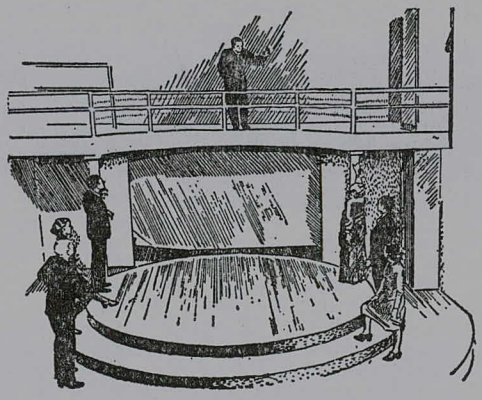
GROUP PSYCHOTHERAPY

A Quarterly



21ST ANNUAL MEETING
HOTEL SHERATON-ATLANTIC, NEW YORK CITY
APRIL 6, 7 AND 8, 1962

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY
AND PSYCHODRAMA

Vol. XIV, Nos. 3-4, September-December, 1961

GROUP PSYCHOTHERAPY

Volume XIV September-December, 1961 Numbers 3-4

CONTENTS

FOUNDED BY J. L. MORENO, 1947

GROUP PSYCHOTHERAPY

Volume XIV September-December, 1961 Numbers 3-4

GROUP PSYCHOTHERAPY

Volume XIV September-December, 1961 Numbers 3-4

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.

THE PSYCHODRAMA OF THE LSD EXPERIENCE—SOME COMMENTS ON THE BIOLOGICAL MAN*

JACK L. WARD, M.D.

The Carrier Clinic, Belle Mead, N. J.

Although d-lysergic acid diethylamide (LSD-25) was first formulated in 1938 and its hallucinogenic properties accidentally discovered in 1943, this amazing drug has been relegated to the laboratory for the most part. It has been viewed generally as an agent to produce a "model psychosis" from which investigators hopefully could learn some of the secrets of schizophrenia. LSD has been ignored as a therapeutic agent even though it has a striking lack of toxicity while other drugs with definite and serious toxic potentials have come into common clinical use (phenothiazines, Iproniazid, MAO inhibitors). Through 1959 some 700 scientific papers pertaining to LSD have been published, but it has not been until the last 10 years that this twenty-three year old drug has had any appreciable use as a therapeutic tool. Since then a small number of clinicians have made cautious therapeutic use of this potent preparation often with unexpected and "unexplainable" positive results (1, 2, 3, 4, 5, 6, 8, 9, 10, 12, 15, 16, 17, 18, 22, 23, 24, 25). Speculations as to the reasons for the relative timidity in the use of LSD are interesting but are not within the scope of this paper.

The results of LSD treatment pose puzzling questions to the clinician. Treatment failures are almost a relief because some of the spectacular successes with the drug do not readily fit into our current modes of thinking as to what psychotherapy is. We are relatively comfortable with the chemical effect of the tranquilizers and anti-depressants which apparently block the action of the noxious chemicals that the body produces, or becomes unable to detoxify or adjust to when an individual is anxious, depressed, schizophrenic, etc. We are somewhat "reassured" with the relapse of the "cured" schizophrenic when he stops taking his phenothiazine preparation. The formulation is easy. One becomes emotionally ill. The symptoms of the illness are mediated through biochemical changes. An antagonist to the chemical which is producing the symptoms is given and the symptoms disappear. But the same reasoning cannot be applied to the apparent reversal

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

of life-long patterns of adjustment (7) or the cessation of refractory alcoholic patterns (14, 27) following one LSD treatment, an agent which has a "body half-life" of only 30 minutes. The following are four such examples:

1. Schizoid Personality with market Depressive Features. 40 year old woman. 14 year history of severe depression with suicidal attempts. Marked difficulties in relations with husband, children and parents. Withdrawal from social activity. Inability to feel close to people of any sort. Psychotherapy 2-5 times weekly for 10 years. Trials on the available tranquilizers and anti-depressants. Acute depressive episodes required 22 EST in the past. Six month follow-up after one LSD treatment—no tranquilizers or anti-depressants; no psychotherapy. Depression greatly improved. Relationships with family and people in general all improved. Engaging in social activity with real accomplishment and personal satisfaction. Feels closer to people than before LSD.

2. Personality Trait Disturbance. Compulsive Personality with secondary Alcoholism and Alurate Addiction. Addicted to Alurate 10 years. 47 year old woman. Various unsuccessful attempts at control with psychotherapy and drugs. Five months follow-up after one LSD treatment—no consumption of Alurate; no compulsive drinking. Functioning better in marriage and in society.

3. Sociopathic Personality Disturbance. 20 year old man. Six year history of anti-social acting out including the use of alcohol and narcotics, criminal acts and sexual difficulties. Had been in jail on one occasion and in a State Hospital for 3 months. Psychotherapy and various tranquilizers used to no avail in the past. He had been expelled from various schools. 8 month follow-up after one LSD treatment—good student, chairman of student council, captain of football team in prep. school. After first term, patient transferred to a prep. school which had fewer problem children. Mother states that the patient is completely changed for the better in family and social relationships.

4. Passive Aggressive Personality with addiction alcohol. 33 year old man. 10 year history of alcoholism, inability to assume social or family responsibility, unreliability, feelings of inferiority, guilt and depression. Psychotherapy attempted without success previously. Five month follow-up after one LSD treatment—no drinking; taking responsibility and assuming a definite role as head of his household. No periods of deep depression or guilt. Increased frustration tolerance. Assertive and self-confident. Taking competitive examinations for specialized training in his field of work and making concrete plans for "bettering himself" through on-the-job train-

ing, outside education, etc. This puzzling state of affairs has remarkable similarity to the spectacular results occasionally reported by Dr. J. L. Moreno with "Psychodramatic Shock" and apparent cure, in one session, of individuals who have not responded to the usual intensive treatment efforts (13, 20).

In comparing LSD treatment (the dosage level in the treatments referred to is 200 to 600 micrograms) and Psychodrama one is struck by people's initial assumption as to what happens or is helpful in each. It is almost invariably assumed that the techniques give catharsis, release of suppressed and/or repressed material which can later be used in psychotherapy, and possibly the development of insight. The techniques are viewed as aids in psychotherapy similar to Sodium Amytal or Ritalin interviews. While both techniques produce the three effects mentioned above and while the three are valuable components in any therapy, certainly these intellectual concepts are not the core of any successful therapy. Catharsis, uncovering and insight may be the paths along which one can move to "work through" in the Freudian terminology; but these three things, no matter how effective their applications can be to destroy the distortions of transference, are not in themselves the "working through" or the corrective experience. They can be the means by which the individual is freed to grow, but they are not growth itself.

I do not pretend to know what growth is, but I think that, I, as well as any other person interested in people, can recognize when it has occurred. It is my conviction that in both the Psychodramatic and LSD treatment experiences the forces leading to growth are somehow concentrated in greater intensity than in other forms of therapy. Therefore I think that it can be profitable to view the similarities or identities in the two forms of treatment.

In both forms of treatment there is no room for the "as if" operation. In Psychodrama, if the protagonist, group or auxiliary egoes are acting instead of living what they are doing, the session will be almost useless. If the converse is true the session is very productive. In LSD there is no "as if" experience. One is not "like" something; one is. It is not as if one were looking at one's self; one looks at one's self. It is not as if one had a heart attack like that which killed father; one has it and so convincingly that on one occasion an empathic physician present felt the same acute physical symptoms himself.

In both forms of treatment it does not matter whether the living that the person does is literal or specific, or if it is in the past, present or future or if it is entirely symbolic or consists purely of dreams and fantasies. It

matters not as long as the person is living it and having the emotional experience. Noted above is the necessity of this for psychodrama. With LSD there often is quite literal "living-through" of actual events and the statement that now one sees from many angles things which previously one could appreciate only from a single prejudiced view. With LSD there are sometimes statements such as, "I've lived through every traumatic event in my life for the last twenty-five years. I've been fighting all day long." And yet the individual saw only symbols. Blue for cold and depression. Red for intensity—hate or sex. Jagged lines for hostility, etc. They were on a wheel, and it kept rotating and as each object came her way she had and dealt with the feeling. Somehow she had resolution of her problems. She lived them at the moment. She had her own intra-psychic Psychodrama in situ symbolically. But she lived and felt and had her "working through" or "corrective experience." She reached the point of liking herself and of realizing, at least for the moment, the ridiculousness of transference distortion. Whether, in the years to come this will hold, is a question, but at the present time it does, just as does the Psychodramatic Shock session of Dr. Moreno's at a state hospital on a"hopeless paranoid" which occurred ten years ago.*

Although I emphasize the concept of the intra-psychic experience above, I do not underemphasize the influence of the audience in either Psychodrama or LSD. One of the reasons for the tremendous emphatic support of the audience in Psychodrama is the fact that the protagonist has been chosen ideally because of the sociometric structure of the group and represents for the group an issue in which the group as a whole is invested. With LSD this is not so except on a global basis in that the intense experiences of the LSD patient are basically common to all of us. This is probably the reason why the LSD patient feels that he has shared with the observers a basic experience even though he often has not spoken about it while going through it. It is obvious that everyone has an exquisite perception of the reaction of those about him when he is undergoing the effect of the drug. Negative comments often bring out paranoid reactions as in one patient who said to a physician who was his friend and who began to probe, "Your fingers are growing long and claw like. It's amazing how someone can change in one minute. I'm not going to answer anybody's questions from now on." More usual, if one has a skilled LSD "Audience," is the unexpected comment, "Thank you for being here and going through this with

* Personal communication.

me." Which remark is very much equivalent to that of the protagonist who has lived on stage and who feels the support of the group even before the group reacts verbally when action on stage has been terminated.

