing ourselves. I'll make a first choice. After our introductions are over, the one I've chosen will select someone he'd like to know better. Will you (pointing to a lively boy) come and sit beside me?"

The group silence broke. Each reacted to this request as if they were the called one, some laughed at the chosen boy, or teased him; others signalled their horror at facing the audience; three withdrawn boys "settled down" in isolation and didn't venture to look up. One overly courteous boy (a homosexual) nodded his approval. Most of the girls giggled. (The patients ranged in age from 14-18, all were court committed and came from farm communities, farms, or small cities in the State.) The group warmed up relatively fast, but were antagonistic to being cooperative.

The director turns his attention (since it is a training seminar) to the audience and explains the interaction to them. "A group of strangers present a task to the director, in any form of group therapy. Most people maintain strong defenses against revealing themselves and are anxious to conceal their felt inadequacies. Some do this by maintaining silence, others by clowning or by frankly expressing dislike of the situation. However, as an individual begins to trust the director and the group (the therapeutic integrity of the meeting) he warms up to the problem and becomes productive and cooperative." The group felt as if someone had come to its aid and responded adequately to the director. The boy came forward and

the director carefully asked of him the information he valued and so sets a model for the group to follow. The director steps down and explains his role to the group as listening carefully for cues which will lead to an enactment of the focal problem of the group.

At the conclusion of the patient interviewing, the director asks the audience-analyst to comment briefly on the observable behavior of the patients.

Audience-Analyst: It seemed to me that some of the intervees were spontaneously comfortable and others seemed to have difficulty in finding words to express themselves."

Director: (Back to the patient group) What do you think of this? Is there anything you'd like to add to this observation?

The session was underway. One of the boys commented that Kathy always acted thataway—sort of sat and waited to be coaxed—away from everyone. The director took the cue and asked to see that situation. Kathy refused, as was to be expected. The director asked someone else to be her, (mirror technique) allowing Kathy to watch and correct any failure of the acting. Kathy warmed up sufficiently to associate this to her family at home . . . nine siblings with a cross mother and a bossy father sitting around a dining table. They were a noisy lot and little Kathy was able to make her presence felt by quietly disappearing from the table. (Discussion of the role-playing by the patients ended their session.)

The audience-analysts again summarizes and provides an opportunity rarely given to ward personnel, to share the knowledge and experience of the vertical structure of the hospital. He invites the group to a discussion.

The director ends the session by explaining some of the techniques which had come out of the action. "The warming up process of the patient to psychodramatic action is effected by a variety of techniques-role reversal, soliloquy mirror, self presentation, double ego, auxiliary ego and role substitution—to the end that the patient is aroused to act—to be himself, to vividly portray his method of reaching for solutions to his life situation. In the above role substitution Kathy moved into action." As these demonstrations unfold and we see different kinds of patients, you will notice that some of the techniques for involving the patients are more stimulating than others. For the isolated patient—the double ego and mirror techniques are effective. It permits the auxiliary ego to show that someone accepts and understands him.

Afternoon Session

The second group of patients was presented as a warm-up to role-playing for the staff-audience. After the patient group was dismissed, the staff was broken into small groups and asked to re-create the life-situation depicted by the patient group and to conclude it. In our experience, at the beginning, participation of the staff in role playing is accomplished more easily when the situation to be enacted is not derived from their own life-situation. This device frees them from self-consciousness and enables them to work on the role-playing skills.

DEMONSTRATION WITH CHRONICALLY REGRESSED FEMALE PATIENTS

Fourteen female patients trailed into the room, conspicuously deteriorated, and seated themselves in the front row with their backs to the audience. The director made a special point of shaking hands with each of the patients and introducing herself to them individually. After briefly explaining the audience, the director asked each to identify herself by name. One patient, Betty, had taken three different names for herself. Someone in the group explained she keeps changing her name, minute by minute, and won't answer unless it's the name she's chosen at the time. The director lets the explanation pass without comment, almost as if "Well, doesn't everyone." "Let's call out the names we remember and people we know." (To the audience) This is another simple way to disclose the warming-up state of the individuals within the group. Some patients responded by being unable to call out any names; some called a few; but, Betty corrected any name designated as hers, and insisted on a different one. The director led this into a psychodramatic portrayal of the occasions when she feels like changing her name. At the end of which the audience-analyst called out—"What name would Betty select as the name she would respond to if she were assigned to the escort service?" "My good name—Betty!" She was placed on that service and made a fairly good adjustment.

The patients left the "stage" and the staff was asked to role-play some experiences with patients who play a role similar to Betty. This affords the members of the staff an opportunity to study their own ability to put themselves in the place of others and stimulate them to look at a situation in more than one way. Typical of the situations enacted by the staff were:

1. Getting a reluctant patient to the shower room

2. Coping with a restless patient who asks for cigarettes, milk and medication and other attention thru the night

3. Dealing with a spoon-swallowing patient

As the ward personnel became comfortable with role-playing as a learning method they began to deal with their hospital relationships to one another. Typical of these situations were:

1. The attendants' annoyance with the shift which leaves work undone 122. Attendants' aggravation with aides-in-training

3. A nurse fears the counselling session in which she must downgrade an attendant

4. The new ward nurse who works with the old-timer attendant who knows the patients and aligns them on his side by granting privileges against hospital regulations

And finally, the rest of the hospital employees were involved with the ward personnel in sessions which examined their relationship to each other and to the patients. Typical of the problems to be aired were:

1. Nurses felt Maintenance ignores their requests for physical changes on the ward.

2. Maintenance felt the change of Nurses on the ward meant a complete switch back to the way it had been before the request

3. The foreman of the industrial areas felt a lack of consideration of ward personnel in communicating whether a patient had been detained on the ward.

4. Industrial therapists felt the pressure of getting work done took precedence over the therapeutic value to the patient.

Many of the sessions are used to solve staff problems and others have been used as a way to increase the understanding of the patient population.

At present the consultant in psychodrama visits once a month—to revive a lagging interest in working with groups; and/or for further training and guiding the ward personnel in helpful group procedures, or to orient new hospital personnel to a group method.

The program is a blending of sociometric processes with psychodrama: sociograms of the adolescent group were made to meet some of acting-out of this group, and we feel has led to reassignments and the growth process of the patients. Nurses are being sociometrically assigned to therapy groups. The industrial areas—housekeeping, farming, all the areas of the hospital are willing to meet and work out problems of communication—of staff to staff and staff to patient.

Many aspects of this type of training program have been briefly dealt with, but the principal features of this method have been reviewed. The results of our experience seem to indicate that the total hospital personnel can be drawn into a therapeutic service and profit from it, but it requires a sustained program in training and the use of patient groups as instruction for the staff. We have further indicated that the expectation of becoming group leaders adds importance and worth in their work with patients. The subtlety of role-playing helper and helped, student and teacher, group leader and member can enlarge the role-range of the participating hospital population and lead to meaningful interaction.

SOCIODRAMA IN A CHURCH SETTING*

REV. JOHN R. GREEN

Episcopal Church, Diocese of Newark, New Jersey

During the past decade group dynamics and role playing have commanded significant attention and consideration as techniques or methods of relating the Christian faith and practice to the lives of the members of several Protestant denominational churches. How widely the aforementioned have been utilized in these churches I do not know. I am keenly aware that group dynamics and role playing have played a considerable role in the thought and planning of the Department of Christian Education of the National Council of the Episcopal Church, my church. This, in turn, has had an impact on local parish churches throughout the Nation, although to what extent I am not prepared to say. I have observed the utilization of role playing in a number of Episcopal churches to interpret and clarify the relationship of the religion of the child, or adult to the everyday living situations in which he finds himself.

My personal employment of Sociodrama has been in the area of what we in the Episcopal Church call Christian Social Relations and what is known in some other Protestant circles as Social Education and Action. My post as Associate Director of the City Mission Society of the Episcopal Diocese of Newark involves my working with the one hundred and fifty Episcopal churches in northern New Jersey in relating their members to the social, economic, political and international problems which confront them and human society. I make use of Sociodrama in the discussions and planning of our clergymen and laymen in the realm of social action to enable them to deal more effectively with social situations and issues.

Yearly, a caravan consisting of clergymen and laymen from the churches of my Diocese visits the New Jersey State legislative assembly in Trenton to lobby for humanitarian legislation. Our group which averages about two hundred in number is personally greeted by Governor Robert E. Meyner, and our Suffragan Bishop, The Rt. Rev. Donald MacAdie, usually addresses the legislative assembly and members of the Caravan discuss with their respective legislative representatives such issues as minimum wages, the plight of the migratory workers in New Jersey, the abolition of capital

* Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, New York, March 24, 1961.

punishment, racial discrimination in employment and housing, the rehabilitation of the handicapped, medical service for the medically indigent, etc.

I employ Sociodrama to prepare some of the members of the Caravan to effectively relate themselves and their goals to their respective representatives in the legislative assembly. Such situations as coping with the very cordial, hail fellow well met, but charmingly evasive representative; the representative who indicates that other people with opposite or different points of view on bill under discussion also have talked with him; what is he going to do; the representative who says, "you elected me, why don't you let me do the deciding on how I will vote on this issue"; the legislator who hasn't even heard of the bill before the assembly which the Caravan member is presenting to him (these are only part-time legislators, having business and professional responsibilities and they can hardly be familiar with every bill of legislation facing the assembly); or the representative who candidly remarks that the Church should stay out of politics; the representative who joshingly asks, "what makes you an authority on this matter"; the representative who tells you that he is all for the bill you are supporting but has been quoted differently by the press; the representative who frankly states his opposition to the bill being supported by Caravan member; the representative who hasn't quite decided where he stands on certain issues; a lobbyist for the opposition who overhears the discussion between a member of the Caravan and his representative and interrupts the proceedings; how to get representatives on the floor before the assembly session officially convenes after they hear that two hundred Chuch people, the majority of whom are women, are waiting to interrogate them, etc., are enacted or previewed in Sociodrama sessions.

Another area of church social concern in which I have used Sociodrama has been that of racial integration. Through the processes of Sociodrama, Church members are oriented as to how to welcome a negro into the fellowship of the local Church when many in the congregation are either openly or silently opposed to such integration; how to encourage the negro to return after he has been cooly treated; how to be at ease with the negro, not offending him through unintended patronization or unnatural cordiality; how to enlist the support of others in the congregation to welcome the negro and to take a stand in his behalf; how to discuss the difficulties pertaining to making the negro a part of the fellowship with the minister of the Church, etc. Conversely, through Sociodrama, I have attempted to prepare negroes desiring to enter the fellowship of a white congregation to cope with such problems as an initial cool reception; some icy stares; perhaps an unkind

remark whether intended or not intended to be overheard; the awkward greeting of some who desire to make them welcome or have mixed feelings about this matter; how to react to those who don't like racial integration in their Church but are resigned to its inevitability; how to deal with the problems of acceptance their children or teen-age youngsters bring to them; how to gradually grow in the fellowship of the Church; how to move in white social circles outside of the Church now opened to them through acceptance in the fellowship of the white congregation and how to introduce fellow negroes into the fellowship of the white congregation. I would like to add that I have employed Sociodrama with negro church members in orienting them as to helpful procedures in procuring adequate housing in a white neighborhood or community and with white church members as a means of aiding them to assist negroes to obtain ample and wholesome living quarters in white communities or neighborhoods where only such dwellings are usually found.

A third area in which I have utilized Sociodrama to further the cause of social concern in the Church is related to Civil Liberties. Rightly or wrongly, I have advocated the abolition of the House Unamerican Activities Committee in my preaching and other communication with Church congregations or Church groups in my Diocese. Sociodrama is enlisted to aid a willing adherent or convert to this point of view to gain support for it among Church members and Church groups. The problem is explored in Sociodrama as to how to deal with the good soul in a Church group, where the abolition of the House Unamerican Activities Committee is being proposed, who indicates that "she is horrified to hear you present such a resolution because only people who have been duped by the Communist conspiracy in America, or are fellow travellers, if not outright Communists would make such a proposal." Also, I have made use of Sociodrama to help the Church member who was promoting her conviction regarding to upholding of the constitutional right of freedom of speech through maintaining that George Rockwell, the self-styled Hitler, had a right to speak in New York in the summer of 1960, although she didn't agree with anything he had to say in his hatred campaign against Jews, Negroes, and Masons. Likewise I have availed myself of the resources of Sociodrama to assist a Church group to understand the philosophy of the Fifth Amendment and the justification in a number of instances for persons having invoked it.

There are other areas of Christian Social Relations in which I have used Sociodrama to an advantage which I will not elaborate upon in this paper. However, I will briefly mention them as follows: Orienting volun-

teers to visit the sick and the imprisoned in hospitals, nursing homes and prisons; orienting refugee resettlement committees in churches which are resettling refugee families from behind the Iron Curtain as to procedure from the communication by letter with the refugee family before it arrives in this country and seeing it settled in work, home and community; orienting Church members who are enlisting support in their respective parishes for the United Nations, the State of Israel and negotiations involving the United States, Great Britain and Soviet Russia toward a realistic and practical agreement for the cessation of the testing of nuclear weapons. Again, I utilize Sociodrama in helping Church members to relate themselves to such community relations problems as bettering the living conditions in public institutions for the sick, aged, children and imprisoned; obtaining better housing, employment and recreational facilities for the aged; problems of juvenile needs and delinquency; obtaining community resources for the rehabilitation of the physically and mentally handicapped and prisoners; and lobbying with the town or city council for more adequate aid for the needy who have to depend upon the public welfare assistance for their support.

While I am aware that Sociodrama has been used by other institutions and agencies to deal with some, if not all, of the aforementioned social issues, its exploitation by the church lends added significance due to the Christian imperative and theological implications regarding the responsibility of those in the Church for the social and economic problems of mankind. I have found the techniques of the role reversal and doubles most helpful. While Sociodrama doesn't really lend itself to all sorts and conditions of Church settings, I have found that those groups and individuals with the Church who have responded to its resources have profited immensely thereby. There is a great need for further development in this area. I am grateful to Sociodrama for its spendid contribution to my work in the service of my Lord. There is hardly anything profound about this presentation, but I believe it reveals potential for further communication.

(All attitudes taken regarding social issues in this article are indicative only of the author's personal viewpoint and do not necessarily represent the position of the Episcopal Diocese of Newark.)