Impressive in both techniques is the amount of spontaneity that human beings are capable of under favorable conditions. In Psychodrama a psychological climate is created in which the development of spontaneity is encouraged and at times almost demanded. It is not unusual for a patient who is rigid and defensive in individual therapy to become alive in the spontaneous climate of the Psychodrama Stage. With LSD the stimulus is chemical, and the individual is freed or forced to experience a great outpouring of feeling often far beyond his conception of his own emotional capabilities. Sometimes the patient becomes so overwhelmed by the unexpected extent of his own spontaneity that he experiences acute (fortunately temporary) panic because of his own "lack of control." However, such feelings are usually followed by a feeling of great peace, a result which is also similar to many successful Psychodrama sessions.

With LSD there is frequently a transcendental phase in which the individual feels at one with everything. Just a the participants in an ideal Psychodrama have found within themselves the roles they are living on stage, the LSD patient finds within himself multitudes of roles and feelings which he has lived. And now in the transcendental phase he finds in himself an essence which ties him to his fellow humans and indeed even to his "Nonhuman Environment."* The feeling of "oneness" as a goal in Psychodrama and all psychotherapy has been variously stated by Dr. Moreno (21).

Somehow many of us who have been interested in Psychological and Social forces and in Psychotherapy have lost the concept of "oneness." We amputate the psyche from the soma and in effect become preoccupied purely with psychological functions while at the same time mouthing a meaningless acceptance of the idea that man is a unit rather than being a duality of Psyche and Soma, each of which influences the other. Perhaps our amputation of the Soma has its roots in our rejection of the older organically oriented approach which concentrated on the soma—on heredity and on the hopelessness of organically based change—and which practically excluded the Psyche.

Against the dead-end organic theories, our enthusiasm for workable psy-

* Dr. Harold Searles proposes the concept that an individual's kinship or lack of kinship with his nonhuman environment is an important factor in his psychological health (26).

chological theories and for our psychotherapeutic successes has been understandable. However, psychological theories are now well accepted and permeate all aspects of our lives. It is no longer necessary to "press home" the point in a single-minded and determined fashion. It is no longer necessary to have blind spots.

Man is a biological organism, not purely a psychological one. When we talk of feeling we must consider not only one aspect of the feeling but the feeling in its totality if we are to learn anything about the feeling or really deal with it. For instance, when we consider fear or anxiety, we must appreciate the increased heart rate and blood pressure, the increased blood sugar, the sweaty palms, the "knot in the stomach," the shift of circulation from skin and viscera to the muscles, the pupillary changes, the bronchial tree changes, the "goose bumps," etc. not as an effect of being frightened, but as *part* of the experience of being frightened.

While approaching the biological we must also appreciate the psychological and social forces which impinge on the individual every moment of his life and which also are a part of any experience of the individual at any moment. I take it that this is what Dr. J. L. Moreno refers to in his discussion of the "Social and Organic Unity of Mankind," the opening sentence of which section is, "A truly therapeutic procedure cannot have less an objective than the whole of mankind" (19). As broad and revolutionary as this idea may appear—especially when compared to some current schools of therapy which are preoccupied with the adjustment of the individual to his particular local society without questioning the validity of that particular society's mores—it is not broad enough in that it does not include man's relationship to animals, vegetation and inorganic materials.* Searles' brilliant insights (based on his own feelings, on his experience with patients and on his exhaustive culling of the literature) challenge us to deny the meaningfulness of our relationships with such non-human things as a dog, a flower or a house, mountain or seashore. Enneis (11) clearly portrays the humanity of the relationship with the inorganic when he describes the attempt of a schizophrenic to give hope to a "hopeless" neurotic group. The schizophrenic explains his love for a building and describes how he has actually hugged the building, a "crazy" stimulation which moves the group members to tears and to consideration of the awful isolation that we can have from each other and from things.

* See however Moreno's Words of the Father, 1951 and Global Psychotherapy, Vol II, Progress 1957 and the principle of "all-inclusiveness" in Psychodrama II, Discovery of the Spontaneous Man, 1955.

SUMMARY:

Stimulated, both by his own and by his patients' LSD experiences, and by instances of spectacular positive changes following one LSD treatment, the author has offered some tentative speculations as to the general areas in which the "je ne sais quoi" of successful therapy might be found. Similarities between the LSD experience and Psychodrama were noted as possibly indicating some of the factors that constitute the effective core of any psychotherapy. It was suggested that man can be understood only if his relationships with animal, vegetable and inorganic matter are considered in addition to his relationships with other humans.

BIBLIOGRAPHY

1. ABRAHAMSON, H. A., ET AL, *The Stablemate Concept of Therapy as Affected by LSD in Schizophrenia.* Jl. Psychol. **45**:75 (1958)
2. ABRAHAMSON, H. A., ET AL, *Lysergic Acid Diethylamide (LSD-25): As an adjunct to Psychotherapy with Elimination of Fear of Homosexuality.* Jl. Psychol. **39**:127 (1955)
3. ABRAHAMSON, H. A., ET AL, *Lysergic Acid Diethylamide (LSD-25):XIX. As an adjunct to Brief Psychotherapy, with Special Reference to Ego Enhancement.* Jl. Psychol. **41**:199 (1956)
4. ABRAHAMSON, H. A., ET AL, *Lysergic Acid Diethylamide (LSD-25): XXII. Effect On Transference.* Jl. Psychol. **42**:51 (1956)
5. ANDERSON, E. W., ROWNLEY, K. *Clinical Studies of Lysergic Acid Diethylamide* MSCHR. Psychiat. **128**:38 (1954)
6. BUSCH, A. K. AND JOHNSON, W. C. *LSD 25 as an Aid in Psychotherapy.* Dis. Nerv. System **11** August (1950)
7. CARRIER, R. C., LE FEVER, H. AND WARD, J. L. *Preliminary Report of the LSD Project at the Carrier Clinic.,* Unpublished paper presented to the Department of Psychiatry of the Temple University, School of Medicine, Philadelphia, February, 1961.
8. DAY, J. *The Role and Reaction of the Psychiatrist in LSD Therapy.* Jl. Nerv. and Mental Dis. **125**:437 (1957)
9. DAVIES, MEB., DAVIES, T. S. *Lysergic Acid in Mental Deficiency.* Lancet **269**:1090 (1955)
10. ESNER, B. G., COHEN, S. *Psychotherapy with Lysergic Acid Diethylamide.* Jl. Nerv. and Ment. Dis. **127**:528 (1958)
11. ENNEIS, JAMES, *"Training Pastoral Counselors by Means of Psychodrama",* Unpublished paper presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama in New York City, March 24, 1961.
12. FIELD, M., GOODMAN, J. R., GUIDO, J. A. *Clinical and Laboratory Observations on LSD-25.* Jl. Nerv. and Mental Dis. **126**:176 (1958)
13. GARBER, R. S. Personal Communication

14. HOFFER, A. *The Use of LSD in Psychotherapy.* pp 18 Transactions of a Conference on d-Lysergic Acid Diethylamide (LSD-25) at Princeton, N. J. 1959. Edited by Harold A. Abramson, M. D., Josiah Macy, Jr. Foundation, New York (1960)
15. LENNARD, H. JARVIK, M. E., ABRAHAMSON, H. A. *Lysergic Acid Diethylamide (LSD-25) XII. A Preliminary Statement of its Effects upon Interpersonal Communication.* Jl. Psychol. **41**:81 (1956)
16. LEWIS, D. J., SLOANE, R. B. *Therapy with Lysergic Acid Diethylamide.* Jl. Clin. and Exper. Psychopath. **19**:19 (1958)
17. LANGER, F. W., KEMP, M.D. Quart. Bull. Pinebluff Sanit. **1**, (1956)
18. MARTIN, J. *LSD (lysergic acid diethylamide) Treatment of Chronic Psychoneurotic Patients under Day-hospital Conditions. Internat.* Jl. Social Psychiatr. **3**:188 (1957)
19. MORENO, J. L. *Who Shall Survive?* Beacon House, Inc., Beacon, N.Y. First edition (1934), Second edition (1953)
20. MORENO, J. L. *Personal Communication.*
21. MORENO, J. L. *Psychodrama Vol. I.* Beacon House, Inc., Beacon, N.Y. (1945)
22. SANDISON, R. A., WHITELAW, J. D. A. *Further Studies in the Therapeutic Value of Lysergic Acid Diethylamide in Mental Illness.* Jl. Ment. Sc. London **103**:32 (1957)
23. SANDISON, R. A. *Psychological Aspects of the LSD treatment of the Neuroses.* Jl. Ment. Sc. **100**:508 (1954)
24. SANDISON, R. A. *LSD Treatment for Psychoneurosis, Lysergic Acid Diethylamide for Release of Repression.* Nurs. Mirror, London **100**:1592 (1955)
25. SANDISON, R. A. ET AL. *Lysergic Acid Diethylamide and Mescaline in Experimental Psychiatry.* Grune & Stratton. New York (1956)
26. SEARLES, H. F. *The Nonhuman Environment.* New York: International Universities Press, Inc. (1956)
27. SMITH, C. M. *A New Adjunct to the Treatment of Alcoholism: The Hallucinogenic Drugs.* Quart. Jl. Alcohol 19, 406 (1958)

ROLE PLAYING IN THE TRAINING OF COUNSELORS[1]

A. EDWIN HARPER, JR., Ph.D.[2]

Bureau of Educational Research, Ewing Christian College, Allahabad, India

This paper describes two programs: One to arouse teachers to the need for counseling, and the other to give them a minimal orientation (rather than "training" in the formal sense). It also demonstrates the author's experience that group methods and role playing are effective in several cultures which differ more or less widely from each other, and from that of the U. S. A.