A NOTE ON AUDIENCE INVOLVEMENT AND ROLE-PLAYING IN SOCIODRAMA

ERWIN O. SMIGEL

New York University

This note was prepared on the premise that it is valuable to build an ever increasing body of knowledge about role-playing and socio-drama techniques based on the individual experiences of the practitioner. The experiences discussed here involve the use of role-playing in a classroom composed of local union leaders. These men, members of the United States Steel Workers, were attending a course on Union and the Community at Indiana University. This report suggests a way of heightening the involvement of the audience in the socio-drama by increasing their participation in the role-playing session and thereby increasing the training value of the technique.

The social situation presented to the class dealt with a long strike in a rural area where the relatively weak local union was trying to enlist farm support. A local labor leader is talking to an anti-union farmer. Two students were selected from the group to play these roles; one, an older labor leader, a man of sixty, who had not only worked for the United States Steel Workers but had come up from the ranks through the United Mine Workers of America and the Kentucky Harlen Battles. This devoted, experienced and tried union leader was asked to play the anti-union farmer. The local union leader was played by a man of twenty-eight who had been sent by his local to the institute in an attempt to encourage bright young men to work more actively in union affairs. The man chosen to play the union leader was not thoroughly convinced of the union's importance. These two appeared before the class, giving arguments pro and con.

The chief reasons for role-playing, in this instance, were to offer insight about people antagonistic to the union and the particular strike. It was used as a training device. Ideally what was called for was a way of more directly involving the entire group in the role-playing session. Given a limit on time—this was impossible. It was felt, however, that if the members of the class who constituted the audience could be made to feel greater responsibility to listen to what was said and for what should have been said, an economical way of involving more of the group would have been found. It is true that audiences usually identify with some role or roles when they watch a play. How close their attention is kept on these roles depends on the interest in the play and/or selected parts. This, however, as playwrights know, calls for great dramatic skill and that lacking, depends on chance—not the surest training device. Written tests such as the Yale Marital Inven-

tory Test, present situational questions involving role conflict between husband and wife, which require internalized role-taking to answer. These tests come consistently closer to what was wanted but probably do not constitute the best training device.

It is true that Dr. Moreno and his students usually try to get the audience involved as participants and the follow up after the socio-drama is normally one in which the audience is called upon to respond in terms of their own participant perceptions. In the union-farmer situation described here the session was structured with the expectation that the participants in the audience would be called upon individually and not voluntarily not only to "verbally respond" about the enactment, but perhaps to take over a reenactment.* This item of preparatory expectancy may offer an additional dimension for the more effective use of the sociodrama. Specifically, to increase general participation and to force internalized role-playing in the classroom situation, the local leaders were told that at the end of the usual role-playing session they would be called upon to criticize, add to, discuss or *give their own version of how the roles should have been played.* The possibility of being called upon involves the risks of public display and means that members of the audience are subject to the reward or punishment of their fellow students and their instructor. The observed end result, which needs to be validated before this technique can be used with certainty, was that: (1) the audience paid closer attention to the socio-drama, (2) the actors, because of possible criticism, tended to take their parts more seriously, (3) because of larger, more serious participation, additional insights and arguments were presented to the group and, (4) both roles were played by members of the audience, again because they may be called upon. The last result is by far the most important, for it means that not only are the actors learning by taking the role of the other, but the audience which is also playing both parts has the advantage of going through a process similar to the actors. While this is not as good a training device as playing the roles overtly—it is more economical in that it does involve more people at the same time and they function not only as an audience but almost as participants in the role-playing itself. This, to sum up, is brought about more forcefully when members of the audience are made aware that they may be called upon and that they actually may have to play the roles themselves.

* In the "classic" sociodrama all participants are expected "to take over a reenactment." See J. L. Moreno *The Concept of Sociodrama, Sociometry,* page 444, Vol. VI, 1943 "one spectator after another tried to act out his own variation of the conflict" (note of the Editor).

USES OF MUSIC THERAPY

ESTHER G. GILLILAND

Musical College, Roosevelt University, Chicago, Illinois

MUSIC AS A MODALITY IN GROUP THERAPY

Patients who are too regressed or confused to respond to the spoken word can be motivated by music because group feeling is engendered on a sub-verbal basis. Sharing emotions on the unspeakable level is more fundamental than sharing ideas. Music, being non-controversial, provides an effective means of unifying heterogeneous groups quickly.

Passive listening to music unifies a group to some extent, but active participation is much more productive, for each is contributing his share, according to his own capacity, no matter how elementary. The one who tinkles a triangle in an orchestra may be gaining more personal satisfaction from the total aesthetic creation than the concert-meister whose years of practice may have made him rather blase to this type of experience. The weakest singer who would never dare to sing a solo can become an integral part of a great chorus, and in blending his voice with the others, will soar on wings of song.

Community singing of familiar songs at the beginning of any type of group activity will establish rapport immediately and prepare the way for acceptance of any task. The church uses music effectively, not only to cement communal feeling, but also create at-one-ment with the divine presence. The singing of hymns provides emotional release, and by the time the sermon is delivered, the congregation is in a receptive mood. Is there any reason why group psychotherapists should not use music to establish rapport?

APPLICATION OF THE ELEMENTS OF MUSIC

Rhythm and sound, the basic ingredients of music, motivate all types of patients, regardless of musical training or talent. *Rhythm* offers the first mode of attack because muscular response is automatic. Movement denotes life, and *movement together* is the first step toward establishing group feeling.

The schizophrenic expresses himself through musculature when all other means of expression have faded. Rhythm can arouse a catatonic; can draw him out of his shell, making him aware of his surroundings. With a rhythm instrument in his hand, his automatic response to the pulsation of

simple, familiar music will attract his attention outward, where all other stimuli have failed.

A rhythm band, a drum and bugle corps, or the opportunity and urge to dance will release tensions and provide a means of expressing aggression in a socially acceptable manner. In many cases, repression of emotions has contributed to his illness, and any means of expression that will break the dam, must first be sub-verbal. Patients who have been mute for years, will often begin to talk after having responded to rhythm. If the leader will dance with him, endeavoring to match the music to his mood and rate of movement, the patient will feel greater release through sharing. Many schizophrenics who hesitate to join in group dancing will dance with one partner with whom he feels safe, and then gradually join in group dancing.

These rhythm techniques are equally effective with the mentally retarded, especially with those who are unable to express themselves through speech. The physically handicapped child also needs rhythmic activity to develop coordination. It is essential to gear the tempo to his rate of movement at first, then gradually change the speed as he progresses.

All children in institutions, including public schools, should be provided with adequate rhythmic experience in the formative years before any other type of music instruction is attempted. The emotionally maladjusted child finds that it is fun to cooperate in such activities. Many a delinquent who has never learned to obey, will follow the intricate instructions of the caller in a square dance, and once having experienced the joy of doing things together, will learn to transfer this feeling to other areas of endeavor.

All adults, in institutions or out, need this type of activity. The great revival of square dancing throughout America is one of the greatest aids to mental hygiene. Jacques-Dalcroze made a significant contribution through his Eurhythmics, not only to the development of musicianship, but also to the development of healthy physiques and self-control.

The recent emphasis on geriatrics often fails to recognize the needs of older people along these lines. Response to rhythm is more rejuvenating than transplanting glands; indeed, research has proven that music can stimulate or relax all bodily processes.

Sound

Survival of all species depends largely upon tonal discrimination; the ability to distinguish between danger and security. Noise still represents danger, and our automatic nervous systems will cause us to jump first, before we even realize what threatens our survival. The raucous noises of our

so-called "civilization" certainly are partly responsible for our battered nervous systems.

Tone, being organized vibrations represents security. The sensuous beauty of musical tone appeals on a physiological level, similarly to rhythm. Tone color or timbre is dependent upon overtones or harmonics, all having definite mathematical relationships, and particularly useful establishing moods, which are classified on the psychological level. The peaceful quality of the flute, largely composed of fundamental tone, contrasted to the stirring characteristics of the trumpet, or the lonesome feeling engendered by the oboe illustrate the possibilities the composer has at his command in expressing his feelings and arousing similar emotions in his listeners.

Melody

The human need for aesthetic expression has resulted in the organization of tone and rhythm to form the art of music. Melody is used by all races to express emotion. Familiar melodies can arouse associations that often provide the psychiatrist with pertinent data. Patients who have been inaccessible for years will start talking if the right melody can be discovered. Folk music has been found useful in many cases. Case histories can be quoted by the dozen, of dramatic responses to this type of stimulus.

Harmony and Form

Usually, only the musically trained are conscious of harmony and form. If we expect to use music effectively in a predictable manner, we must know the patient's cultural background and the extent of his previous musical experience. In treating an accomplished musician who is sensitive to all the finer nuances of great masterpieces, one must be careful in subjecting him to elementary examples that would appeal to the uninitiated, for the results may be disastrous. I have seen professional musicians driven into a psychotic episode by being subjected to rhythm band activities.

Music as Recreation—Education—Therapy

Most institutions catering to long-term patients recognize music as an integral part of the Recreation Program and while no professional Music Therapists are employed, carry on an active music program with the aid of volunteers. Other institutions with more extensive personnel include music in the Education Program. The more progressive institutions have made appropriations to employ qualified, registered Music Therapists to carry on a vital program under medical direction. While Recreation is as vital a part

of rehabilitation as Education, music deserves to be extended to the therapeutic level, with regular conferences scheduled with other members of the treatment team, and regular reports submitted for discussion and unity of action.

Responsibility of the Music Therapist

Personality. According to most authorities, the interpersonal relationship between the therapist and patient is more important than the modality used. In working with the handicapped, the leader should constantly endeavor to manifest maturity on all levels, intellectual, emotional, social and moral. Because of the potent influence of music on behavior, the patient is prone to identify himself with the music leader, often following his example blindly. He transfers the perfection of the art of music to the Music Therapist,—his ego-ideal, and feels free to confide his innermost thoughts and feelings. In the therapeutic situation, one must constantly endeavor to be objective, practicing empathy rather than sympathy. By using spontaneity and creativity, the Music Therapist is able to supply the opening wedge for psychotherapy.

Understanding the Patient and Knowing the Music. Understanding the patient as a total personality, together with his potentialities and limitations will determine the proper type of music activity to be used, according to the physician's prescription. Knowledge of all music forms and styles is presupposed, of course,—classical, semi-classical, popular, and folk music, especially from the area from which the patient originated. Music is a very complex art-science, and to use it effectively, the Music Therapist must have a broad and varied music education, with skill in directing vocal and instrumental groups. He also should be conversant with the great amount of research in music psychology and be able to employ the most effective type of activity to each patient's needs.

Music in the Total Treatment Program

The integration of music into the total treatment program is dependent upon institutional organization of the various therapies. The role that the therapist should play in the interpersonal dynamics must be established by staff conferences so that the handling of the patient will be consistent. In some institutions this is the responsibility of a Supervising or Coordinating Therapist under direct medical supervision. A number of institutions have set up a Department of Rehabilitation in order to coordinate facilities.

It really is immaterial which department the Music Therapist is identified with, so long as the work is coordinated. Music serves every

department of the hospital, and is most useful in establishing community relations, where the results are often spectacular. Good will can be engendered between all types of workers in the institution. Wherever talent is available, it should be encouraged. Not only will the patients enjoy these informal contacts with the personnel, but attendants, nurses, physicians, laboratory technicians, carpenters, cooks and electricians will all develop a better esprit de corps and understanding of the patient, through music participation.

Music as Ancillary Therapy

The Music Therapist can lend invaluable aid to the Speech Therapist by emphasizing diction and vowel formation during singing; to the Physical Therapist by suggesting appropriate music for exercises and relaxation; to the Occupational and Industrial Therapist by providing background music. Research on Music in Industry has proven that properly selected music facilitates all types of work, especially routine tasks. Many dentists use music to relieve pain and anxiety.

In General Medical and Surgical Hospitals, music is being used during operations under local anaesthesia. Private ear phones are provided to supply each patient with the type of music he prefers, and thus the surgeon and his assistants are not distracted by interference with their conversation. Obstetricians testify to the successful use of music during labor and delivery. In Mental Hospitals music is used during insulin and electric shock treatments to allay fear and to bring about quicker orientation afterwards. After prefrontal lobotomy and other brain surgery, music has been found valuable in retraining patients.

Mealtime and Bedtime Music. Soft dinner or salon music (instrumental) helps digestion, improves table manners, and appetite. Relaxing, soothing music saves on sedatives at bedtime; is cheaper and non-habit forming, also relieves pain. Many institutions provide individual earphones with a choice of programs available.

Summary

This paper on The Uses of Music Therapy has endeavored to show *why* and *how* music is useful in Group Therapy; the factors necessary for successful application, and the types of patients who can be benefited. Limitations of space have prevented development of the functional uses of music in prisons and in various types of industry, also as a prophylactic, but the principles presented can be used in any group situation with predictable results fairly certain, provided the therapist applies the knowledge available and the techniques that have proven successful.

SELF-GOVERNMENT FOR PATIENTS ON A GERIATRIC SERVICE

N. CHARLES BOURESTOM, PH.D.

Mental Health Institute, Independence, Iowa

In the time allotted I shall attempt to deal with the application of selected aspects of group psychotherapy in the management of elderly psychotic patients. There may be some doubt as to whether or not the technique I will describe can legitimately be termed group psychotherapy, but at the same time, there is little question that group method is involved, that therapeutic benefits accrue and that the mechanisms of group identification and belongingness constitute the basis for these benefits.

As we all realize, one of the growing problems in our society is the increase in the aged segment of our population. This increase is apparent not only in our communities, but also in our institutions. Recent surveys (1, 2), for example, have shown that elderly psychotic patients comprise roughly 1/3 of the entire patient population in neuropsychiatric hospitals at present and that within the next decade this number will increase markedly. Since conventional therapeutic approaches have proven to be of limited value there has been a growing demand for new techniques to meet the special problems posed by this group of patients. Unfortunately, there has been a poor response to this challenge perhaps because of the many real difficulties involved as well as the popular misconceptions which many people have about older persons.

One of the greatest obstacles encountered with most elderly psychotics is the difficulty in communicating with them. With many, profound isolation and withdrawal characterize their defensive patterns rendering them socially ineffectual and unmanageable. Because of apparent deterioration processes, attempts to establish contact by means of the use of logic or rational methods such as advice, guidance and persuasion usually meet with failure. Ginzberg (3), recognizing these problems, has recommended that the elderly psychotic be approached on an emotional level, appealing to and capitalizing on his needs for appreciation, acceptance and respect rather than relying on the processes of thinking, understanding and verbalization. He has argued further that despite the patient's deterioration and defensive patterns, there still exists a powerful social hunger and motivation for group identification and belongingness. Gilbert (4) makes much the same point in stating that the important parts of psychotherapy for older psychotic patients are support,

reassurance and acceptance in a manipulated environment rather than face-to-face contacts designed to resolve specific conflicts.