FIRST PROBLEM

About three years ago we were casting about for an effective way to launch a guidance program in the dozen schools and colleges of the North India Synod of the United Church of Northern India. We would be dealing with teachers most of whom had never even heard of the words "counseling" or "guidance", in their technical senses. Yet our basic hypothesis was that many teachers *do* counsel, so our problem was not so much to start a program as to call attention to the need to increase, even if only slightly, the effectiveness of what was already being done. And, secondly, we wished to arouse an interest and sensitivity to these needs among those who were now doing nothing.

We rejected the most obvious mothod, lecturing, for several reasons:

(a) Lectures often tend to arouse defense mechanisms, rejection, even hostility to any change or new ideas. The teachers say to the lecturer, particularly if he implies that they *ought* to be doing more counseling, "But you don't understand our problems." (And frequently he doesn't, really.) There is a need for solutions to come from the teachers concerned, rather than from outside, if they are to be really effective.

(b) Or lectures may lead to a purely "theoretical" and talking about it" response. Great enthusiasm is developed, and there are endless discussions—which tend to become a substitute for action.

(c) Lectures are, by their nature, fairly abstract. It is hard to illus-

---

[1] This paper was presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, New York, March 24, 1961.

[2] I wish to acknowledge the aid of J. N. Kamble, M. A. Cassady, and Sushil K. V. Liddle in leading the sessions in India, and in the development of these ideas and techniques.

trate them in ways which are meaningful and *applicable* or *transferable,* in a particular situation. We all know that the "classic" cases described in the classroom are seldom met in real life—while the real life cases are far too complex for a brief *verbal* description.

"Discussion" or "seminar" approaches are somewhat better than straight lecture, but they often suffer from the same defects. There is a degree of abstraction and generalization which is necessary, but which often makes it difficult to get down to the level of concrete reality and practical applications.

It was in this impasse that we decided to experiment with role playing as a means of reaching our objectives.

The procedure described here has been used with over a score of school and college teacher groups, of both men and women, in three widely separated and different parts of India (U. P., Punjab, Kolhapur), and in Lebanon. The groups have ranged in size from 8 to 30, and have represented sometimes a single and sometimes two or more institutions. Sometimes we have had two two-hour sessions with a group (including a half-hour for tea) on successive days, sometimes a single two to three-hour session. Our experience has been that a group of 15 to 20, representing a single institution, meeting for two sessions on successive days seems to work out best.

Procedure For First Problem

The first session begins with a fifteen-minute "warm-up"—first getting acquainted with leaders, and then a brief talk on the general nature of counseling, the program we are starting, etc. Although all of the participants knew some English, they were assured that both drama and discussion could be carried out in any language that they felt most at home with. Usually, a mixture of languages were used in the discussion. Each leader was provided with personal interpreter, where necessary.

After the warm-up, two volunteers were called for to put on "a psychodrama". (The word is irresistable, even if it does not technically apply to the product!). While the volunteers were taken outside for briefing by one of the leaders, the other explained to the audience what was to happen. He told them the situation to be portrayed, explained that the players were *not* playing themselves but were playing "typical teacher" and student, and asked them to take the production seriously. (Embarrassing laughter and giggling did sometimes take place during part of the drama, and in at least one instance the players "hammed it up" quite

deliberately as a comedy; yet, oddly enough, this did not seem to affect the seriousness or value of the discussion which grew out of the drama.)

The briefing consisted in suggesting a situation fairly common in India: A student has finished his high school examinations, and now wonders what to do next. The volunteers chose their roles, and were allowed a short time to rough out a plot. They were asked not to make this too specific, as they were to "make it up as you go along", and were allowed not more than three to five minutes for this phase. (In the one case where a longer time was allowed, the resulting drama fell quite flat.) The person playing the teacher role, particularly, was told: "Do not play yourself. Show, rather, how you think a typical teacher in your school would react to this problem." This was to protect the individual from feeling that he, individually, was being criticized, in the discussion which followed. (The role was, obviously, a projection of the individual, but we tried to minimize awareness of this both by the individual and the group.)

The drama was then presented to the group. Sometimes it ran to its natural conclusion; otherwise, it was cut off at the point where it began to become repetitious and unproductive. It was seldom allowed to run more than 5 to 10 minutes.

A second pair of volunteers was then asked for, and taken out for briefing. The second leader usually used this time to hand out the paper and pencils that the leaders had brought, but without any explanation other than that they would be needed later.

Actually, the leaders considered the first drama as part of the general warming up, and the second as the significant experience. This second situation was also one which is not uncommon in India: This student has failed his examinations, but does not know why he has failed —he actually expected to do well. He is confused, lost, depressed, lacking in any insight. He fears to face his parents, may refuse to go home, may even threaten suicide. He comes to his teacher with his problem. Our teachers had no difficulty empathising with this role, and it produced some very absorbing and dynamic little dramas, which brought the difficulties and challenges of the counselor's task into sharp relief.

After the second drama was finished, the members of the audience were asked to write down their comments, what they would have done had they been the counselor, etc. It was explained that these comments were for each individual's own use in the discussion, and not to be handed in—so they could be brief in any kind of "short-hand" that they wished. They were advised to write their comments on the second drama first ("since it is freshest in your mind").

This "writing down" was felt to be a vital part of the procedure, and the leaders always brought pencils and paper with them to be sure it would be done. It was felt that (a) this preserved spontaneous reaction, before ideas and opinions were changed by discussion (where one or two leaders often mould the group to their own opinions); and (b) when they had first committed themselves to paper, they seemed more willing to speak up to their own opinions in the group discussion.

At this point, the group usually broke up for refreshments. In the schools where there were two sessions, this was the end of the first. For safe-keeping, the leader collected all of the comments in a large envelope, emphasizing that he had no intention of looking at them but just did not want them lost.

The second session (or the second part of the single session) began with a reminder that the role-players had *not* been playing themselves; especially, that the teacher who played the counselor had been attempting to portray a "typical teacher of this school" in that role. Therefore, the discussion of what had happened could be quite free and objective, without anyone feeling that there was any direct criticism of the teachers who dramatised the counseling sessions.[3]

The discussion centered mainly around the second drama, and around the elements common to both. Two somewhat different approaches were used, depending on the discussion leader:

When the writer of this paper led the discussion, he usually asked the first person to read out the comments he had written; the second was asked to read any not already mentioned by the first; and so on, around the circle. The discussion then centered around such questions as, "What would *you* have done?" and "What advice would *you* have given?" Further discussion of the conflicting advice suggested usually led to the insight that "advice" giving is wrong—the student must be helped to make his own

3. The leader received only one bit of "negative feed-back" that led him to question the effectiveness with which he had "impersonalized" the drama roles. In this instance, due to lack of time, only the second drama was discussed. He was later told that the teacher who played counselor in the first drama "felt hurt because you did not discuss her case too". Dr. Abel K. Fink's paper, "Some Action Hypotheses for the Consideration of Directors of 'Open Group' Sociodramas", presented in the same meeting of the ASGPP, led to the insight that the use of role reversals would have further protected the individuals from being identified with particular roles. Roles were occasionally reversed to heighten the drama at critical points, or because one actor was much better than another, or to stimulate a greater variety of ways of handling the problem being shown; but this was not done consistently.

decision. Further questions were, "What did the student *really* want? Advice? . . . sympathy? . . . understanding?"

A second approach to the discussion period was probing by the group leader, with the notes serving only for individual reference, but not read out to the group. This was the approach developed by Mr. Jivanrao Kamble, whose basic question, very effectively reiterated, was: "Was the student helped?" The discussion around this question, and the whys and hows of the answer given, sometimes led very deep.

In Lebanon the above outline had to be modified somewhat because of (a) the limitation of most meetings to only an hour, and (b) the lack of a second leader. Two modifications were introduced: (a) The warm-up lecture was cut to about 5 to 7 minutes; and (b) "buzz session" groups of about 3 to 6 discussed the two dramas, rather than having individuals write down their comments. We were dealing with a fairly articulate group of teachers, so the net effect of the "buzz sessions" was to assure a good spread of ideas and opinions while drastically cutting down the interval necessary between the dramas and the full group discussion.