Based on the thinking of Ginzberg and Gilbert, we designed an experimental group-centered action program on the geriatric service of the Tomah Veterans Administration Hospital—a program which was later to be known as self-government. The program was designed to determine the extent to which lines of communication could be established with these patients, their isolation and withdrawal could be counteracted and improvements effected in their social adjustments through their purported tendency toward group identification.

Self-Government Program

The geriatric service of the Tomah Veterans Administration Hospital is a 328-bed unit of an 1176-bed neuropsychiatric hospital. There are approximately 164 patients on each of 2 buildings. Each building is divided into 4 wards with 40 patients on each ward. At the start of the program only 2 of these wards were open—at the end it was possible to open 6 of them. The majority of patients were chronic psychotics over 60 years of age whose average length of hospitalization was 15 years. They were extremely regressed, almost completely inactive and presented numerous nursing problems.

Originally, 2 discussion groups (one on each of 2 wards) were organized on an informal basis. The psychiatrist and clinical psychologist played very active roles attempting to stimulate patients by initiating discussions. Nurses and aides also participated. The patients were told at the outset that the meetings were for the purpose of communicating their complaints, suggestions and comments to these representatives of the treatment team. Initially, there was very poor response. Most patients did not react and retained their chronic attitudes of withdrawal and negativism. Gradually, however, roughly over a period of 6 months, patients on both wards became more responsive. Incidental complaints on the ward were brought up and there were many heated reactions to these problems. At this point a more democratic spirit and desire for independence emerged. Suggestions were made to elect leaders among the patients. Later, secretaries were elected to take minutes at each of the meetings and present them to the group for approval at subsequent meetings.

From this beginning interest flourished among patients and the program developed rapidly. The current structure is as follows: Patient groups are organized on each of the 6 open wards. Each group has its own chairman and secretary whom they elect periodically. These persons preside over a half-

hour meeting on their respective wards once a week. Discussion topics are varied, and range all the way from petty grievances to individual plans for leaving the hospital. Three standing committees have been organized. The first is known as the Executive Committee. It consists of all the chairmen and secretaries from the different wards, and has a total membership of 12 patients. The committee meets weekly for one hour preceding the ward meetings, is elected every six months, and has as its principal purpose the planning and coordinating of all activities concerned with the general membership. The second standing committee is designated the Club Committee. It consists of 2 elected patients from each open ward, who are rotated on a monthly basis. The Club Committee of 12 patients meets daily with a psychiatric aide and has as its purpose the improvement and maintenance of a newly established Geriatric Club Room. The third standing committee is called the Advisory Committee. Its members are recently retired chairmen and secretaries from the respective wards. This committee functions as an advisory group and counsels newly elected officers on parliamentary procedure. It meets regularly with the Executive Committee. From time to time additional committees are formed as the needs arise. The clinical psychologist and selected nursing personnel meet with the standing committees and with the joint body of patients. They function primarily as liaison personnel between patients and staff.

Results

What are some of the concrete results of this effort? First, the patients have developed and organized an exclusive club room, which is situated on the geriatric service apart from the wards. Through suggestions made during the group meetings and with the cooperation of the administration, they have procured for the club a television set, a radio, a shuffleboard set, soft-drink dispensers, a piano, and a variety of games. The club is nicely furnished and decorated with flowers and pictures. It is operated and maintained by the patients themselves and they take great pride in its existence. The Club Committee is mainly responsible for its cleanliness, but all patients partake in its maintenance and make suggestions for improvements.

Another development of the program is the impetus it has given to ward activity. Weekly, through the group meetings, patients are assigned by the group to ward housekeeping duties which they are capable of doing, such as making beds, dusting furniture, cleaning floors and assisting staff. For the most part, these assignments are volunteered for, and are accepted willingly as a matter of conforming with group wishes. This has had the effect of

increasing interaction among patients on the ward, providing purposeful and meaningful activity for them and greatly improving the appearance of the wards.

Through their group meetings and with the help of Special Services, the patients now plan and coordinate their own recreation activities. These include social dances, birthday parties, special musical shows, bingo, and card games. During clement weather, fishing trips, all-day bus excursions, picnics, baseball, and watermelon feasts are planned. Both intra-group and inter-group competitive sports are arranged in pool tournaments, bowling tournaments, and baseball. Thus, activity is not confined within the older age group, but is extended and combined with activity in other parts of the hospital. Decisions relative to the details of the activity are made during the meetings, and patients who indicate a desire to participate are selected in a democratic fashion.

The Executive Committee has drawn up a constitution and set of by-laws to add additional structure to the program. This constitution, among other things, provides a name for the organization, specifies the purposes, and outlines the order of business. The constitution, after having been organized by the Executive Committee, was printed as a geriatric patient project and then distributed throughout the hospital by the patients themselves. The distribution was made primarily to give additional status to the program.

Our experience with this program suggests that such a group-centered method has definite therapeutic value for elderly psychotic patients in terms of counteracting their withdrawal mechanisms and improving their social adjustment. In general, the results were most gratifying in indicating the possibilities of preserving the personalities of even those aged persons who seem badly deteriorated. Probably the greatest value of such a program lies in its potential for restoring to the helpless, defeated and insecure elderly psychotic, feelings of personal worth and adequacy. Through this kind of group activity the patient perhaps comes to realize that he is not rejected, but accepted and respected by peers with problems similar to his own, as well as by authority figures in the hospital. Self-respect and dignity, profoundly devastated among elderly psychotics, begin to emerge in a new light as the patient finds himself a responsible member of an active committee who purpose is to help achieve a common goal for the group with which he is already strongly identified. The program encourages active participation in the events of daily life, develops the patient's interest in other persons and things outside of himself, and helps to dispel the feeling of being lonely

and isolated. Additionally, such a program provides a direct and convenient channel of communication between patients and staff and often facilitates the solution to administrative problems.

REFERENCES

1. Civic, M., Our aging population: trends and causes, in Studies of the Aged and *Aging, published by the Committee on Labor and Public Welfare, U.S. Senate.* Washington, D.C., Government Printing Office, 1957, vol. 8, pp. 73-78.
2. Smith, T. L., The changing number and distribution of the aged population, *Ibid.* pp. 23-34.
3. Ginzberg, R., Geriatric ward psychiatry—techniques in the psychological management of elderly psychotics, *Am. J. Psychiat.* 4: 296-300, 1953.
4. Gilbert, J. G., Understanding Old Age. New York, Ronald Press, 1952.

GROUP PSYCHOTHERAPY AS A WAY OF LIFE

ALICE R. FRIEDMAN, PH.D.

Harlem Valley State Hospital, Wingdale, N.Y.

A large group of institutionalized patients is in need of a group psychotherapy program rather than one or two therapy groups. This becomes evident even as new patients arrive to enter group psychotherapy. In the program discussed here, patients are first seen in an orientation group to determine the participation in group therapy. Groups are differentiated into active and semi-active therapy groups. Some cases are introduced into individual or combined individual-group therapy.

There is a tendency to encompass all patients capable of being treated into some form of group therapy. These decisions are arrived at by the patients and the therapist who is concerned about the amount of treatment to be administered. Cases only seen once or twice in orientation groups maintain sometimes the therapeutic contact throughout their stay at the hospital, meeting the therapist occasionally on the ward or on hospital grounds. Others are in active therapy six to nine months in weekly sessions. A program adjusted to the needs of a large and comparatively fast-changing patient population must also pay attention to the capacities and interest in both the patient group as well as the therapist. A program so adjusted makes group therapy into a way of life.

In psychotherapy the discussions of all vital problems will make the sessions into a living program. Considerations like "Why did I have to come to the hospital?" lead into the psychotherapy and handling of almost all human problems. Discussions will climax in what to do about these problems: "How to find a way to stay well"; in fact, "How to find a better way of life."

There are large numbers of patients who will not be satisfied by a therapy "just by talking"—as they say. There are groups of mental patients who do not endure under energetically conducted psychoanalytically oriented psychotherapy over a longer period of time. There are also other possibilities within a group therapy program.

In including activities in our group therapy program we are taking care of a factor that otherwise might cause difficulties. There comes a point where the patient in group therapy may want to act out. These needs are taken care of in a controlled manner in offering this opportunity in a varied program of not only talking.

Through the variety of interests the group therapy program fits in with all the activities that go on in the hospital. Group therapy is not an isolated but a related program also in this respect. However, it differs from a mere activity program by an emphasis on psychotherapy. Activities follow psychotherapeutic indoctrination of the patient.

Recently, a new idea was established within the group therapy program. This relies on the principle to encourage the patient not to lower personal and professional standards when entering the hospital which so often happens. Many of our patients are still interested and studious; others are teachers who later want to return to their profession. These can be brought together in a school-type program which contains many therapeutic elements. The patient-teacher and the studious patient function in a classroom. The therapist remains more or less in the background. There are many motivations for the patient to participate in such a group while therapeutic contacts still remain with the therapist. A school-type program takes care of guilt feelings of patients who have not completed their education. Furthermore, it offers an opportunity to young mothers who want to keep up with their children's schools. There is a place in academic classes also for the patient with a foreign language background. There is the meticulous patient who wants to brush up on grammar, vocabulary, and spelling in such a program. Finally, the patient who always evaded financial responsibility and arithmetic sometimes appears to be fascinated to participate in some type of business mathematics.

Teaching and studying proves to be an important element in the rehabilitation of the schizophrenic patient by training of concentration, logical thinking, and memory. Another element in the emotional area to be considered is the great need of the schizophrenic patient for closeness and tenderness. While very little can usually be done about it, a school-type program allows for taking the students under your wing in a form that is generally approved.

There is also a way of handling personal problems in an indirect way in the classroom: the handling of psychological questions in literary discussions. Reading "Little Women," a high school group of young adult patients discussed sibling rivalry, the role of the parents, and the feminine role in changing times. All of the problems of the participants came up during this course when the patients compared their experiences.

This school for the young adult in the mental hospital functions by delegating part of the transference to the teacher-patient.

A similar process of "per proxy" therapy may be found in appointing

a patient as a producer of a play in the psycho-drama group. The psycho-drama takes place rather in the production of the play than on the stage. With the therapist again in the background the patient-producer aids in therapy by delegation or "per proxy" powers. There have been cases who resisted any kind of therapy up to the point when assigned a function like producing a play; then therapy began to work. Why? Because therapy, in fact, *has to be* a way of life.

There are other functions in the production of a play that utilize patient's dynamics in some cases in a useful manner. We find the meticulous patient busy in copying the individual roles of patients; followed by those who make use of their routine and compulsive dynamics as typists. The expression in music and dancing always used in the play goes far beyond these talents. It is an indirect handling of personal problems that adds to the psychotherapeutic process in an encouraging way.

These re-formulations of part of the therapy process also remodel to some extent the role of the therapist as an elastic participant in group therapy—not always leading and not only a leader but part of the group.

A new form of communication between group and therapist also was found in a group-paper—written, typed, illustrated and edited by a group and therapist together. That gives the patients a chance to report on the work they are doing in the hospital and the therapist an opportunity to address the patients in a general form on therapy.

Some of the editorial decisions that come up in our newspaper sessions reveal the group thinking. When editing an article on Susan B. Anthony, the group searched for and couldn't find a portrait that might be included. They finally made the decision that "any profile of any woman could represent Susan B. Anthony, just as she had represented all the women."

Our group newspaper, "The Group Letter," serves in orientation-groups to inform the patient about group activities. Some of the articles are written so that they require the reading and discussion as part of the group therapy program. If you are, together with your patients, creating a program including as many forms of human endeavor and expression as possible, you will find that group therapy becomes a way of life.

The principles in this group-therapy program are:

1. Group therapy is varied to fit the needs and interests of the patients' group served, making it into a way of life.

2. The group-therapy program must prevent lowering standards of the individual patients, and create new approaches for this purpose.

3. One of these new approaches for group therapy is delegation or per

proxy therapy which gives patients a leading role with the therapist in the background.

4. An example for this therapy by "remote transference" is our young adult classroom in the mental hospital, responding to needs of the hospitalized patient.

5. Activities built on psychotherapy work as an outlet of controlled aggression, complementing group therapy "just by talking." This also provides an indirect approach to psychological treatment.

6. The role of the therapist is re-formulated by this program, not just as the leader, but in a much larger sense as an organizer of a psychotherapy program complementing therapy by activities. On the other hand, not just as a leader but as part of the group.

PATIENT PARTICIPATION IN THE NATIONAL ELECTION

ROLF KROJANKER, M.D.
St. Louis State Hospital, St. Louis, Missouri

PURPOSE OF THIS STUDY

One of the objects of this study was to find out whether the increased degree of reality contact in the "improved" or "convalescent" patient would be reflected by an increased response to important environment events.

From a different viewpoint, one might observe the effects of different approaches to patient groups, using varying degrees of patient participation in a meaningful environmental occurrence.

The three groups would serve as mutual controls with the previous understanding of their limited value as control groups, since their composition in terms of mental health and social adjustment was different. These groups had in common only about equal prevalence of schizophrenic reaction over other disorders and the exposure to the same psychiatric and medical personnel. As a result of these limitations, previous hypotheses were not entertained.

Jacob Moreno, in his book "Who Shall Survive?" has reported extensively that sociometric tools can be employed to interpret changes and trends of opinions in human groups.

Sociometric tools used in this report were re-election polls on one ward, and mock election with electoral ballots on election day on two wards. On the third and most regressed ward, in lieu of the mock election, spot checks were made with a representative sample of patients, since the patients as a group on this ward did not show their ability to mark their choice on a ballot.

The polls were taken by show of hands in response to the question, "Who do you predict will be the President-Elect of the United States?" These polls were conducted prior to the television campaign and after the television debates, only four days prior to the election day. The ballots were simply made on a sheet of paper with a margin for voting; on the left for the Nixon/Lodge ticket, and on the right for the Kennedy/Johnson ticket. Such a sheet was offered to each voter in return for signing his name on a general voting list. The voter was then told to go into a side room, mark his sheet, fold it conveniently and then insert it into a slot of an election box in public.

Description of Wards

J-4 is an Open Ward with 95 patients having either full or limited privileges and running the Ward by a Patient Ward Government and its respective sub-committee. They are assisted by one Attendant on each shift. These patients are engaged in different phases of discharge planning, since their mental state has improved sufficiently to permit them to take part in running the Ward as well as their own affairs.

I-4 is a closed 50 bed Ward with a Student Nurse Training Program and Service for Continued Treatment. Patients are not improved enough in their mental status to honor an Open Ward Policy and its' responsibilities. However, they are not usually acute and disturbed enough to need several attendants on the Ward and most of them are engaged in an intensive treatment program in which an average of 10 student nurses and one supervisor participate. The Ward has a Psychodrama and sociometric studies are conducted on it. It has a Patient Ward Government in its initial phase of development and for this particular function, obtains help from J-4 which furnishes the Chairman of the Ward Government.

J-3 is a closed 96 bed Ward which functions in various phases of habit training for regressed patients and occasional cases in need of a security ward. It has a Student Nurse Program (10 students) and a Remotivation Program. An average of from three to four attendants on a shift; the day shift is headed by a Registered Nurse.

All three wards have television and radio facilities.

Impact of Election Campaign

The Patient Government on J-4, Open Ward, initiated an Election Campaign Committee during the latter part of September 1960. They voted to give the Naitonal News Cast and Presidential Candidates' Debates on television preference over any other television program and urged their fellow patients to listen to these programs. They conducted a poll prior to these debates which resulted in 28 votes for Nixon and 25 for Kennedy. A poll conducted on the 4th of November after the four television debates showed a shift toward Kennedy with 19 votes for Nixon and 47 for Kennedy.

On the day of election, a mock election was conducted with the ballots described as above. The outcome was as follows: 17 Nixon, 57 Kennedy.

I-4 had no polls and only optional television viewing of the Candidates' Debates. The Student Nurses conducted the election day and the outcome was 14 for Nixon, 15 for Kennedy.

It is my feeling that since the poll is similar to the results of the poll

conducted on J-4 previous to the television debates, the tendency to favor Nixon might be due to the lack of exposure of patients to the influence of television debates.

J-3: Since no organized group existed prior to the time of election and most of the patients remained uninterested in lieu of a vote, medical and ward personnel conducted repeated spot-checks in lieu of voting, asking patients whether they knew about the election and for whom they would vote. Most of the patients did not even know that an election was taking place and those few who knew, did not care to express their choice to the interviewer.

Commentary

In reviewing the results, one finds that the general tendency to slightly favor Nixon or Kennedy appeared on I-4 as well as J-4 in the poll conducted prior to the television debates. One might then try to explain the shift toward Kennedy on J-4 on the basis of the organized exposure of its members to the influence of the television debates. On the other hand, one might also speculate on the major contact with reality on J-4 as compared to I-4 which could have favored a shift more in accordance with the shift occurring in St. Louis toward Kennedy at the same time. These two possibilities might underline the importance on the part of patients in terms of programs as well as the medial importance of measuring the reality contact of patient groups by means of sociometric methods. Apart from the television debates and the decreased patient participation, one could emphasize the importance of open door policy in increased patient contact with the outside world. Furthermore, the didactic approach of personnel and students toward patients in an effort to have them grasp outside occurrences was not efficient. (This might be an unfair conclusion considering the regressed condition of the patient population on a habit training ward.) Finally, there was an increased response of the improved patient to outside environmental occurrences.

GROUP PSYCHOTHERAPY WITH GERIATRIC PATIENTS IN A VETERANS ADMINISTRATION HOSPITAL

KURT WOLFF, M.D.

Veterans Administration Hospital, Coatesville, Pa.

The geriatric patient—60 years of age and older—has become a very great problem within psychiatric institutions. With the increasing life expectancy in the world of today, the number of geriatric patients in all branches of medicine continues to increase.

According to statistics of the Federal Council on Aging, there are more than 22 million veterans of World War I and II. In 1960, there were more than one million and a half veterans, 65 years of age and older. According to the census at the Veterans Administration Hospital, Coatesville, Pennsylvania in January, 1961, 38% of the patients were veterans of the First World War and were over 60 years of age. Most of the psychiatric patients in this age group are chronic schizophrenics, while the number of acute brain syndromes is relatively small. Many of our schizophrenic patients however also suffer from a chronic brain syndrome due to senility or cerebral arteriosclerosis or other causes superimposed on the schizophrenic process for which they were hospitalized.

These patients frequently sit idle and dejected on the ward. Their facial expression is one of hopelessness. They feel that their relatives consider them superfluous and a burden. Their lives are generally empty. They have lost their goals, have no ambition, and seem waiting to die.

Few psychiatrists show interest in these patients or are willing to offer more than custodial care.

Individual psychotherapy has been tried in recent years with success. Psychoanalysts (Goldfarb (1), Meerloo (2), Kaufman (3), Grotjahn (4) and others) have treated geriatric patients with individual psychotherapy with good results. There therapists do not believe that the geriatric patient is too rigid or inflexible for a therapeutic approach.

Group psychotherapy has been attempted with geriatric patients by Silver (5) and has been used successfully by Linden (6), by Rechtschaffen (7), and by Wolff (8). According to my experience, group psychotherapy is to be preferred over individual psychotherapy because it is less alarming to elderly patients than talking to the therapist in an individual session. Anxiety is decreased in group psychotherapy, transference to one or more members of the group is easier to achieve because of the variety of choice,

and meaningful discussions are possible because a common goal or interest can be found with less effort. In this way the interpersonal relationships can improve more quickly and with less resistance. Critics of group psychotherapy mention that insight can hardly be achieved in a group and that no real interpretations of the patient's psychodynamics can be given. However, even if true, insight is not the only goal and purpose of psychotherapy, as Moreno (9) has pointed out. Enhancing the process of resocialization and helping the patient to rehabilitation in the circle of his family and community are no less important goals of psychotherapy.

Criteria of Selection. The geriatric patients of this study were selected for group psychotherapy after careful consideration of their physical and mental condition. Patients with excessive physical complaints or serious physical sicknesses were excluded. Those chosen were able to hear and see fairly well those to whom they talked. They were free of confusion, were in fairly good contact with their surroundings, and were not overly psychotic or restless. They also revealed no signs of a fast and progressive deterioration of their intellectual faculties or of their memory. Hostility and delusional ideas were acceptable, as long as the patients were in contact with reality at times, or had the potentiality to get in contact again. Seclusive patients were welcomed. They could show retardation of their psychomotor activity, as long as they were not completely mute.

All patients were evaluated by psychological testing before group psychotherapy was started. They were tested again before preparing to discontinue group psychotherapy and leave the hospital. Many of them, concomitantly were advised by a vocational counselor.

Composition of the Group. Group psychotherapy (with geriatric patients at Osawatomie State Hospital (Kansas) and at Galesburg State Research Hospital (Illinois)) have given excellent results when the members of the group were of mixed sex. The difficulties in relating to members of the opposite sex, after many years of hospitalization, were decreased when the patients were released from the hospital. Furthermore it seemed that they became better adjusted on the outside if they were prepared by group psychotherapy with the opposite sex. Therefore the group of elderly veterans in this study was composed of male and female patients.

The number of participants was not greater than six patients at any session. The average age of the members of the group was 63.5 years. The average duration of hospitalization in Veterans Administration hospitals was 20 years.

Sixteen geriatric patients—4 females and 12 males,—took part in the

group psychotherapy meetings. These sessions were started in November 1959 and continue up to the present time. The meetings were held once weekly. The average length of time of the meetings was 50 minutes. Fruit juice and cigarettes were offered to make the patients more comfortable and to give them some oral gratification.

The psychiatric diagnosis was only of secondary importance. Thirteen patients were diagnosed as chronic schizophrenics, 2 suffered from a chronic brain syndrome and 1 from an involutional psychotic reaction.

Thought Content of the Patients. In contrast to the geriatric patients in State Mental Institutions, these patients were relatively less shy, less seclusive and less embarrassed. They revealed less difficulty in talking and relating to members of the other sex. They were relatively better groomed and well nourished and showed greater self-confidence. Generally they felt less lonesome and rejected.

They had a better understanding of what was going on outside the hospital.

While for elderly patients in State Mental Hospitals religion, marriage, love life, historical events and food were the most frequent topics of discussion, the veterans of this study were more interested in daily political events and in the current economic situation. Most of them read the newspaper daily and watched television. At times they distorted political facts and misinterpreted economic conditions. On these occasions they could get angry and excited and ventilate hostility. Frequently they tried to rationalize their own feelings of insecurity by considering themselves victims of unfortunate circumstances and believed they were justified in finding and asking for protection at all times.

One of the most outstanding features of our patients was that they were proud to be veterans. They implied that all non-veterans owed them respect and gratitude. They expected special consideration and privileges.

Money and possessions were of extreme value for them and represented security. Religious problems were discussed frequently, showing their strong concern with life after death. However, the general attitude was one of apathy and disinterest when other persons were involved.

A further characteristic attitude was their conservativism and their resistance against any changes. They even resented a change from a closed to an open ward where they could enjoy more freedom of movement. Changes in recreation or in industrial therapy assignments were not welcome. Changes of places in the dining room were opposed. New physicians or new nursing

personnel were regarded with distrust. They did, however, keep close ties with their own families who considered them not much of a burden.

In connection with their resistance against changes, most of our patients lacked motivation to return to their family and community life. They thought themselves surrounded by a hostile world without empathy and pity and were afraid to try and adjust themselves outside the hospital again and look for an occupation.

Results

Of the 16 patients, 7 showed remarkable improvement as shown in their lessened hostility, greater alertness and better interpersonal relationships. Five of these patients, 4 males and 1 female, were released from the hospital. One of these had been hospitalized for 28 years and had been disturbed and hostile as recently as a year before group psychotherapy. This patient after six months of group psychotherapy is able to adjust himself well in a foster home and comes daily to the hospital as a volunteer to help other patients. At the moment he is writing an English grammar and hopes to find a publisher. The other 4 patients released after 6 to 9 months of treatment with group psychotherapy are able to hold a job in the community and are not in need of further psychiatric help. The woman patient returned to her own family, where she is making a good adjustment as housekeeper for her brothers and sisters.

Of the remaining 11 patients, 2 more are beginning to show some improvement, after 4 months of group psychotherapy, and might be able to leave the hospital in the near future. One male patient, 68 years old, who became more alert after 3 months of group psychotherapy, died suddenly of a coronary thrombosis. The emotional condition of the remaining 6 patients is still unchanged, after 4 months of group psychotherapy sessions.

It is felt that about six months of group psychotherapy with geriatric patients is needed to get favorable results.

Conclusion

The most prominent problems of hospitalized elderly veterans with a history of emotional disturbances for many years are: dependency to hospital routine, fear of leaving the hospital and resentment against changes of any kind. In spite of the fact that the 16 geriatric patients who took part in group psychotherapy were relatively well adjusted at the hospital, they all showed a lack of motivation to leave and had to be remotivated to return in the circle of their own family or community.

The goals of therapy with the elderly veterans at Coatesville were

directed to resocialization in the hospital, encouraging motivation to leave and to adjust themselves in the community. For this purpose group psychotherapy with a mixed group of geriatric veterans appears to be effective and worthwhile.

REFERENCES

1. GOLDFARB, A. I., "Psychotherapy of Aged Persons." Psychonal. Rev., 1955, 42, 2, 180-187.
2. MEERLOO, J. A. M., "Transference and Resistance in Geriatric Psychotherapy." Psychoanal. Rev., 1955, 42, 72-82.
3. KAUFMAN, M. R., "Psychoanalysis in Later Life Depressions." Psychoanal. Quart., 1937, 6, 308-335.
4. GROTJAHN, M., "Analytic Psychotherapy With The Elderly." Psychoanal. Rev., 1955, 42, 4, 419-427.
5. SILVER, A., "Group Psychotherapy With Senile Psychotic Patients." Geriatrics, 1950, 5, 147-150.
6. LINDEN, M. E., "Group Psychotherapy With Institutionalized Senile Women: Study in Gerontologic Human Relations." Intern. Journ. Group Psychotherapy, 1953, 13, 150-170.
7. RECHTSCHAFFEN, A., ATKINSON, S., AND FREEMAN, J. G., "An Intensive Treatment Program For State Hospital Geriatric Patients." Geriatrics, 1954, 9, 28-34.
8. WOLFF, K., "Group Psychotherapy With Geriatric Patients in a Mental Hospital." Journ. Americ. Geriatrics Soc. 1957, 5, 13-19.
9. EHRENWALD, J., "Psychoanalyst vs. Psychodramatist. A Dialogue." Group Psychotherapy, 1960, Vol. XIII, No. 2, 69-75. (Moreno's Discussion of Ehrenwald' Dialogue, idem, pag. 74-75).

PSYCHODRAMA FOR NURSES IN A GENERAL HOSPITAL*

CALVERT STEIN, M.D.

Dept. of Neuropsychiatry, Springfield Hospital, Springfield, Mass.

The emotional and physical reactions of student nurses to the daily challenges of the sick room are the same as for other laymen, with the added disadvantage that nurses are not supposed to show how they feel. Many girls are so successful in concealing their reactions that most people remain unaware of the daily grind of emotional traumata which may influence their health as well as their efficiency. Even veteran medics can be taken off guard by some of the more subtle stimuli that assail them through almost every sensory modality.

Whether at home or in a hospital the sick-room automatically recalls multiple previous assaults on the nervous system and also introduces new ones. Odors, sights and sounds are the most obvious associations; but the mere alteration of the daily pattern, not only for the patient, but also for those who attend him can disrupt an entire household.

The sick-room is a bedroom with multiple life-long associations. It may also be a retreat from tensions, a haven of safety, and at times an exile for penance—as in the old days, when being sent to bed without supper was equivalent to an indeterminate sentence to Siberia, especially for a sensitive child. The necessary invasion of privacy, plus variable degrees of nudity plus alterations of habits of elimination, sleep and eating, plus actual separation can be disturbing enough in themselves. But the addition of physical discomfort, along with natural anxieties over the unknown, inevitably affect not only the patient but also his family and his visitors. Vicariously even the doctors and nurses may be involved with recollections of previous "cases" that may not have turned out too well.

Patients also add psychological overlays to their distress by natural worry over future pain, delayed recovery, and possible deformity. Occasionally a nurse or doctor tries to anticipate this anxiety by estimating the duration and depth of the pain, on the theory that honesty is the best policy. We prefer to accentuate the positive by reassuring patient and family that he will be made as comfortable as possible, and that whatever distress may appear doesn't really have to worry them because it won't last very long, and won't do any harm.

---

* Read before the 20th Annual Meeting of the A.S.G.P.&P., New York City, Mar. 24, '61.

The fear of the angel of death is seldom far away and may be poorly disguised either in the faces of visitors, or in the routine "precautions" of the therapeutic (medical or surgical) program, or in the hurried visit of a clergyman to someone down the corridor, or in the past recollections of the patient himself.