Certain Phenomena

We found it necessary to explain certain phenomena to the discussion groups, as they tended sometimes to be confused by them.

First was the phenomenon of condensation and rapid movement of psychological processes in the role-playing drama. We explained that a psychological process which might take an hour, or even many hours, might take place in a few minutes in this situation. Since the "problems" were of short duration and not deeply enmeshed in the individual's personality, as they would be in a real situation, the solution was equally quickly arrived at. Yet the basic psychodynamics of the process, though highly condensed, seemed roughly the same as in a "real" situation.

Second was the involvement of the player in the role, in the sense that it became very real to him, and he developed a great deal of insight into it. This was often a very valuable resource in the discussion period, although drawing on it too soon might bring the discussion to an end. There was the very vivid portrayal by a lady teacher of a girl who had failed, and was hysterically threatening suicide. (Post-examination suicide is a very real problem in India.) After a long and heated discussion on "was she helped?", someone finally turned to the teacher who had played the girl's part, and said, "*Did* you commit suicide?" Her very positive "no" was obviously the final word on the matter.

We were prepared to try to avoid "depth" problems that might arise from too great projection of the individual in his role, but our fears proved groundless. Perhaps because we had told them "Do not play yourself," the teachers did not seem to project their own problems particularly into the roles. Had they done so, we would have attempted to steer the discussions away from these sensitive areas. A better way of avoiding them might have been role reversals (see footnote 3).

As mentioned earlier, we were even able to use for serious discussion the one instance in which the role-players treated the whole thing as a farce. We did this by ignoring the comedy (beyond a good hearty laugh), and concentrating on the dynamics of what counseling actually did take place.

Finally, we were most impressed by the movement of the group discussion from the particular to the general. As mentioned earlier, movement from the general to the particular is often very difficult, if not impossible. But when we *started* with two particular instances of teacher-student counseling, and focused on them in detail, significant generalizations usually emerged. And we felt that insights gained this way were much more likely to be applied next time a student comes for counseling, than any number of "basic principles" copied down from a lecture. One group came back at the leaders with demand for better job information and career descriptive materials, another decided to set up a cumulative record system in the school. It has been our bitter experience that when these things are merely supplied or imposed from the outside, they are largely ignored by the "too busy" teachers.

Second Problem

Last November the writer was invited to Lebanon, to lead a three-day workshop for secondary school teachers, on the problem of counseling. The workshop was preceded by travel around the country seeing each school, and a meeting with the full faculty of each of the schools. (There was also a separate half-day conference for college and seminary teachers.) Each school sent several teachers to the workshop, making a total group of about twenty-five. This group included not only teachers but some principals and administrators as well.[4]

[4] There were actually two groups in the workshop, one studying Bible teaching under the leadership of Dr. Mary Lyman, of Union Theological Seminary. Of the total of 50, about half the teachers and principals were in her seminar. The two groups came together for a worship service in the morning, and for a joint session in the evening, in which one or the other of the two leaders spoke. It was interesting that there turned out to be a great deal in common between the two leaders' approaches:

When the writer speaks of three days of training for counselors, he is obviously using the words "counselor" and "training" in a very minimal sense. In fact, he would prefer to call it "orientation of attitudes," on the hypothesis that a development of proper attitudes will form a base for further growth through reading and sensitive experience. Those of us who work in countries where resources of trained personnel are severely limited, must find ways to live with and work within these limitations.

The workshop began with discussion, and listing on the blackboard the various things which the group wanted to have covered. Among other things were "the development of self-understanding" (psychodrama has obvious possibilities here, but the writer did not then know enough about it to hazard its use), and "counseling personal problems." This paper will ignore the various things which took up the first day and a half, and concentrate only on the last of these areas.

Throughout the sessions the leader refused to lecture. This created a good deal of frustration, but the leader felt that it was actually because of this frustration that the most significant learning took place. At one point, however, the pressure to "Please give us a lecture" built up to such an intense point that the leader felt it necessary to interpret to the group *why* he refused to lecture. Had there been more time, the leader would have preferred to let this problem resolve itself. However, three days are very short, and this interpretation seemed necessary to get the group moving again.

The "pièce de résistance" of this part of the workshop was a tape recording of a role-playing session. This proceeded in the following steps:

1. A "typical" problem was chosen out of the group's discussion. This involved a parent coming to see a teacher about her child's problem. The parent was belligerent and hostile, assuming the school to be entirely at fault, and with no insight into her own responsibility.

2. The teacher who had first described the problem (it was an actual case) was asked to take the role of the parent, while the leader took the role of a teacher. The problem was played out. The leader (as teacher) handled the parent in a relatively accepting, "non-directive," "client-centered" way, reflecting feelings, etc. About half-way through, the leader deliberately changed to a more defensive, negative, and finally an aggres-

---

a general tolerance for a diversity of opinions, a deep respect for the integrity of the individual, etc. There was even a demonstration of the use of spontaneous dramatics in gaining insight into Biblical history.

sively attacking role of trying to "show the parent where her fault lies." This entire session was tape recorded.

3. The tape was then replayed straight through. The group was asked to remain silent. The two role players were asked to make notes on "how I felt" and "what I was thinking" during each teacher-parent interchange.

4. Then the tape was played a second time, but this time it was stopped at the end of each parent-teacher exchange. The participants read out their notes, and the group discussed what had happened. The emphasis was primarily on the parent (client), and her reactions to what the teacher (counselor) said. The main problem was, what sorts of statements helped, and what hindered. Insights developed rapidly for most of the group. The group was very aware of the point at which the counselor changed his method, and of how rapidly the situation deteriorated after that.

There were some hold-outs who insisted that, "I would have handled it in [a very directive] way." Here, role-reversal proved effective. The teacher was asked to play the role of the parent, and someone else to counsel him in the way that he had suggested. Being on the receiving end of what he had thought was the best type of handling usually developed insight into the actual effect of "how I would have handled it."

In going through the tape item by item, there was some danger of losing sight of the forest because of the trees. The group, in fact, did not feel it necessary to go through the entire tape, as most of the insights were developed in the first few exchanges, and the rest at the point where the counselor changed his approach. Finally, we re-played the entire tape, partly to get the movement of the entire session again, and partly to fix in the teachers' minds the various insights which had grown out of the discussions of the various exchanges.

Summary

This paper describes two uses of role playing with school and college teachers in India and Lebanon: (1) as a means of arousing teachers to the need for better guidance; and (2) as a means of giving a minimal orientation in the philosophy and techniques of personal counseling. In the first instance, two brief counseling situations were acted out, as a means of focusing a two to three-hour conference. Discussion proceeded from the particular dramas to the general principles of counseling and guidance. In the second instance, the role playing was tape recorded. The

tape was then played through, with the "counselor" and "client" making notes of how they thought and felt during each verbal exchange. The tape was then played again, stopping after each exchange, using the participants' reports as a basis for group discussion. Insight was developed as to what types of statements by the counselor lead to growth, and what types lead to deterioration of the counseling situation.

DIAGNOSTIC USE OF PSYCHODRAMA IN FORENSIC PSYCHIATRY*

NEVILLE MURRAY, M.D.

San Antonio, Texas

In those states where there is no court employed psychiatrist, the private practitioner is frequently involved in legal contest to establish criminal responsibility. Such burdens are part of the community responsibility of the aware specialist in the diagnosis and treatment of psychological disorders. Often he is unwilling to enter into such contests due to the fundamental value system differences between he and his ambivalent court bed-mates, the members of the legal profession, most of whom have recourse to psychiatric testimony as a desperation measure or a calculated ruse to "beat the rap."

In those circumstances there is often difficulty in obtaining sufficient and meaningful observation of the criminal in question. He has seldom had previous psychiatric interaction and his motivation for consultation is primarily to assist in legal defense and for this purpose he may be schooled by his astute counsel.

There is no more penetrating or dissective process of observation than that afforded by the therapeutic group. It has been my practice to involve patients under psychiatric observation for legal purposes in therapeutic group activities for investigative and indirectly therapeutic purposes. This can be easily accomplished when the accused is under bond pending trial. Since most courts have heavily booked dockets, it is sometimes a six to eight month period before a case is finally brought to trial.

In one celebrated instance I was able to observe an accused rapist of twenty-one years in group activities over a six month period. Since rape is punishable by death in the electric chair in the state of Texas, he was on trial for his life.

During the many hours he worked in group he manifested his vivid and exotic phantasy life in playing many grandiose and expansive roles and he would always proclaim to the other members of the group that he was going to commit suicide rather than be taken into custody. He reenacted his suicide using cyanide powder in the bathroom at home. The majority

* Presented at the Annual Meeting of the Academy of Psychodrama and Group Psychotherapy, Hotel Morrison, Chicago, May 7, 1961.

of the members of the group were satisfied that he had not been guilty of committing the hideous and violent crime for which he was indicted. It was only after involving both of his defense attorneys in a special session in which they participated in a mock trial with the criminal playing the role of the chief witness for the prosecution, the raped woman, were they then able to realize that he was unable to participate in his own defense because of his insanity and his obvious pathological need to be found guilty of the crime, to which he was merely an accomplice after the fact. His companion, who was still at large, was the principal violator.

As the trial date grew closer, his anxiety heightened. The week before trial he again proclaimed his suicidal intentions and an extension into future time, a mock memorial service was acted out by the group, who left the room and returned, simulating their behavior on having heard of the untimely death of their fellow group member since the last session. After a moment of silence held in memorial for him, he observed with some emotion from his perch in the psychodramatic "heaven" that he deeply regretted his action.

To bring this narrative to a close, since it will be more fully documented in a monograph to be presented at a later date. The patient committed suicide in the court room on the second day of his trial, preceeded by a six hour cross-examination period of myself by an enterprising, but not too effective district attorney. On the witness stand I was forced to strip the patient of the benefits of his delusionary systems as well as to pronounce him legally insane.

After this disastrous event the group met the following week. They appeared to be reconciled to accepting the tragic situation in view of the previous warm-up. In fact, no memorial was held and the members of the group appeared satisfied that everything possible had been done to avert the tragedy, but, due to circumstances beyond the groups' control, the issue had come to a tragic end.

In summary, it is suggested that therapeutic groups can be utilized for investigative and observational purposes pertinent to forensic matters. Secondly, that in such circumstances the group appears to have built in protective measures designed to guard itself against damage from the possibly unhappy turns of events that interaction with the criminally indicted often provide.

BIBLIOGRAPHY

MORENO, J. L. "Forensic Psychodrama", Progress in Psychotherapy, Grune & Stratton, Vol. IV, p. 9, 1959.

UNIVERSITY TRAINING IN HUMAN RELATIONS SKILLS

JANE SRYGLEY MOUTON, PH.D., AND ROBERT R. BLAKE, PH.D.
The University of Texas, Austin

In the areas concerned with human behavior, such as psychology, sociology, anthropology, management, education, home economics and so on, college classroom procedures rarely depart from conventional teaching methods. The assumptions guiding learning about human factors are the same as those in any area concerned with a student's acquiring understanding and factual information. Yet cognitive learning, of the sort that takes place in a classroom, frequently has little effect on day-by-day behavior of an individual working with others. The phrase is widely heard, "There is a wide gap between principles and practice." If the classical approach to teaching in the area of human relations is ineffective for achieving concrete individual changes in behavior, what is an alternative?

The present paper describes a university laboratory training program conducted in connection with an undergraduate course in social psychology based on a theory of learning drawn from the activities of a scientist in contrast with the assumptions surrounding the learning situation of a student in the clasical sense. The content of the course centers on theory and results from experimental work concerned with human behavior on the interpersonal, group and intergroup levels. The aim is not only to increase the student's knowledge concerning systematic principles, but also to develop his sensitivity and ability to understand social phenomena. The final anticipated impact on the student is an expansion of the individual's capacity for effectively adjusting within these social frameworks. The way in which behavior change is brought about in a human relations laboratory program can be understood by contrasting the concept of the student with that of a scientist.

THE STUDENT VS. THE SCIENTIST

The first question that comes to mind is, "How does the conventional classroom differ from an approach to behavioral change based on procedures designed to simulate those of a scientist?"

Conventional Classroom Techniques: Teacher Tells—Students Listen—Teacher Tests

Let's begin with the ordinary classroom. What happens in it? How does it work? Conventional teaching centers on the concept of an "expert,"

a person who imparts what he knows to students who are less knowledgeable than he. The role of the *teacher* as a teller is critical in comprehending the assumptions underlying the classroom theory of learning. But all teaching isn't just talking. Beyond telling, the expert demonstrates; he shows students "how it is to be done," or "how it works," or "what it means." A variety of ancillary devices may be used to arouse interest, secure attention or motivate remembering. The devices, though, are extensions of the teacher as the expert.

What is the role of the students? Students listen and ask questions to clarify in their minds what the expert is saying. In addition, they drill, or rehearse until "practice makes perfect." Thereafter, the expert evaluates, by examinations and term papers, what the students have learned. If the teacher has not been successful in communicating what he considers to be important, the student is "failed." He either repeats the work or drops out.

What does this method of training *do* to people, particularly when the goal is to learn about human situations? The student becomes *dependent* on the expert. The student may "gain" all right in terms of understanding, but he loses if you measure his *real* independence—his freedom to think and to formulate problems and solutions for himself. Classroom teaching has positives and negatives associated with it. On the positive side, it is a good way of getting people to acquire understanding and factual information. Principles and their application can be passed on in the hope that people will profit by diagnosing the mistakes of others and learning about their insights and solutions to problems. On the negative side, it tends to make students "dependent." Rather than helping a person to be self-directed, it pushes him towards being "other directed." In addition, complaints such as, "But my situation is different," or "It just isn't like *me* to handle it that way," or "That's all right for someone else," all point to the conclusion that cognitive learning of the sort that takes place in a classroom frequently has little effect on the day-by-day behavior of the individual in interaction with others.

Laboratory Training: Dilemma-Invention-Feedback-Generalization Cycle

What is laboratory training as it applies to human behavior? Laboratory training stems from the procedure a scientist uses when he seeks new information or relationships.

"How does a scientist proceed to determine which ideas or concepts should and should not be related?" The simple minded answer is, "He experiments." An experiment involves orderly comparisons between a

standard situation and other conditions which are varied in certain significant respects from the basic situation. Changes in outlook and action follow from the discovery of new relationships through the examination of comparative conditions and their consequences.

Dilemma. The strategy of experimentation begins with a dilemma. A dilemma occurs when, for a given situation, there is no sound basis for selecting among alternatives, or there is no satisfactory alternative to select, or habitual actions are no longer effective. In other words, a person doesn't know what to do. Traditional, "second nature" kinds of behavior don't apply; custom offers no solution. The goal of the teacher or trainer in the laboratory setting is to create situations concerned with social interaction requiring resolution by the students facing them.

What do people do when confronted with a dilemma? Do they begin to experiment or to invent? The answer, true almost without exception, is, "No." The *immediate* reaction is to try out *older* methods of behaving with which one already is secure or else to get guidance from an "expert." In this way, the anxiety so invariably associated with not knowing what to do can be avoided. In the laboratory then, the anticipated first reactions by participants to a dilemma are to try traditional ways of responding. These "frozen behaviors" are ones based on more or less automatic assumptions so deeply rooted that most individuals are unaware of making them. They define the true meaning of second nature.

Invention. Only when conventional or traditional ways of dealing with a dilemma have been tried—unsuccessfully—are conditions ripe for inventive action. Now people are ready to think, to shed old notions because they haven't worked, to experiment and to explore new ways of reacting to see if they will work. If they don't work better, they may be rejected or modified, or a struggle to apply traditional ways of solving the dilemma may reoccur, until new and more adequate ways of responding are proposed, applied and evaluated.

The period, when old behavior is being abandoned and when new behavior has yet to be invented to replace it, is an "unfrozen" period, at times having some of the aspects of a crisis. It is surrounded by uncertainty, confusion and anxiety. If people have to work together to come up with something, there is likely to be criticism, accusation, attack, withdrawal, flight or defensiveness. Rather than trying arbitrarily to eliminate such reactions, the goal is to understand and to harness them towards constructive learning ends.

One way of dealing with a dilemma is to look backward to trace the

steps that lead to the present impasse. By doing so, it may be possible to spot points at which the present dilemma could have been avoided and also to develop a clear perception of what is required if the situation is to be solved.

Thinking of an inventive kind, thinking that contains proposed solutions with which members are unacquainted in their prior experience, may occur with or without a prior period of backward thinking. Propositions presented call for experimentation; they have to be tried to see if they will work in this particular situation. Very commonly, situations are proposed as a quasiexperimental maneuver, "Let's try this for 30 minutes and then shift to that one to see which of the two works better." An act of comparison is inventive behavior for now people are reaching for solutions in the "here-and-now," rather than hugging tradition, acting from "memory," appealing to an "authority," or grasping for straws. They are acting in a self-directing manner, not in an historically directed or an outer-directed fashion.

Both retrospective thinking and search thinking are highly important to experience if human learning is to take place. Without one or the other, or both, people are likely to continue along conventional lines even though inappropriate and ineffective. They are likely to learn little from the experiences they encounter.

Feedback. Fullest learning from the dilemma-invention situation occurs when two additional types of actions are taken. One is *feedback*, the process by which members acquaint one another with their own characteristic ways of feeling and reacting in a dilemma-invention situation. Feedback aids in evaluating the consequences of actions that have been taken as a result of the dilemma situation. Such reactions and feelings may be in the area of thinking, or feeling, or motivation. They may be centered on personal behavior aimed at telling an individual what he is doing that "blocks" problem-solving or experimenting or, in a more general way, how to devise methods and procedures for experimenting. Feedback also may be centered on actions which hinder or contribute to effective group problem-solving, such as reactions to being in the minority on a majority vote, or responding with enthusiasm and commitment to a decision that wipes out the last shred of reservation. True feedback of this sort is extremely hard to come by outside of the laboratory setting.