Other menacing invasions of the sick room include the wail of an ambulance siren, the shrill cry of a telephone bell, needless whispering or tiptoeing, malicious gossips who talk to patients about "poor Mrs. Jones", and "my cousin who had the same diagnosis, and even the same doctor . . ." and careless remarks which are sometimes dropped within hearing of the supposedly sleeping or unconscious patient.

The prejudices which most people have for or against certain types of illness naturally extends to conversion phenomena, and psychogenic factors which inevitably accompany all disability either as cause or result. Most of us recognize this quite easily in others, but have blind-spots in ourselves. We are taught to search for such emotional traumata in psychiatric history taking, as the medical student learns to ask for a history of familial diseases, and for previous personal illness, accident or operation. But when training professional personnel, it is often more effective to emphasize objectivity, everyday experiences and normal physiology than to pursue conventional analytical concepts directly.

For instance, the medic is not repelled by the smell of anesthetics but this does not imply immunity from all odors. Most olfactory stimuli of the sick room pass unnoticed by the professional worker, but if one of them happened to recall a dying parent, the reaction could be disturbing. On the other hand, most people are repelled by the unpleasant odors of a tannery, yet Louis Pasteur as a homesick teen-ager yearned for the familiar smells of his father's occupation. Similarly, certain surgical dressings would not bother an experienced professional, but could cause a novice or a layman to become violently ill. Even for the convalescent patient, the mere function of elimination, which is so simple and private in normal life, can be a disturbing source of embarrassment.

As with other normal people the emotional involvement of the student nurse may produce conversion reactions affecting one or more of her visceral and somatic structures; and, just as naturally, the causes are usually unrecognized. Instead she finds herself either avoiding "difficult" patients, or involved and dependent on others whom she overprotects. But more often she is made aware of a problem by such situations as these: A visitor (or patient) who tries to date her, or who keeps pumping her for information,

or advice; an unjust complaint—sometimes by a senior nurse or a physician; mounting tensions with a chronic or incurable disease; hysterical visitors, malingering patients, the amputee, imminent or sudden death. Ten years of conventional teaching made no more than the usual polite acknowledgment and superficial recognition of the theory of psychosomatic medicine, and the psychodynamics of a conversion reaction as a vital aspect of human illnesses. But the inclusion of interpersonal problems and a shift from lecture to group psychotherapy has produced a radical change.

For the past five years those students who have attended our weekly groups at the Springfield (general) Hospital have experienced a rapid indoctrination. They are reluctant to participate in psychodrama when supervisors are present, but they pitch in nobly when supported by their peers. A few scenes of role-playing, with the help of experienced auxiliaries often teaches them more dynamics and more self-confidence than several years of graduate experience on the wards. This is an actual evaluation by older nurses who also drop in and participate from time to time.

Invariably the role-playing of such scenes stimulates recall of personal associations, so that occasionally I have to step in to protect the girl from needless embarrassment—not only for her own sake, but also for the sake of the group and for future students who will be influenced by her reactions and reports.

An effective way of replacing a sense of failure with an ego lifting experience is to reverse roles, or to put the student nurse into an authoritarian or therapeutic role as soon as possible so that she can leave with a feeling of accomplishment. This is done chiefly with signals and self-effacement by the director.

Another effective way of combining teaching with protection is through emphasis on communication—both verbal and non-verbal. Freud's Psychopathology of Everyday Life is recommended reading for amplification of the mistakes, neologisms, slips, forgetting, accident-proneness etc. which keep cropping up. But non-verbal communication is also stressed. This is especially valuable in helping the nurse with her personal and interpersonal problems. For example she learns to observe the tell-tale signs of body posture and tensions of feet and hands as well as more familiar facial expressions. But she is also reminded of the value of a reassuring smile as she proffers her medication, of a gentle shaking of the head as she restrains a garrulous visitor, of the light touch of the hand on the shoulder or head of someone bowed in grief, and of the firm grasp of the hand of the frightened patient or relative. She is also reminded of the psychotherapeutic

values of propped up pillows, back rubs, keeping her promises to return before going off duty, and of the use of positive language in place of hesitancy or negatives: e.g. "Here's a nice, cool, refreshing drink," "This is the very latest treatment." "You're a *wonderful* patient." " Take this wonderful healing medicine and you'll feel *so* much better." "Doctor ordered this especially for you." "This is a brand new syringe, and it doesn't *have* to hurt at all" (said just before injections and followed by casually diverting the patient's attention to flowers, cards, or the "smart" new bed-jacket as the needle is deftly inserted).

Our nurses are not expected to become expert psycho-therapists but scarcely a day goes by that does not offer them an opportunity to lessen tensions by just listening for a few minutes as the suddenly disturbed patient is encouraged to spout off about his recent visitor as well as complain about his pains, his treatment, his nurse and his doctor. It's astonishing how long it takes for some members of the healing profession to learn that they themselves are not necessarily the direct objective of a patient's hostilities and aggression.

Our student nurses learn, no matter how much their dates or patients expect of them, how to avoid emotional traps that are set for them, how to dump the unfair question right back into the laps of the aggressive visitor, how to say "No" with a smile, how to reassure their patients both verbally and non-verbally, how to build up confidence in the doctors and when to admit that they really don't know all of the answers.

Most important of all—they learn how to deal with their own personal and family lives, to re-evaluate past grievances, to alter their expectations from certain friends or members of their families, and to develop a new concept of self-respect. Many of them continue to learn by returning voluntarily on their time off, long after their training program is over. Usually they bring along a friend; and sometimes they are also rewarded by seeing former patients who have been helped through psychodrama, as a result of their own first efforts and encouragements in the sick-room.

Since sickness in one form or another has touched everyone's life, these situations afford excellent didactic material for any group of students. Children play "nurse" or play "doctor," every boy or girl scout must know something about first-aid, druggists repeatedly dispense medicines which they themselves prescribe, policemen take courses in obstetrics, and firemen and lifeguards become experts in resuscitation. Even lawyers do not consider themselves as practicing medicine without a license when they tell their friends to take an aspirin or a laxative. But nearly everyone (whether

qualified or not) tends to give advice on personal and family problems, for these are no longer the exclusive province of priest or oracle. The use of psychodrama in resolving emotional tensions of the sick-room is a valuable didactic and therapeutic medium.

BOOK REVIEW

MENTAL HEALTH IN EDUCATION, By Merl E. Bonney, Allyn and Bacon, Inc., 1960.

There has been a need in the field of education for a book whose subject matter is specifically focused on mental hygiene within the framework of the school's milieu. Dr. Bonney's book *Mental Health in Education* has met this need by bringing together principles of mental hygiene and relating it to the total school program. In this clearly written and easy to read book, Dr. Bonney has presented to all students of human relations "a body of material that bears on the total development of children and that, although related, are not closely involved in the teaching of academic skills and content."

The approach to the concepts of personality development, behavioral influences, interpersonal relations and psychosocial adjustment is an interdisciplinary one. The emphasis, however, is placed on how teachers can promote mental health objectives in and through groups.

The book is divided into six major parts. Part I gives the problems, their nature and sources; Part II describes the major goals or behavioral objectives for mental health education in our schools; Part III deals with description and evaluation of some instruments designed for interpersonal assessments of pupil's personalities; Part IV is concerned with classroom management and techniques of group discussion and sociodrama activities; Part V attempts to show the role of teachers as group leaders rather than instructors; and their classes as groups and not individuals; Part VI focuses on teacher adjustments with primary importance being mental health and teacher's personality.

The author presents numerous mental health problems that may be observed in and outside the school environment. Useful suggestions based on research, theory and experience, are offered as to prevention and amelioration of these emotional states. The value of sociometric techniques, group discussions, and role-playing sociodrama is referred to quite often with conditions and procedures outlined for the reader. Great importance is placed on obtaining quantitative data on the attraction-repulsion patterns and of evaluating these data in terms of mental hygiene objectives.

Dr. Bonney has introduced an interesting treatise which offers the reader a greater understanding of emotional and behavior disorders in children, their prevention, and a description of conditions and processes necessary for effective social living in the school environment. Only by

understanding the process as well as the results can educators construct their mental hygiene programs intelligently and positively.

Edwin L. Biggerstaff
North Texas State College
Denton, Texas

ACADEMY OF PSYCHODRAMA AND GROUP PSYCHOTHERAPY

Historical Background

The first Academy was held in Beacon, N. Y. in the spring and summer of 1940. It preceded the foundation of the American Society of Group Psychotherapy and Psychodrama by two years. Among the members of the advisory board of the Academy were Professors John Dewey, William H. Kilpatrick, Gardner Murphy and Dr. Nolan D. C. Lewis. Among the participating students were S. Chase, Dr. Ernest Fantel, Joseph Sargent, Frances Herriott, Anita Uhl, Denton Morford, Dr. Bruno Solby and M. Treudley.

The second Academy took place on June 28, 1941. Among the participants were Professors F. Stuart Chapin, Leonard Cottrell, George Lundberg, Margaret Hagan, Paul Lazarsfeld, Margaret Mead, Helen Jennings, George P. Murdock, Samuel Stouffer, Adolf Meyer, Theodore M. Newcomb, Werner Wolf, Dr. S. Bernard Wortis, Dr. Eugene Hartley and others.

The Director of the Academy (then called the Psychodramatic Institute and the Sociometric Institute) was J. L. Moreno, M.D., its founder. Two training centers developed within the Academy, one at Beacon, N. Y. in 1940, the other in New York City in 1942. A third training Institute recognized by the Academy developed at St. Elizabeths Hospital, Washington, D. C., first under the direction of Frances Herriott, now under the direction of James Enneis. Most of the training of Psychodramatists and Group Psychotherapists in the course of the last twenty years took place in these three training Institutes. The Academy of Psychodrama and Group Psychotherapy operates as a Training Center autonomously and separately from the American Society of Group Psychotherapy and Psychodrama. The scientific and professional relationship of these two organizations however, has been recently further cemented by the establishment of a joint committee consisting of representatives of both the Academy and the Society which will constitute a Committee of Training and Accreditation. This Committee in turn has formed the American Board of Group Psychotherapy and Psychodrama which will make possible the Certification of trainees as Diplomates in the separate fields of Group Psychotherapy and Psychodrama. Certification of candidates as Diplomates in both of these disciplines will be available to those who qualify.

Minimum Professional Standards for Psychodramatists

1. *"Diplomate" in Psychodrama*

The candidate has to fulfill the requirements for Director in Psycho-

drama set by the Academy of Psychodrama and Group Psychotherapy (APDGP). He has to fulfill requirements for Fellowship of the American Society of Group Psychotherapy and Psychodrama (ASGP&P). He has to have six or more years of specialized experience in Psychodrama, two years of general experience in group and social work or other additional specialized experience, total experience to be eight years. He must show excellence, competence and experience in the use of Psychodrama in at least four of the following fields: Therapy, teaching, industry, community, and institutional settings.

Substitution of Education for Experience

Directorial requirements of the Academy of Psychodrama and Group Psychotherapy (APDGP) and Fellowship requirements of the American Society of Group Psychotherapy and Psychodrama (ASGP&P) can not be substituted.

Education may be substituted for experience as follow: for up to six years of the above experience, graduate and undergraduate work at an accredited college or university may be substituted. To be creditable toward meeting experience requirements, the education must have included six semester hours per year in one or a combination of the following fields: psychology, sociology, social work, cultural anthropology, other social sciences, nursing education including a course in psychiatric nursing, medicine, or courses in related fields which indicate the applicant has a knowledge of the basic concepts of normal and abnormal psychology, psychiatry, or personality development.

The successful completion of study in nonaccredited institutions will be accepted on the same basis, provided that such institutions give instruction of definitely collegiate level and that the State University of the state in which the institution is located accepts the courses for credit. (In those states where there is no State University, the evaluation and acceptance of college credit as made by the state department of education will be accepted.)

2. *"Director" in Psychodrama*

A candidate must fulfill training requirements of the Academy of Psychodrama and Group Psychotherapy (APDGP). He must also fulfill membership requirements of the American Society of Group Psychotherapy and Psychodrama (ASGP&P).

Four or more years of progressively responsible specialized experience with two or more years of general experience in the area of group work or additional specialized experience, total experience 6 years. In addition show proficiency and experience in only one area of application, i.e., teaching, industry, therapy, community, or institutional settings.

SUBSTITUTION OF EDUCATION FOR EXPERIENCE

The substitution of education for experience for Director in Psychodrama may follow the same pattern as for Diplomate in Psychodrama.

3. *Training Status*

A candidate who has a status of a resident requires three or more years of progressively responsible specialized experience plus two years of general experience or two additional years of specialized experience. Education as outlined in section (1) may be substituted for experience except one year of specialized experience is required.

A candidate who has the status of an Intern or any similar status requires two years of progressively responsible specialized experience for which two years of general experience may be substituted or education may be substituted for experience as outlined in section (1).

The Council of the Academy of Psychodrama and Group Psychotherapy (APDGP) voted to establish a standing committee with representatives from each area in which psychodrama is used as a major tool. This Committee is empowered to appoint an examining board which would meet with one Committee member and applicants for the rank of Diplomate in Psychodrama or Director in Psychodrama for the purpose of determining their qualifications for these ranks. The examining board will meet annually at a time and place set by the Committee for Accreditation and Training.

Students of the Academy who feel that they meet the minimum standards for Diplomate in Psychodrama or Director in Psychodrama should write to the Chairman of the Academy requesting application forms to be completed and returned not later than the annual meeting of the Academy *of Psychodrama and Group Psychotherapy in 1962, at which time exami*nation by the Board will be necessary to achieve status of Diplomate in Psychodrama or Director in Psychodrama.

Until that date each application will be reviewed by the Committee and the examining board, appropriate action will be taken and a certificate will be sent to those individuals meeting minimum requirements.

MINIMUM PROFESSIONAL STANDARDS FOR GROUP PSYCHOTHERAPISTS

1. *"Diplomate" in Group Psychotherapy*

The candidate has to fulfill the requirements for Fellowship of the American Society of Group Psychotherapy and Psychodrama (ASGP&P). He has to fulfill the requirements for Director in Group Psychotherapy set by the Academy of Psychodrama and Group Psychotherapy (APDGP). He has to have six or more years of specialized experience in Group Psychotherapy, two years of general experience in group and social work or other additional specialized experience, total experience to be eight years. He must show excellence, competence and experience in the use of Group Psychotherapy in at least four of the following fields: Therapy, teaching, industry, community, and institutional settings.