Generalization. The final step in the dilemma-invention cycle is *generalizing* about the total sequence to get a comprehensive picture of the "common case." When this is done, people are searching to see to what

extent behavior observed under laboratory conditions fits outside situations. If generalization isn't attempted, the richness of dilemma-invention learning is "lost." If people fully generalize from their laboratory experiences, it is likely that a lot of training in home and work situations would shift away from "teacher-tells-demonstrates, students-practice, teacher-tests" toward an approach much more along the lines of the dilemma-invention-feedback-generalization learning cycle outlined here.

Summary. The theory of learning basic to laboratory approach to learning about human factors is that when faced with a dilemma, a person experiments; he invents, devises and tests ideas and methods out on himself; he gets feedback, and he generalizes, leading to new and different ways of reacting. Translated into operations, then, the purpose of the laboratory in human relations training is to create dilemmas that lead to the invention-feedback-generalization cycle outlined above. This way of thinking about learning involving human factors are certain implications for the design of training programs as described below.

Ingredients of a Laboratory Training Program in Human Relation Skills

The next question is, How is the dilemma-invention-feedback generalization theory of learning carried out in a laboratory training program designated to effect behavior change in social interaction?

Under laboratory conditions, participants study their *own* behavior under various social conditions. Rather than diagnosing, analyzing, proposing actions, observing consequences, and evaluating the behavior of someone else, the subject matter is the student's own actions, reactions, feelings and attitudes that are produced as he interacts with others.

The role of the trainer or teacher is that of creating dilemmas or contrasting experiences through which participants are able to invent, devise, seek out and select new or different ways of behaving, try them out, test their consequences through various feedback procedures and then formulate generalizations regarding the utility of solutions to the original dilemma which may serve as the basis for changed behavior when the same situation arises again.

Dilemmas Posed by the Development Group

The fundamental dilemma producing feature of a human relations laboratory is the development group. The development group is composed of 8 to 12 members, whose explicit goal is to study their own interactions

as a group. No leader or power structure is provided. No rules or procedures are given to structure interaction. No task, topic or agenda for discussion is inserted to serve as a guide for action. Thus, the group is faced with critical dilemmas in several fundamental areas of relationships in a group situation. What shall we do or talk about? How shall we relate to one another? What are our rules for interactions? What can we accomplish? How do we make a decision on any of these things? All of these issues and many more are dilemmas initially present in the development group. Thus, the stage is set for the first step of the learning cycle.

The initial reactions of participants are in terms of "frozen" behaviors, habits and traditions that have become routine in the past. Because these differ from person to person and since they don't really fit this new situation, as they are tried, they prove to be ineffective. The group becomes unfrozen. Members are ready to seek alternative ways of proceeding. The way is paved for experiments in group action concerned with alternative methods for decision-making as a group, procedures for agenda determination, variations in the area of leadership, and so on.

In addition to group level phenomena, much attention is centered on individuals trying out new and different ways of relating to each other. For example, an overbearing, long talking person may try being silent for an extended period of time; a person who withdraws when under attack may experiment with more aggressive forms of reactions; feelings may be openly expressed. The dilemmas posed by the development group impel inventive, seeking, searching behavior on both the group and the individual level.

Feedback and Generalization

Trying alternative ways of behaving is not fruitful, however, without the last two steps in the cycle. These two steps blend naturally into one another. After the consequences for action of alternatives are tested, then the dilemma can be wrapped up through generalizations concerning the predicted outcomes of various actions in resolving the initial problem.

Feedback, in the university laboratory being described here, is given in two basically different ways. One is direct feedback, through discussions of participants concerning their perceptions and feelings regarding the impact of another's behavior or events on themselves. The other approach utilizes "instruments" in the form of scales and measures designed to aid people in analyzing and diagnosing certain features of individual and group development.

Direct Face-to-Face Feedback. Experimenting with one's behavior in interactions with others can lead to change only when there is a basis for evaluating the impact of an action. One way to gain information concerning the impact of one's own behavior is through self-observation. This means that a person is both a participant in the action and an observer of the reactions of himself and others.

In addition, through the use of feedback, or getting signals from others, one's perceptions can be crosschecked for validity. Feedback concerning another's feelings and attitudes also may tap sources of information that otherwise might be unavailable from surface observation. The distinctive feature of this social mirror is that people tell one another what they ordinarily avoid saying. This continuous checking and rechecking process in development and consultation groups permits a person to evaluate how his own behavior is seen by others, whether he can accurately assess the motivation of other persons, whether his judgments of human events fit what others see, and whether he understands various aspects of group operation. Through feedback evaluations, it is possible to experiment with and to try different modes of approaching a problem with the possibility of testing consequences and improving behavior in the here-and-now situation. Ordinary classroom situations rarely provide a person the open, free opportunity to test his own personal skills against training feedback.

Feedback through Instruments. When feedback through instruments is employed, all members fill out a set of scales designed to accentuate certain features of group development. Three basic forms of measurements are utilized: check list, ratings, and rankings.

The most frequently used ranking is one concerned with ingroup influence. A check list is used for such purposes as characterizing the atmosphere of the meeting and indicating decision-making procedures or types of agenda items.

Either two or three dimensional rating scales also are employed. Typical two dimensional scales are ones such as how clear were the group's goals (completely unclear to completely clear), how did the group work (fat and happy to lean and hungry), and was I leveling with the group (closed and hidden to open and free)? Three dimensional scales are built around positive, negative, and neutral or indifferent ratings. For example, Did I get help as needed? contains as extremes, "No, my needs completely were disregarded," "Yes, my needs were met in a completely satisfactory manner," and "No help was needed."

These types of quantitative data are guides to the progress of the group. They serve to sound the depths of action. The data are summarized by the members themselves and posted on charts immediately after each session. Wall charts on which group means are plotted in different colors, routinely are used for summary purposes. These charts invite comparison, analysis, and generalization, particularly when the data tabulation is rotated among all members.

The data emphasize the significance of feedback. Since each person systematically gives data as part of the laboratory procedure, it then becomes "routine" to give feedback. Participants understand that feedback is helpful, and impetus is given to qualitatively examining within the group session many of the features of group operation that are represented in the scales.

Second, the quantitative aspect is important. People sense that, however globally, it is possible to apply a yardstick to interaction situations. Feelings and perceptions can be assigned a number and summarized much like inches and pounds. The part that feelings play as "facts" to understand and consider, then, attains significance in increasing the effectiveness of group action. Participants can plot their own values against the group average. This becomes a checking devise though which members are able to learn more about themselves relative to others.

Comparisons of meetings through longtitudinal evaluation is aided by the participants having a concrete record in the form of a wall chart. By plotting results from scales for several groups on the same chart, intergroup comparison is facilitated. Informal discussion among participants from different development groups is prompted when differences in trends become apparent.

The use of instruments as feedback mechanisms, then, highlights areas of behavior for examination, aids in analyzing and diagnosing, and points towards generalization. Instruments are not sufficient in and of themselves but enrich direct face-to-face feedback among people.

Activities Which Strengthen the Feedback and Generalization Stages

Although the development group situation constitutes the mechanism through which dilemmas are created and provides the basic experience for analysis, there are additional activities for increasing the scope of feedback and generalization of significance in a laboratory training program.

Consultation Groups

The consultation group is a subunit of the development group composed of 3 or 4 people. The purpose of this smaller group is to increase and to intensify personal feedback. Within the intimacy of this group, an individual can secure open and forthright reactions by others to his personal behavior. The consultation group is used primarily for exchanging feeling, attitudes, and reactions, but it also is employed in diagnosing strong and weak points and for planning and assessing individual experiments to be carried out in the development group.

The uses of measuring instruments described above were in connection with aspects of group development or to an individual as a group member. Another significant way in which ratings and rankings are employed is to strengthen feedback concerning personal behavior. Ratings of items of personal behavior such as talks too much, speaks clearly and concisely, dominates, shows that he likes us, and so on are made on 9-point scales, ranging from always to never. Every group member rates himself and every other member on each item. The ratings of each person by everyone else are returned to him for use in connection with a consultation group. The task of the consultation group is to aid an individual to gain a richer perception of himself through the ratings and by direct examples of the "whys" and "wherefores" of his actions as reacted to by others.

Development Group Vignettes

Conducting two development groups simultaneously in one laboratory has several advantages. One is to provide an "outside" source of feedback for group and individual actions which is not based on the concept of an expert. This is done through the development group vignette. The strategy is for one development group seated around in a circle to start its meeting before another development group which is assembled around them in a larger circle as an audience. The demonstration group continues the session for a period of fifteen to twenty minutes. After each period is completed, the watching group exchanges places with the interacting group for a discussion of the first group's interaction. The second group is practicing analysis and feedback. The first group has an opportunity to see itself as "outsiders" do. After a ten or fifteen minute discussion, the floor is opened for questions and discussions back and forth between the groups. The use of an outside group aids the inside group in diagnosing its own assumptions and provides an additional source of insight.

Systematic Experiments as the Basis for Focusing Issues in the Development Group

Miniature experiments as the basis for providing controlled and contrasting experiences have been employed for emphasizing personal and group experimentation with different behaviors in and out of the development group. For example, one general area of concern is in terms of the personal use of power and consequences of various power distributions for interpersonal and group relationships. The use of a demonstration-experiment in which each participant either gives or receives three different types of power orientation provides a background experience for participants to examine the consequences of exercising various degrees of power. This is usually followed by ingroup discussion of personal power use and consultation groups in which influence ratings are used as the basis for members to focus on an individual's *actual* power in the development group. The contrasting experiences obtained in the experimental demonstration also increase the likelihood of adequate generalization.

Intergroup Competition

A third significant level of social interaction occurs in connection with relations between groups. Creating conditions of intergroup conflict and collaboration between two or more development groups serves several purposes. First, the impact on personal behavior of membership in a group when one's group is in conflict with another group, can be seen clearly. Pressures towards loyalty and protection of group interests operate to produce a degree of uniformity of action among group members that may not otherwise be available for examination. Feedback and generalizations regarding the consequences of competition between groups poses another dramatic dilemma of our times for laboratory participants. It is, How can collaboration between groups be brought about against a background of competition? The dilemma-invention-feedback-generalization cycle again is appropriate, but this time the issues are at the level of intergroup experimentation rather than group or individual level actions.

Generalization from Systematic Knowledge

In addition to the laboratory experience the routine factual type information regarding relevant, systematic principles and the supporting experimental work is inserted along the way. The objective here is to expand the background against which generalizations can emerge.

The Teacher and Student Roles

The role of the teacher in a laboratory program is different in many respects from that of a teacher in the conventional classroom. Rather than being cast as an expert who knows and gives answers, his concern is for producing conditions under which students find their *own* answers. He creates the basic dilemma situations, insures that the feedback model is being applied, sets standards for giving and receiving feedback, and aids in focusing and expanding generalizations. In other words, his role is one of intervening into the ongoing situation in such a way that students are motivated to invent, try out and apply altered ways of behaving. The "answers" come from the students themselves as they diagnose, analyze, and generalize from their own experiences.

In a laboratory situation, the student's activities are quite different from the conventional classroom role, also. Rather than being a more or less passive recipient of facts and information and a duplicator of the expert's advice, the student is an active participant in seeking for himself and giving to others relevant information regarding his experiences in the various social situations.

The question might arise at this point, Isn't it easier just to *tell* people how to analyze a situation, what types of social phenomena are present under various conditions, the appropriate way to act to avoid pitfalls, and so on? The answer is *no*. The reason is that the laboratory approach is a tested solution to the dilemma created by a telling approach in the first place, namely, that little or no carry over into action could be demonstrated through only presenting relevant material concerning social interaction under the lecture type of classroom learning condition.

Evaluation

A final question needs to be considered. It is, What is the impact of such a laboratory training program on individual performance?

Personal Behavior

What are the types of personal actions that students find in their own behavior that they want to and can change? The concrete examples given below are ones that have been brought under examination in feedback sessions as areas of strong and weak points and which then served as the basis for individual experimentation and personal change.

"I show too much temper on controversial subjects."

"Initially I dominated the group, but without really giving leadership

to it. After practicing, I feel I am more comfortable and effective in a chairmanship role."

"When somebody disagreed with me, I immediately backed down. Now I can hold to points I believe in."

"At first I was afraid to express my true feelings because I might step on someone's toes."

"I usually am highly anxious in social situations that people won't like or accept me. This fear has inhibited me considerably. I am able to relax more and enjoy being with others."

"I find I can help others to participate in the group by showing encouragement instead of hostility to timid group members."

"My inability to look others straight in the eye when talking to them was irritating to group members."

"I wouldn't participate on topics that were not personally interesting to me, but recently have pushed myself into the activities, and when I do, I usually become involved and interested."

These are but a few examples of the kinds of personal behavior that are examined in a laboratory. The goals of feedback as expressed by one group member are "to try to minimize the differences between how others see us and how we see ourselves" (increasing in social sensitivity), and "to help ourselves and others become more effective individuals and group members" (social skill).

Responses to questionnaires and open-ended statements indicate that the experience of receiving open and honest reactions to one's personal behavior is a rewarding and impactful one. Approximately 86 per cent of the participants express the conviction that insight into the effect of one's own actions on others plus experimenting with the alternative modes of acting resulted in changed behavior.

Group Experiments

Not only is personal behavior brought under examination, but also group experiments are conducted in which development group members pursue some course of action and then stop to examine the process and consequences of what has occurred. Some interaction is spontaneous in the sense that it is not preplanned. At other times, a decision is made deliberately to "try out" some type of changed procedure, content, or member behaviors. Several examples are given below of the kinds of planned "experiments" that are likely to occur.

"We shifted from a period of rigid control by one member to everyone participating when they wanted to."

"The quiet members were assigned an active role, while the talkers tried to say very little."

"We picked a controversial issue to discuss in order to contrast group action on a highly emotional topic with progress made in discussing a topic that was of little concern."

"We compared the effect of two conditions on silent members. In one, there was an appointed 'gate keeper'; in the other, the structure was one where everybody tried to encourage silent people to participate more."

Through examination of group process under training conditions, sensitivity is increased to such phenomena as acceptance-rejection dynamics, pressures toward uniformity or conformity, power struggles, the impact of various styles of leadership on group action, changes in cohesion, involvement in group action, commitment to group decisions, and so on.

In addition to subjective evaluations of increased skill in group action, it has been demonstrated objectively through test situations that training under development group conditions does aid participants in more effectively mobilizing the resources of persons in the group. As an example, the superiority of a group's decision to a complex problem over the average of individual decisions is significantly greater when group decisions are made by members who have completed a laboratory training program in comparison with persons who have not.

Summary

An alternative theory of learning about human factors has been presented in comparison with the conventional classroom procedures where the sequence is teacher tells and demonstrates, students listen, practice and drill, teacher tests and evaluates, and students pass or fail. The approach to learning described here is the dilemma-invention-feedback-generalization cycle based on the model of the scientist's activities.

The idea underlying the latter approach is simple. It says people acquire information about themselves, about others, and about more complex situations *best* when searching for the resolution which is superior to other possible solutions to a *dilemma*. A condition also needed to be present for learning to occur is that conventional ways of reacting to the situation, "habits or second nature" are inappropriate for solving the particular problem. If they were, then the situation wouldn't constitute a dilemma because tradition would dictate the solution. A dilemma is a model situation

for learning about human behavior when the solution requires *imaginative, original, creative, inventive* thinking either because there is no "good" answer or old actions are considered ineffective and, furthermore, a range of alternatives are possible, but the best one can be spotted only if it is actively searched out.

Another critical step in the process is *feedback;* testing the adequacy of inventions or alterations in behavior, measuring their consequences and examining them to see how they came about and to determine whether other, even more inventive ways of proceeding might have been possible. The final aspect is *generalization:* stating the principle for why the action was effective and indicating how widely it applies to other situations.

The application of each aspect of the four part learning theory to a laboratory training program was described. The basic dilemmas confronted by students in a laboratory are within the setting of a development group, which has no imposed rules, power structure, agenda or goal other than to experiment with and study one's own and others interactions. Since conventional methods of coordinating activities are not appropriate, students are impelled to devise, invent, experiment with, or try out alternative ways of proceeding. Feedback in the development and consultation groups aids in understanding the events that occur, testing the consequences of actions and in steering future behaviors. Other ancillary devices include more structural experiments, cross group comparisons, and situations of intergroup competition and collaboration. The final step of generalization from various experiences completes the cycle.

Assessment by observers as well as personal evaluation point to the conclusion that the laboratory method of human relations training is a valid means of expanding an individual's capacity for effective adjustment on the interpersonal, group and intergroup levels.

GROUP PSYCHOTHERAPY AND PSYCHODRAMA FOR ALCOHOLIC PATIENTS IN A STATE HOSPITAL REHABILITATION PROGRAM*

FERNANDO J. CABRERA, M.D.

Spring Grove State Hospital, Catonsville, Maryland

In recent years there have been many developments in the field of alcoholism, including the active role of state institutions in the diagnosis, treatment, and rehabilitation program for the alcoholics. Those persons who have been interested in the program for alcoholism have become gradually aware that in many states most of the alcoholics have been hospitalized in state institutions for treatment of their acute conditions and for help in their rehabilitation. While the first—treatment of the acute condition is generally well practiced, the latter—rehabilitation—has been almost absent. The alcoholic patient will remain on an admission service for a period of from 5 days to 2 weeks and, after recovering from the acute phase, many ask to be discharged. Discharge is generally granted with the result that the alcoholic will continue to use the state facilities at state expense as drying-out places, and physically fit will leave the hospital to drink again. Others may be sent to various areas of the state hospital to participate in industrial therapy activities for the benefit of the hospital before their release, having no special activities oriented toward the alcoholic patient nor an introduction to the different therapies of how they can achieve sobriety. In fact, many of these are discharged outright without any referral to a clinic, perhaps because of the lack of these clinics, or because available clinics do not like to work with the alcoholic patient, or because there is a lack of follow-up program by the state hospital.

These previous policies probably are due to the lack of education of the problem of alcoholism of those involved in handling these patients, or due to their negativistic attitudes in handling the alcoholic patient.