SUBSTITUTION OF EDUCATION FOR EXPERIENCE

Fellowship requirements of the American Society of Group Psychotherapy and Psychodrama (ASGP&P) and directorial requirements of the Academy of Psychodrama and Group Psychotherapy (APDGP) can not be substituted.

Education may be substituted for experience as follows: for up to six years of the above experience, graduate and undergraduate work at an accredited college or university may be substituted. To be creditable toward meeting experience requirements, the education must have included six semester hours per year in one or a combination of the following fields: psychology, sociology, social work, cultural anthropology, other social sciences, nursing education including a course in psychiatric nursing, medicine, or courses in related fields which indicate the applicant has a knowledge of the basic concepts of normal and abnormal psychology, psychiatry, or personality development.

The successful completion of study in nonaccredited institutions will be accepted on the same basis, provided that such institutions give instruction of definitely collegiate level and that the State University of the state in which the institution is located accepts the courses for credit. (In those states where there is no State University, the evaluation and acceptance of college credit as made by the state department of education will be accepted.)

2. *"Director" in Group Psychotherapy*

A candidate must fulfill membership requirements of the American Society of Group Psychotherapy and Psychodrama (ASGP&P). He must

also fulfill training requirements of the Academy of Psychodrama and Group Psychotherapy (APDGP).

Four or more years of progressively responsible specialized experience with two or more years of general experience in the area of group work or additional specialized experience, total experience 6 years. In addition show proficiency and experience in only one area of application, i.e., teaching, industry, therapy, community, or institutional settings.

SUBSTITUTION OF EDUCATION FOR EXPERIENCE

The substitution of education for experience for Director in Group Psychotherapy may follow the same pattern as for Diplomate in Group Psychotherapy.

3. *Training Status*

A candidate who has a status of a resident requires three or more years of progressively responsible specialized experience plus two years of general experience or two additional years of specialized experience. Education as outlined in section (1) may be substituted for experience except one year of specialized experience is required.

A candidate who has the status of an Intern or any similar status requires two years of progressively responsible specialized experience for which two years of general experience may be substituted or education my be substituted for experience as outlined in section (1).

The Council of the Academy of Psychodrama and Group Psychotherapy (APDGP) voted to establish a standing committee with representatives from each area in which psychodrama is used as a major tool. This Committee is empowered to appoint an examining board which would meet with one Committee member and applicants for the rank of Diplomate in Group Psychotherapy or Director in Group Psychotherapy for the purpose of determining their qualifications for these ranks. The examining board will meet annually at a time and place set by the Committee for Accreditation and Training.

Students of the Academy who feel that they meet the minimum standards for Diplomate in Group Psychotherapy or Director in Group Psychotherapy should write to the Chairman of the Academy requesting application forms to be completed and returned not later than the annual meeting of the Academy of Psychodrama and Group Psychotherapy in 1962, at which time examination by the Board will be necessary to achieve status of Diplomate in Group Psychotherapy or Director in Group Psychotherapy.

Until that date each application will be reviewed by the Committee and the examining board, appropriate action will be taken and a certificate be sent to those individuals meeting minimum requirements.

MINIMUM STANDARDS FOR INSTITUTIONS FOR TRAINING IN PSYCHODRAMA AND GROUP PSYCHOTHERAPY

1. *Training at the Intern and Resident Level*

Intern training must be of at least twelve months' duration and include work in sociometry, group dynamics, psychopathology, psychotherapy, as well as specialized training in psychodrama. Emphasis is on auxiliary ego techniques and the development of proficiency in these and directorial techniques to the extent that the intern can handle therapy groups with personal supervision and can plan and run role playing groups with report and planning supervision.

Personal supervision is defined as directing sessions in the presence of a qualified psychodramatist or group psychotherapist who may offer supervision in the course of the session, in addition to planning prior to the session, and in reporting on the content and conduct of the session afterwards.

Planning and report supervision is defined as conference to clarify objectives and make plans for sessions prior to the trainee's directing. Following the session the trainee reports on the session and discusses content and techniques used.

Survey conferences are defined as periodic conferences with trainee in which progress in his various activities is discussed.

Resident training must be of at least twelve months' duration and offer a brief review with performance tests for the functions outlined in intern training. Emphasis is placed on directorial skills in therapeutic psychodrama and group psychotherapy and the development and use of specialized techniques such as tension system closure, psychodramatic shock therapy, hypnodrama, social change in large groups, intensive therapy in small groups, and staff groups. Supervision progresses from personal to report and planning, ultimately leading the resident to proficiency in directing therapy and training groups with weekly survey conferences.

2. *Basic Training*

Interns and residents will participate in the core or basic training program of the institution with other trainees where feasible. Content of this core program must include sociometry, psychopathology, group dynamics, psychotherapy, and directed reading with periodic discussion groups.

3. *Faculty*

Faculty must include a psychodramatist and group psychotherapist eligible for fellowship in the American Society of Group Psychotherapy and Psychodrama. In addition, he must have had a minimum of four years progressively responsible specialized experience in operating a psychodrama and group psychotherapy program.

A psychiatrist and a psychologist who are at least Board eligible must participate regularly as a consultant to the training program.

Other disciplines usually present in institutions, i.e., social workers, psychiatrists, psychiatric nurses, et cetera, should be utilized whenever available.

4. *Facilities*

The library of the institution must contain current recognized works in the fields of psychodrama, sociometry, and group psychotherapy.

A wide range of patient population must be available for clinical experience and must include neurotics and psychotics covering the age span from adolescence through old age.

There must be a psychodrama theater sufficiently large to accommodate a minimum group of ten and to have a stage area of at least fifteen feet in diameter.

There should be opportunities to work with normal groups as hospital staff, university classes, et cetera, in training sessions.

There must be periodic consultation with other staff members working with patients receiving psychodramatic therapy.

The Academy has organized a Board of Examiners who will determine the qualifications of persons to be nominated as Diplomates in one of the three categories, that is, of Group Psychotherapy (Gp), of Psychodrama (Pd), or of Psychodrama and Group Psychotherapy (Pd&Gp), as well as passing on organizations to be nominated as Training Institutes. The recommendations of the Academy will then be passed to the American Board of Group Psychotherapy and Psychodrama.

The Board of Examiners of the Academy consists of the following ten members:

Mary Angas (provisional)
Robert S. Drews
James Enneis
Martin R. Haskell
Helen H. Jennings
J. L. Moreno (Chairman)
Zerka T. Moreno
Marguerite Parrish
Hannah B. Weiner
Lewis Yablonsky

The Academy runs training programs at regular intervals. The next training periods are scheduled for July 1 through 31, 1961, and August 5 through 25, 1961. Students of all categories are invited. Upon completion of the course students may be eligible for one or another category of certification. The Academy gives three levels of Certificates: Certificate of Attendance, Certificate of Training and Certificate of Director. These certificates are given by the Academy solely representing the status of a student in his training development. They are also natural steps towards his application for Director or Diplomate.

J. L. Moreno, M.D.
Director
Academy of Psychodrama and
Group Psychotherapy
Beacon, N.Y.

ANNUAL MEETING OF THE ACADEMY, 1961

The Academy has an annual meeeting preceding the meeting of the American Psychiatric Association. The next one to be held will take place in Chicago on May 7th at the Hotel Morrison. The President of the 1961 Academy is Dr. Robert S. Drews, 12500 Broadstreet Blvd., Detroit 4, Michigan. Information on participation may be obtained from Dr. Drews.

ANNOUNCEMENTS

Scholarships and Internships

The Moreno Institutes in Beacon and New York have granted twelve scholarships for the year 1961-62.

St. Elizabeths Hospital has available five one-year internships with stipends from $3,200 up to $3,400 for qualified applicants.

Anniversary Issue of Group Psychotherapy

A special anniversary issue of the journal is in preparation to commemorate the banquet and session entitled "Twenty-Fifth Anniversary of the American Theatre of Psychodrama." Speakers at the banquet are invited to send in their manuscripts recapturing in essence their contribution to the banquet.

AMERICAN BOARD OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Meeting of the Joint Council of the Committee on Accreditation and the Committee of the Academy of Psychodrama and Group Psychotherapy

This meeting took place during the 20th annual meeting of the Society (ASGP&P) at the Hotel Commodore on March 25, 1961.

a) Members of the joint committee, all of whom were present, are:

Robert S. Drews
James Enneis
Martin R. Haskell
J. L. Moreno
Zerka T. Moreno
Jack L. Ward
Lewis Yablonsky

b) The decision was reached to form an "American Board of Group Psychotherapy and Psychodrama" consisting of the members of the joint committee. This Board is to pass on all matters of standards and policies in the field.

c) Three types of Diplomates were suggested: 1) Diplomate of Group Psychotherapy (Gp); 2) Diplomate of Psychodrama (Pd); and 3) Diplomate of Group Psychotherapy and Psychodrama (Gp&Pd).

d) The Board passed favorably on the application of the St. Louis State Hospital as a Training Institute for Psychodrama and Group Psychotherapy. Approval is contingent upon the satisfactory completion of a three year period. In accordance with the standards of the Board an inspection will be required in one year. There are now three other such Training Institutes: the Academy of Psychodrama and Group Psychotherapy in Beacon, the Moreno Institute in New York City, and the Psychodrama Department at St. Elizabeths Hospital.

Formalized Structure of the Board

1. The Board is to be legally incorporated. It will be strictly separated from the existing societies and training institutes. 2. It must have a constitution consisting of: a) rules; b) a grandfather clause, i.e., founders of the movement automatically become diplomates due to their experience and leadership in the field; c) requirements for new diplomates; these have to pass examinations set up by the Board. 3. Members of the Board can be designated after the Board has been incorporated. The seven who now represent the provisional Board can incorporate, but the final nominations must be made later. Once the Board is legally formed all officially recognized societies existing in the U.S. will be approached. In the future, members of the Board may or may not be identified as members of the societies or any other organization.

MORENO INSTITUTE FOUNDERS FUND

A committee has been formed by Dr. Lewis Yablonsky for the raising of funds consisting of the following individuals: Max Ackerman, Robert S. Drews, James M. Enneis, Martin R. Haskell, Helen H. Jennings, Walter Klavun, Wellman J. Warner, Hannah B. Weiner and Lewis Yablonsky. By March 31, 1961 the sum of $4,000.00 from 144 contributors has been received. A list of contributors follows.

Dr. Robert R. Blake
Dr. Lewis Yablonsky
Dr. Helen H. Jennings
Bishop Robert Hatch
Mr. Max Rosenthal
Mr. Willard Beecher
Dr. James M. Sacks
Miss Sally Stern
Dr. Martin R. Haskell
Mr. Arnold H. Dreyer, Jr.
Mr. and Mrs. J. R. Rodale
Dr. and Mrs. Joseph I. Meiers
Miss Janet Haas
Mr. Leah Gold Fein
Dr. Ruth Fox
Chaplain A. Herbert Fedder
Mr. Jim Thomas
Miss Mary Angas
Dr. Helen I. Driver
Dr. Marjorie Creelman
Mrs. Laurie Mae Carter
Mrs. Eya Branham
Dr. Edgar Trautman
Dr. E. Paul Torrance
Miss Agnes Moritz
Dr. Ida Gelber
Mr. James C. Logan
Dr. Lyle L. Miller
Mr. and Mrs. Alexander King
Mr. Nahum Shoobs
Dr. Danica Deutsch
Dr. Gustav Machol
Miss Hannah B. Weiner
Mrs. Marguerite M. Parrish
Mrs. Asya L. Kadis
Mr. and Mrs. A. Burroughs
Mr. Eugene Eliasoph
Mrs. Beverly Eliasoph
Mr. James M. Enneis
Mrs. Gladys Fownes
Miss Lani Kent
Dr. Calvert Stein
Mrs. Esther G. Gilliland
Mr. Walter Klavun
Dr. Edgar Borgatta
Mr. Leon Fine
Mrs. Reiko Fine
Dr. William Moore
Mr. Donald E. Beckerman
Mrs. Jane W. Carol
Dr. Burman H. Preston
Dr. Irving Chelnek
Dr. Friedy B. Heisler
Dr. Rolf Krojanker
Dr. Fernando J. Cabrera
Mrs. Sylvia Ackerman
Dr. Max Ackerman
Dr. Morris V. Borenstein
Miss Leah Torff
Mr. Bobker Ben Ali
Mr. Abel Fink
Mrs. Elaine Fink
Dr. Anna Brind & Dr. Nah Brind
Dr. and Mrs. Jack L. Ward
Dr. Norman Bourestom
Mr. Malcolm Shaw
Dr. Helene Papanek
Mrs. Sylvia R. Heimbach
Dr. Arthur Lerner
Dr. Harry Martin
Dr. A. W. Pearson
Dr. and Mrs. Neville Murray
Dr. Jack J. Leedy
Dr. Kurt Wolff

Mr. Wiley C. Bowyer
Mr. Malcolm J. Marks
Mrs. Cecilia G. Wells
Rev. John R. Green
Mr. Richard Rawdon
Dr. Joachim Auerbach
Dr. Walter J. Garre
Dr. Abel G. Ossorio
Dr. and Mrs. Wellman J. Warner
Dr. Walter Bromberg
Dr. Jan Ehrenwald
Dr. and Mrs. Norville L. Peterson
Dr. J. L. Moreno
Mrs. Zerka T. Moreno
Jonathan D. Moreno
Dr. Benjamin Kotkov
Dr. Martha Brunner Orne
Dr. Josephine M. Chapin
Dr. Rudolph V. Basso
Dr. Doris Twitchell Allen
Dr. George R. Bach
Dr. Anita Uhl Brothers
Mr. Theodore W. Franks
Dr. Eldred F. Hardtke
Dr. Joseph Wilder
Dr. Herbert A. Otto
Dr. Jordan Scher
Dr. Paul E. Johnson
Dr. Joseph Bernstein
Mr. Herbert Cohen
Dr. Isadore W. Stillman
Dr. Robert P. Odenwald
Mrs. Adaline Starr
Mr. Richard Korn
Mr. and Mrs. Henry Feinberg
Mr. Charles Neu
Mrs. Dorothy Brin Crocker
Dr. Alfred J. Marrow
Miss Georganne W. Hendry
Dr. Katharine W. Wright
Dr. and Mrs. Robert S. Drews
Mr. Sol Levine
Mr. and Mrs. Samuel W. Pearl
Miss Rose Garlock
Dr. Charles W. Slack
Dr. M. Weiner
Mrs. Priscilla B. Ransohoff
Dr. Robert D. Wirt
Miss Mary Orlando
Dr. Henry S. Sager
Miss Margaret Hagan
Mr. Austin M. Davies
Dr. Robert Boguslaw
Dr. Robert H. Fortier
Mrs. Phyllis Smith
Mrs. Jane Dunn
Dr. Henry Stratton

The fund raising activity continues and the Chairman of the M.I.F.F., Dr. Lewis Yablonsky, will report on its progress at regular intervals. The dedication of the plaque has been postponed until October 1st, 1961.

PROGRAM OF THE TWENTIETH ANNUAL MEETING OF THE AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

The Commodore Hotel
42nd Street at Lexington Avenue
New York City
March 24 and 25, 1961

Moreno Institute
236 West 78 Street
New York City
March 26, 1961

OFFICERS—President, Zerka T. Moreno; *President-Elect,* Martin R. Haskell; *Founder,* J. L. Moreno; *Secretary,* Hannah B. Weiner; *Treasurer,* Sylvia R. Heimbach.

COUNCIL MEMBERS—Mary Angas, Malcolm Shaw, Eugene Eliasoph, Jack Ward, Paul Johnson, Cecelia Wells, Marguerite M. Parrish, Calvert Stein, Kenneth Priestley, Robert B. Haas.

IN CHARGE OF REGISTRATION—Rochelle Haskell, *Chairman;* Ellen Goodman, Marion Koenig, Elaine Pellicane, Gilda Franklin, DeOnne Sorenson, Mary Nothhelfer, Sue Carlin, Nancy Grinberg.

Full Registration—including attendance of sessions and Banquet: Members $12.50; Non-Members $15.00.

Sessions Only: Members $2.50; Non-Members $5.00.

Registration Periods: 9:00-8:00 p. m., Friday; 9:00-5:00 p. m., Saturday; 9:00-1:00 p. m., Sunday.

PUBLICITY—Hannah B. Weiner

PROGRAM PLANNING—Zerka T. Moreno, Hannah B. Weiner, Martin R. Haskell, Lewis Yablonsky.

PUBLICATION OF PAPERS—Manuscripts of papers contributed to the program should be sent in duplicate, double spaced typewritten copies to: P.O. Box 311, Beacon, N.Y., at least one week before the meeting. Program Chairmen will collect papers at the meeting.

The Editorial Committee of *Group Psychotherapy,* the official journal of the Society, will select those contributions worthy of publication.

PROGRAM—Friday, March, 24, 1961

REGISTRATION

8:45 a. m.-8:15 p. m.—Ballroom Floor

OPENING MEETING—9:45-10:00 a.m.

Welcoming Address by the *President,* Zerka T. Moreno.

Introduction of New Fellows of the Society

MORNING MEETINGS—10:00-12:00 a. m.

SECTION I: *Windsor Court, TRAINING OF PROFESSIONAL PERSONNEL—Chairmen:* Calvert Stein—"Emotional Challenges of the Sick Room" and Abel G. Ossorio—"Use of Psychodrama in Resolving Interstaff Tensions." *Speakers:* Richard B. Hicks—"Psychodrama with Hospital Staff"; Theodore W. Franks—"Training of Psychiatric Hospital Administrators"; Adaline Starr—"Psychodrama and Sociometry in the Training of Ward Personnel in a State Hospital Staff Development Program"; Edna Rainey—(Topic to be announced); A. Edwin Harper—"Role Playing in the Training of Counselors"; With audience participation.

SECTION II: *Parlor B, SOCIOMETRY, GROUP DYNAMICS AND GROUP PSYCHOTHERAPY—Chairman:* Helen H. Jennings—"Sociometric Concepts and Personality Growth." *Speakers:* Laurie Mae Carter—"The New Role of the School Principal"; Hilary A. Gold—"Ideology and Sociometric Positions in the Classroom"; Paul Hurewitz—"The Neutral Isolate"; John H. Mann—"The Effectiveness of Group Psychotherapy"; Jim Thomas—"Problems of Sociometry as related to Group Psychotherapeutic and Psychodramatic Procedures"; Jacob Chwast—"Group Process in Leadership Training for Older Adults"; J. L. Moreno—Discussion, With audience participation.

SECTION III: *Parlor C, PSYCHODRAMA AND RELIGION—Chairman:* James Enneis—"Training Pastoral Counselors by Means of Psychodrama." *Speakers:* Allan N. Zacher—"The Use of Psychodrama in Pastoral Therapy"; John R. Green—"Sociodrama in a Church Setting"; Dale A. Anderson—"Religious Psychodrama"; David J. Greer—"Psychodrama and Worship"; With audience participation.

AFTERNOON MEETINGS—2:00-5:00 p. m.

SECTION I: *Windsor Court, THE PATIENT AND THE MENTAL HOSPITAL—Chairmen:* Kurt Wolff—"Group Psychotherapy with Geriatric Patients"; and Leon J. Fine (Topic to be announced). *Speakers:* Fernando J. Cabrera —"A Rehabilitation Program for Alcoholics in a State Hospital Set-up"; Manual J. Vargas—"Group Psychotherapy in an Admission Ward"; Janet A. Haas—"The Treatment of Alcoholics"; John J. Pearse—"Influence of the Open Door Policy in Mental Hospitals on the Group"; John J. Hoffman—"Psychodrama with In-Patients"; Alice R. Friedman—"Group Psychotherapy as a Way of Life"; Herman R. Weiss—"Group Psychotherapy in a VA Hospital"; N. William Winkelman—"The Silent Patient"; Nina

Toll—(Topic to be announced); Rolf Krojanker—"Sociometry in a State Hospital to Measure the Impact of the National Elections"; With audience participation.

SECTION II: *Parlor B, THE OPEN COMMUNITY—Chairman:* Hannah B. Weiner—"Recent Developments of Psychodrama in the Community." *Speakers:* Abel K. Fink—"Sociodrama in Open Groups"; James M. Sacks—"Psychodrama and the Improvisational Theatre"; Sylvia Ackerman—"Use of Psychodrama in the Treatment of Obesity"; Neville Murray—"The West Texas Syndrome in Psychodrama"; Doris Twitchell Allen—"Psychodrama as an Aid to Cross-National Communication"; Betty Murray—"The Recognition and Management of Group Self-Destruction in Psychodrama"; Jiri Nehnevajsa—"Role Playing Techniques in the Analysis of Political Behavior"; Eya Branham—"Plan for a Therapeutic Community"; DeOnne Sorensen—"Observations on the Use of Psychodrama in Open Sessions"; With audience participation.

SECTION III: *Parlor C, PSYCHODRAMA AND GROUP METHODS WITH CHILDREN AND ADOLESCENTS—Chairman:* Marguerite M. Parrish—"Group Techniques with Teen-Age Emotionally Disturbed Girls." *Speakers:* Herbert Cohen—"Psychodrama with an Adolescent Group"; Cecilia G. Wells—"Psychodrama with a Sociometrically Structured Group of Children"; James C. Logan—"Psychodrama Among Adolescents in the Orphanage Milieu"; Robert M. Carr—"Group Psychotherapy and Psychodrama with Children in the Sixth Grade"; John E. McManus—"Group Techniques in a Child Welfare Agency"; Benjamin Kotkov—"Group Psychotherapy of Children"; With audience participation.

EVENING MEETING—8:00-11:00 p. m.

PLENARY SESSION: *West Ballroom, Chairman:* Zerka T. Moreno. *Speakers:* Paul F. Lazarsfeld—"Sociometry in its Relation to Sociology"; J. L. Moreno—"Communism, Psychoanalysis and the Group Psychotherapy Movement." The final part of this session will consist of "Psychodrama of Marriage and Family," A Demonstration by J. L. Moreno.

Saturday, March, 25, 1961

REGISTRATION—8:45 a. m.-5:00 p. m.

MORNING MEETINGS—9:45-12:30 p. m.

SECTION I: *Parlor A, NEW APPROACHES TO PROBLEMS OF INDUSTRY—Chairman:* Robert R. Blake—"An Organic Approach to

Management Development and Organizational Improvement." *Speakers:* Priscilla B. Ransohoff—"Human Reliability Insurance"; Wallace Wohlking —"Psychodrama Applied to Labor Relations Training"; Malcolm Shaw— "Role Training of Salesmen"; Robert Boguslaw—"Spontaneity Training Revisited"; Jerry M. Rosenberg—"Group Psychotherapy and Psychodrama in Industrial Automation"; Theodore W. Franks—(Topic to be announced); With audience participation.

SECTION II: *Parlor B, TREATMENT OF MARITAL PARTNERS AND FAMILIES—Chairman:* N. L. Peterson—"Simultaneous Group Treatment of Married Couples." *Speakers:* Martha Steinmetz—"Psychodrama with Unmarried Mothers"; W. Marlin Butts—"Psychodrama with Graduate Students and Their Wives"; Clarissa Jacobson—(Topic to be announced); Malcolm Marks—"Simultaneous Treatment of Husband and Wife"; Joseph Mann—"Families in Treatment"; With audience participation.

SECTION III: *Parlor C, PSYCHODRAMA AND GROUP METHODS IN EDUCATION—Chairman:* Abraham E. Knepler—"Group Methods in Informal Adult Education." *Speakers:* Sylvia R. Heimbach—"Group Psychotherapy and Sociometry in a Retarded Class"; Arthur R. Laney— "Use of Psychodrama in Human Relations"; Jane S. Mouton—"University Training in Human Relation Skills"; Jerome M. Goodman—"Psychodramatic Techniques in Play Therapy"; Jay Sanford—(Topic to be announced); With audience participation.

MEETING OF THE COUNCIL

12:30-1:30 p. m.

Room to be announced

AFTERNOON MEETINGS—2:00-5:00 p. m.

SECTION I: *Parlor A, CRIME AND DELINQUENCY—Chairmen:* Lewis Yablonsky—"Criminology and Psychodrama" and Martin R. Haskell —"An Alternative to More and Larger Prisons, Role Training for Social Reconnection." *Speakers:* Harold F. Uehling—"Nine Years of Group Psychotherapy at Wisconsin State Prison"; Richard Korn—"The Relation of Professional Crime and Other Forms of Exploitation to the General Decline of Empathic Capacity"; Robert P. Odenwald—"Outline of Group Psychotherapy for Criminal Offenders"; Harold Greenwald—"Treatment of Call Girls in Group Psychotherapy"; Vernon J. Fox—"Applications of Group Methods in Criminology"; Eugene Eliasoph—"Psychodrama and Group Psychotherapy Applied to Problems of Juvenile Delinquency"; Sheldon W.

Weiss—"Bridging the Gap from Confinement to Community Living"; With audience participation.

SECTION II: *Parlor B, NEW HORIZONS IN PSYCHODRAMA AND GROUP PSYCHOTHERAPY—Chairman:* Robert S. Drews—"Psychodrama in Individual Psychotherapy." *Speakers:* Norman Bourestom—"Selected Aspects of Group Psychotherapy"; Jack Ward—"The Psychodrama of the LSD Experience, Some Comments on the Biological Man"; Walter J. Garre—"A Holistic Approach to the Human Personality"; Henry Feinberg—"The Ego Building Technique"; Max Ackerman—"The Role of Identification in Group Psychotherapy"; Joseph Wilder—"Recordings of Transference in Group Analysis"; W. John Weilgart—"The WERT in Group Psychotherapy"; Thomas A. Rouch—"Psychodrama in a Rehabilitation Center for the Blind"; With audience participation.

SECTION III: *Parlor C, PSYCHODRAMA, AUTOGENIC RELAXATION, PSYCHOMUSIC, PSYCHODANCE AND PSYCHOPUPPETRY —Chairmen:* Eya Branham—"Methods of Sound and Movement" and Reiko Fine—"Psychodance with Hospitalized Schizophrenic Patients." *Speakers:* Leo C. Muskatevc—"Principles of Group Psychotherapy and Psychodrama as Applied to Music Therapy"; Esther Gilliland—"Music Therapy"; Gertrud Rothman—"Autogenic Relaxation Applied to Group Psychotherapy"; Dorothy Brin Crocker—"Music Therapy"; Jonathan Moreno—"Demonstration of Psychodrama with Puppets"; With audience participation.

DUTCH TREAT COCKTAIL PARTY

West Ballroom—6:00-7:30 p. m.

EVENING MEETING—7:30-10:30 p. m.

BANQUET, PLENARY SESSION: West Ballroom, Twenty-fifth Anniversary of the American Theatre of Psychodrama, Highlight of the Pioneering Developments in Group Psychotherapy and Sociometry. Review of progress. Living contemporaries will reflect upon their "kairos" in the movement. *Chairman:* Zerka T. Moreno. *Among those invited as Guests of Honor:* Dr. Lovell F. Bixby, Mr. Austin M. Davies, Dr. and Mrs. Jacob Greenberg, Dr. Eugene Hartley, Mr. and Mrs. Alexander King, Commissioner Anna Kross, Mr. and Mrs. William Moreno, Dr. Gardner Murphy, Dr. Henry A. Murray, Dr. and Mrs. Winfred Overholser, Dr. George S. Stevenson, Dr. and Mrs. Leonard K. Supple, Dr. and Mrs. Wellman J. Warner.

Participating Past Presidents and Officers of the Society—Miss Mary Angas, Dr. Edgar Borgatta, Dr. Robert S. Drews, Mr. James Enneis, Dr. Abel Fink, Dr. Martin R. Haskell, Dr. Sylvia R. Heimbach, Dr. Helen H. Jennings, Dr. Abraham E. Knepler, Dr. Joseph I. Meiers, Dr. J. L. Moreno, Dr. Howard Newberger, Miss Marguerite Parrish, Mr. Nahum E. Shoobs, Mrs. Adaline Starr, Dr. Calvert Stein, Miss Hannah B. Weiner, Dr. Lewis Yablonsky.

Sunday, March 26, 1961

Moreno Institute, 236 W. 78th Street

MORNING MEETING

10:00-12:30 p. m.—Street Level

PLENARY SESSION: Dedication of the New Theatre of Psychodrama—Presentation of a Plaque to J. L. Moreno, Founder of Group Psychotherapy, Sociometry and Psychodrama. *Chairman:* Lewis Yablonsky; Informal participation from the floor.

Business Meeting for Members—12:30-1:30 p. m.

AFTERNOON MEETING—2:30-4:00 p. m.

PLENARY SESSION: Town Meeting of Group Psychotherapists and Psychodramatists. *Chairman:* Martin R. Haskell—The Summing Up by Chairmen of the Sections—Informal participation from the floor.

Election Results, 1961-62—President-Elect, J. L. Moreno; Vice-Presidents, Abraham Knepler, Hannah B. Weiner; Secretary, Mary M. Angas; Treasurer, Zerka T. Moreno; Members of the Council: Max Ackerman, Arnold Dreyer, Leon Fine, James M. Sacks, Jordan M. Scher, Kurt Wolff.

PSYCHODRAMA AND SOCIODRAMA OF JUDAISM AND THE EICHMANN TRIAL

J. L. MORENO, M.D.

Director, American Academy of Psychodrama and Group Psychotherapy

To the Presiding Judge of the Eichmann Trial in Jerusalem, Moishe Landau, and to his Associate Judges.
To the Prosecuting Attorney Gideon Hausner.
To the Defense Counsel Robert Servatius.
To the Prime Minister of Israel, David Ben-Gurion.
To the People of Israel.
To all Contemporaries Around the Globe.
To Adolf Eichmann.

On Sunday, May 7th, 1961, a session was held entitled "Psychodrama and Sociodrama of Judaism and the Eichmann Trial," during the Annual Meeting of the American Academy of Psychodrama and Group Psychotherapy, presided over by Dr. Robert S. Drews. The session was directed by Dr. J. L. Moreno who was assisted by: Lewis Yablonsky, Eva Salomon, Richard Korn, Adeline Starr, Calvert Stein, Neville Murray, Manuel Vargas, Max and Sylvia Ackerman, Zerka Moreno; it took place at the Hotel Morrison, Chicago, Illinois, U.S.A.

INTRODUCTION

This Psychodrama is not identical with a court of law, but the re-enactment of Eichmann's life and deeds within the framework of Judaism. It is not a theatre, but the representation of the experiences of actual victims.

On trial is not only Eichmann himself, but practically every human being living, in various degrees of involvement. Category 1, are the Jews who have actually been in the Nazi concentration camps and have undergone various ordeals of persecution but who managed to escape or survive, and are now the *living witnesses*. Category 2, are Jews whose relatives, friends, neighbors, have been taken to camps and vanished. Category 3, are Jews who are not involved by direct connection through concrete individuals but by role identification, because they are Jews. Often it is a cold involvement, or indifference, but involvement just the same. Category 4, are the Germans who have been on the other side of the fence, actually and concretely participating in the persecution of the Jews, either as members of the Nazi party or due to prejudices of their own people who have been Nazis in action and

are still in thought, or Category 5, those who have forgotten or were converted to a different attitude. Category 6, the Germans who have never participated in action but who are still Nazis at heart. Category 7, the Germans who have never been part of the Nazi system but fought it, who have never been guilty in action or thought, but who are persecuted because they are Germans. Category 8, the Gentiles who are not Germans but Nazi in thought and action. Category 9, the non-Jews of varying ethnic origins as the French, English, Italian, Hindu, Chinese, they are all here to participate with distantly involved emotions and astonishment.

The Psychodrama

The session consisted of a mock trial of Eichmann, in the presence and with the participation of an audience of Jews who have been in concentration camps during the Nazi persecution and survived, eye witnesses of murder, rape and many forms of persecution, an audience of Gentiles of various ethnic origins, and of criminologists, psychiatrists, psychologists, ministers and rabbis. In the spirit of a forensic psychodramatic trial all members of the audience participated to the degree in which they were involved personally or symbolically. The meaning of the psychodrama was not to duplicate the trial but to replace it by a trial of a different order in which the true and hidden experiences are brought before the conscience of the world. It was a trial of the world's conscience not only of the world's criminals. Adolf Eichmann was there, not the real one, but his symbolic double; he was not in a cage but free to speak and act for himself. In the actual Eichmann trial before a court of law in Jerusalem there is an enormous dormant psychodramatic element: the testifying of actual witnesses as to their experiences. They provide an infinite number of clues for a forensic psychodrama in the meaning of this report. Therefore, the session ended with the following recommendations to the Israeli court as to how to carry out and conclude their trial.

RECOMMENDATIONS

1. Adolf Eichmann shall be taken out of his cage and be given the full range of the courtroom to act out crucial episodes of his life, carefully selected and known to be true, under the direction of a skilled psychodramatist with a staff of auxiliary egos. He should be warmed up to a maximum intensity of self participation so that only the true experiences can come forth and distortions be hindered. The auxiliary egos should be instructed to present his father and mother, his teachers, significant episodes of his early childhood, his early indoctrination as a Nazi, his meetings with Hitler,

Heidrich, Himmler, his superiors and subordinates, to portray his dreams, his delusions, his hallucinations, his delusions of grandeur, his fears and panics and his complete abandonment of any feeling, episodes after the Nazi war was lost and he tried to escape, fleeing from country to country until he is finally captured and brought to Jerusalem and put on trial.

2. The first part of the psychodrama should be the process of re-enactment; the second part should be the process of catharsis. For Eichmann himself, his attorney, the court, and the world witnessing, in order to make the catharsis truly world-wide and meaningful, all mass media should be used to make a mass co-experience possible. Television, motion pictures, simultaneous psychodramatic re-trials in many parts of the world.

In this true purging of the psychodrama Eichmann should be carefully prepared for giving himself entirely to the task at hand. He should be instructed by the director to *reverse* roles with every Jew he has put into the gas chamber and should be made to relive the anxiety and panic of such a victim, he should be made to *reverse* roles with every Jew hiding from his men and being caught, he should be made to play the parts of children and young people whom he starved and sent to the deathcamps, he should be put in coffins, playing the part of corpses, he should be buried, thrown out into unknown places, he should be made to *reverse* roles with all the Jews he has actually humiliated, based on recall of actual episodes or actual dreams of episodes. In order to make the reversals real any "artistry" should be avoided; all that is buried in Eichmann's conscience should be mobilized. In every role reversal Eichmann has to be made to take the part of the victim and an auxiliary ego has to take the part of Eichmann or his henchmen. In order to intensify his production of reversals he has to be assisted by doubles and the use of other psychodramatic techniques so as to make his experience ultimate and universal. The entire psycho- and sociodrama should not last longer than about five hours, two sessions of two and a half hours each, in order to make it realistic and feasible. It should be reenacted at the end of the *formal* court proceedings. The entire Eichmann trial may find in the psychodrama of Judaism its true climax.

RECOMMENDED READING

PSYCHODRAMA, Volume I and II, J. L. Moreno, M.D., Beacon, N.Y.

Progress in Psychotherapy, Volume IV, "The Current Climate of Social Psychotherapy, J. L. Moreno, M.D., Grune & Stratton, Inc., 1960.

PSYCHODRAMA AND GROUP PSYCHOTHERAPY MONOGRAPHS

No. 2. Psychodramatic Treatment of Performance Neurosis—J. L. Moreno (List Price—$2.00)
No. 3. The Theatre of Spontaneity—J. L. Moreno (List Price—$5.00)
No. 4. Spontaneity Test and Spontaneity Training—J. L. Moreno (List Price—$2.00)
No. 5. Psychodramatic Shock Therapy—J. L. Moreno (List Price—$2.00)
No. 6. Mental Catharsis and the Psychodrama—J. L. Moreno (List Price—$2.00)
No. 7. Psychodramatic Treatment of Marriage Problems—J. L. Moreno (List Price—$2.00)
No. 8. Spontaneity Theory of Child Development—J. L. Moreno and Florence B. Moreno (List Price—$2.50)
No. 9. Reality Practice in Education—Alvin Zander, Ronald Lippitt and Charles E. Hendry (List Price—$2.00)
No. 11. Psychodrama and Therapeutic Motion Pictures—J. L. Moreno (List Price—$2.00)
No. 13. A Case of Paranoia Treated Through Psychodrama—J. L. Moreno (List Price—$2.00)
No. 14. Psychodrama as Expressive and Projective Technique—John del Torto and Paul Cornyetz (List Price—$1.75)
No. 15. Psychodramatic Treatment of Psychoses—J. L. Moreno (List Price—$2.00)
No. 16. Psychodrama and the Psychopathology of Inter-Personal Relations—J. L. Moreno (List Price—$2.50)
No. 17. Origins and Development of Group Psychotherapy—Joseph L. Meiers (List Price—$2.25)
No. 18. Psychodrama in an Evacuation Hospital—Ernest Fantel (List Price—$2.00)
No. 19. The Group Method in the Treatment of Psychosomatic Disorders—Joseph H. Pratt (List Price—$1.75)
No. 21. The Future of Man's World—J. L. Moreno (List Price—$2.00)
No. 22. Psychodrama in the Home—Rosemary Lippitt (List Price—$2.00)
No. 23. Open Letter to Group Psychotherapists—J. L. Moreno (List Price—$2.00)
No. 24. Psychodrama Explores a Private World—Margherita A. MacDonald (List Price—$2.00)
No. 25. Action Counseling and Process Analysis, A Psychodramatic Approach—Robert B. Haas (List Price—$2.50)
No. 26. Psychodrama in the Counseling of Industrial Personnel—Ernest Fantel (List Price—$1.50)
No. 27. Hypnodrama and Psychodrama—J. L. Moreno and James M. Enneis (List Price—$3.75)
No. 28. The Prediction of Interpersonal Behavior in Group Psychotherapy—Timothy Leary and Hubert S. Coffey (List Price—$2.75)
No. 29. The Bibliography of Group Psychotherapy, 1906-1956—Raymond J. Corsini and Lloyd Putzey (List Price—$3.50)
No. 30. The First Book of Group Psychotherapy—J. L. Moreno (List Price—$3.50)
No. 32. Psychodrama, Vol. II—J. L. Moreno (List Price—$10.00)
No. 33. The Group Psychotherapy Movement and J. L. Moreno, Its Pioneer and Founder—Pierre Renouvier (List Price—$2.00)
No. 34. The Discovery of the Spontaneous Man—J. L., Zerka and Jonathan Moreno (List Price—$2.25)
No. 35. Group Psychotherapy and the Function of the Unconscious—J. L. Moreno (List Price—$2.00)
No. 36. Twenty Years of Psychodrama at St. Elizabeth's Hospital—Winfred Overholser and James Enneis (List Price—$1.50)
No. 37. Psychiatric Encounter in Soviet Russia—J. L. Moreno (List Price—$2.00)
No. 38. An Objective Analysis of the Group Psychotherapy Movement—J. L. Moreno and Zerka T. Moreno (List Price—$0.75)

SOCIOMETRY MONOGRAPHS

No. 2. Sociometry and the Cultural Order—J. L. Moreno (List Price—$1.75)
No. 3. Sociometric Measurements of Social Configurations—J. L. Moreno and Helen H. Jennings (List Price—$2.00)
No. 6. The Measurement of Sociometric Status, Structure and Development—Bronfenbrenner (List Price—$2.75)
No. 7. Sociometric Control Studies of Grouping and Regrouping—J. L. Moreno and Helen H. Jennings (List Price—$2.00)
No. 8. Diagnosis of Anti-Semitism—Gustav Ichheiser (List Price—$2.00)
No. 9. Popular and Unpopular Children, A Sociometric Study—Merl E. Bonney (List Price—$2.75)
No. 11. Personality and Sociometric Status—Mary L. Northway, Ester B. Frankel and Reva Potashin (List Price—$2.75)
No. 15. Sociometric Structure of a Veterans' Cooperative Land Settlement—Henrik F. Infield (List Price—$2.00)
No. 16. Political and Occupational Cleavages in a Hanoverian Village, A Sociometric Study—Charles P. Loomis (List Price—$1.75)
No. 17. The Research Center for Group Dynamics—Kurt Lewin, with a professional biography and bibliography of Kurt Lewin's work by Ronald Lippitt (List Price—$2.00)
No. 18. Interaction Patterns in Changing Neighborhoods: New York and Pittsburgh —Paul Deutschberger (List Price—$2.00)
No. 19. Critique of Class as Related to Social Stratification—C. P. Loomis, J. A. Beegle, and T. W. Longmore (List Price—$2.00)
No. 20. Sociometry, 1937-1947: Theory and Methods—C. P. Loomis and Harold B. Pepinsky (List Price—$2.00)
No. 21. The Three Branches of Sociometry—J. L. Moreno (List Price—$1.25)
No. 22. Sociometry, Experimental Method and the Science of Society—J. L. Moreno (List Price—$10.00)
No. 23. History of the Sociometric Movement in Headlines—Zerka T. Moreno (List Price—$0.40)
No. 24. The Sociometric Approach to Social Casework—J. L. Moreno (List Price—single issue, $0.25; ten or more, $0.15)
No. 25. The Accuracy of Teachers' Judgments Concerning the Sociometric Status of Sixth-Grade Pupils—Norman E. Gronlund (List Price—$2.75)
No. 26. An Analysis of Three Levels of Response: An Approach to Some Relationships Among Dimensions of Personality—Edgar F. Borgatta (List Price—$2.75)
No. 27. Group Characteristics as Revealed in Sociometric Patterns and Personality Ratings—Thomas B. Lemann and Richard L. Solomon (List Price—$3.50)
No. 28. The Sociometric Stability of Personal Relations Among Retarded Children—Hugh Murray (List Price—$2.00)
No. 29. Who Shall Survive?, Foundations of Sociometry, Group Psychotherapy and Sociodrama—J. L. Moreno (List Price—$14.75)
No. 30. Sociometric Choice and Organizational Effectiveness—Fred Massarik, Robert Tannenbaum, Murray Kahane and Irving Weschler—(List Price—$2.00)
No. 31. Task and Accumulation of Experience as Factors in the Interaction of Small Groups—Edgard F. Borgatta and Robert F. Bales (List Price—$1.50)
No. 32. Sociometric Studies of Combat Air Crews in Survival Training—Mario Levi, E. Paul Torrance, Gilbert O. Pletts (List Price—$1.50)
No. 33. The Validity of Sociometric Responses—Jane Srygley Mouton, Robert R. Blake and Benjamin Fruchter (List Price—$1.50)
No. 34. Preludes to My Autobiography—J. L. Moreno (List Price—$2.00)
No. 35. Group Training vs. Group Therapy—Robert R. Blake (Ed.) (List Price—$3.50)
No. 36. Role Playing in Industry—Ted Franks (List Price—$3.50)
No. 37. The Methodology of Preferential Sociometry—Ake Bjerstedt (List Price—$3.50)
No. 38. The Sociometry of Subhuman Groups—J. L. Moreno, Ed. (List Price—$3.50)
No. 39. Definitions of Sociometry—Ake Bjerstedt (List Price—$2.00)
No. 40. Function of a Department of Human Relations Within the U.S. Government—J.L. Moreno (List Price—$1.00)
No. 41. Glimpses from the World of the School Child—Ake Bjerstedt (List Price—$3.50)