In the State of Maryland, the state mental hospital has been receiving an increasing number of alcoholic patients to be treated and rehabilitated. We have felt this gradual increase in our hospital and we have recognized the need for a rehabilitation program oriented for the alcoholic patient. The authorities of the hospital found it essential that one person be in

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

charge to organize and integrate the treatment and rehabilitation of the alcoholic patient with the modern concepts. Knowing that alcoholism is a multi-faceted problem and that our trained personnel on this problem was very limited, we had to use help from our community agencies, groups, and individuals to assist us in our work. We designated one modern convalescent-area cottage with a capacity of 70 beds for the alcoholic unit. Normally the patients are admitted to our admissions building or our Medical-Surgical unit for treatment of their acute conditions and as soon as they sober up, a mental examination is performed. Once the diagnosis of alcoholism is established, the patient is transferred to this unit to participate fully in our Rehabilitation Program for the alcoholics. Therefore, we have in this unit diagnosed alcoholics for participation in a broad program oriented towards sobriety, using the different therapies available.

As the patient comes to the unit, he becomes involved in a therapeutic community environment. He is received by a cottage committee who is selected on a bi-monthly basis by the patients themselves. This committee represents the patient in the government of the unit and takes care of all the social activities held in the area. The cottage committee meets with the patient, explains the rules and regulations of the unit and of the hospital, what is expected of each patient and how he is to behave, explains the program and what the program can give to him. The patient is given a schedule of the activities he has to attend and of the interviews already planned by our medical, nursing and Research Department every 2 weeks. The patient is then interviewed by our head nurse, a member of the Alcoholics Anonymous, who after her interview, passes him to the physician's office for a complete evaluation of his mental status, evaluation of his motivation towards sobriety, and the attempts, if any, that he has made towards sobriety. Then, since we have treatment and research combined, the patient is seen by the psychologist for a preliminary interview and finally by our social worker.

Due to our treatment and research program being combined, generally the patient is completely out of medication during the first week except those who still need to take some kind of medication. He passes through a series of psychological tests and other evaluation by our Research Department. Every patient has an electroencephalogram, liver function test. After one week the patient is placed on our research medication for a period of 30 days. Following this period the drug is discontinued, and the same procedures are started all over again. In the meantime, he is evaluated by another physician weekly. Then the patient participates in different

activities on a daily basis, besides living in the therapeutic community where the patient meets with other patients and personnel to discuss any problems that may arise while he is resident in the hospital. Patients have been given increasingly more responsibility in the maintenance, care, and development of the program.

The activities that we have in this unit are various and include group psychotherapy, psychodrama, informal group discussion, chemotherapy, and motivation groups led by an A.A. member, a group discussion led by an ex-patient who had participated in the program before, a discussion group led by the head nurse of the unit, Chaplain's meeting—individual and group-wise, the Alcoholics Anonymous meetings in and out of the hospital, industrial therapy, groups led by the leaders of convalescent homes for alcoholics and by our social worker, and there is also an educational part which includes lectures for patients and personnel on the subject of alcoholism and movies, followed by group discussion led by the patients.

Group psychotherapies are held in the unit and the patients are divided into groups—one composed of patients who are experiencing their first admission to this hospital, and the other composed of patients who are readmitted. I found it was necessary to divide the patients into two groups because it was more difficult to work with the first admission patient than the readmitted patient in the matter of acceptance of Alcoholics Anonymous and guidance toward sobriety. Group psychotherapy was mainly didactic, repressional, inspirational, and sometimes analytic. The analytical groups are very few but sometimes the patient brings many emotional problems from which the others will benefit. As I say, mainly, group psychotherapy meetings are oriented toward sobriety and the acceptance of the A.A.

Psychodrama meetings are held on a monthly basis for each group of patients. Briefly, the following procedures are used: one patient will play the role of a patient who is leaving the hospital, and another patient will play the role of a relative, the wife or mother. Others will play the role of neighbors, friends, etc. The individual who is leaving the hospital dramatizes being received by members of his family, being taken to his home, and also he dramatizes seeing his alcoholic friends, what he does about it, and also how he will try to seek employment and the reaction of the employer. The patients obtain a great deal of benefit from this situation, giving them a great deal of insight and motivation on their problem and helping to understand themselves better.

The informal group discussions are held at any time in the unit. A

small group of patients will meet together with any member of the personnel or myself, and we will discuss the problem related to alcoholism, etc.

The motivation groups are led by a volunteer worker who is well trained in the program of alcoholism and is a member of A.A. The patients' reactions to her meetings have been excellent. Since the volunteer is a prominent citizen, she tries through active discussion to give motivation for the patient toward sobriety.

The group discussion led by an ex-patient, who has participated in this program and who has been able to stay sober, also has been well received by the patients. This individual's main emphasis has been how a sober alcoholic can help a drunk. He uses the Alcoholics Anonymous' approach of complete abstinence of alcoholic beverages on a 24-hour basis. It helps the patient to see a successful alcoholic, whose life had been ruined through the continued use of alcohol but who now has remained sober after having participated in the program and accepted the Alcoholics Anonymous fellowship.

The discussion group led by the head nurse on a weekly basis is held as informally as possible on a voluntary basis. She starts the meeting by stating her name and the fact that she is an alcoholic and a member of A.A. She always introduces in the beginning the twelve steps of the A.A., the prologue of the A.A. From then until the end of the meeting continuous rebuttals and questions are free-flowing; no effort is made to guide or lead or limit the discussion within the broad general subject of alcoholism. She does, however, encourage the members of the group to consider the subject subjectively as it applies to them personally rather than critically or intellectually as a social problem.

The Alcoholics Anonymous fellowship has played an important role in the rehabilitation of the patient in our unit since most of our meetings are oriented toward the acceptance of this fellowship. Our group was formed twelve years ago, and there has been a weekly meeting in our unit, and for 60% of the patients this has been the first opportunity they have ever known that this fellowship was beneficial to them. Forty-two of our early meetings have been sponsored by each different existing group in the State of Maryland, and also we have encouraged our patients to attend outside A.A. meetings, and at least 60% of all the evenings that a patient has spent in our unit he has been dealing with the A.A. fellowship. We have permitted the interest of outside persons in our community to participate in our meetings, and they are the ones who have furnished the trans-

portation for our patients to go to outside A.A. meetings. Also, it facilitates obtaining a sponsor for the patient before he leaves the unit.

The Chaplain's meeting provides group discussion and pastoral counseling. The purpose of this meeting is to provide an opportunity for the patient to discuss social and family problems and to relate them to religious practices. Any alcoholic who has a perverted outlook on what life really is goes to our Chaplain. The Chaplain is the leader in our alcoholic group, and he sees himself as a religious symbol and teacher to the patient. Always his purpose has been to be non-directive and noncommittal, permitting the patient to freely express himself. The topics for discussion are selected by the Chaplain with suggestions given on a monthly basis by the group. He hopes that the patients will realize that church and religious organizations are concerned about them and their need. As a result of this meeting he hopes that the patients will become more confident as they mature emotionally and develop more satisfying and meaningful relationships with each other.

The social worker plays another important role following the patient and his relative throughout the hospitalization, trying to resolve any social problem which may arise. The pre-parole groups are led by her with all personnel attending this. As soon as the patient's 50 days in this unit are over, the patient automatically is placed in our pre-parole group so that the whole therapeutic team can plan and work with the patient on his discharge, what is best for him, where he can go to live, and what he can do. Many patients go to their own homes, but some have no relatives nor homes and are referred for foster boarding care or referred to the convalescent home for the alcoholic which will, as soon as they accept the patient, continue working with our social service department. Sponsors of A.A. are obtained for those patients who request them, and referrals to clinics for alcoholics and to our own clinic are made before the patient leaves the unit. In a twelve month period this unit handled 306 alcoholic patients out of a total of 389 male alcoholics who were admitted to this hospital and also handled all the female alcoholics. Although they live in a separate unit, they are followed in the same way as the male alcoholic. It is interesting to know that the population of alcoholics admitted to this hospital during the fiscal year of 1960 amounted to 39.2% of the total number of male admissions. Of the 306 alcoholics admitted 269 were discharged; 10% of these returned to the hospital within a period of one year, and many of the 10% are chronic offenders or the skid-row type of alcoholics.

In my opinion, many more things can be done. It is my feeling that the building of this therapeutic team of mature and growing individuals, who have learned how to work together and rely on each other for the patient's best interest and welfare, has been the greatest asset to the program.

PSYCHODRAMA WITH CHILDREN IN A SOCIOMETRICALLY STRUCTURED SETTING*

CECILIA G. WELLS, M.E.

Personnel Department, Board of Education, Detroit, Michigan

During 1958-1960, "Psychodrama with School Children in a Sociometrically Structured Setting" proved a lively adventure in spontaneity, and an artistic experience in human relationships.

The writer, then an Assistant Principal in a Detroit elementary school, chose role playing, sociodrama, and psychodrama as a creative means for supplementing the usual techniques for learning and counselling. Earlier use of these action methods was limited to children in the school program who were having difficulties.

For the project here outlined, a sociometric survey was made of thirty-five boys and girls in a normal fifth and sixth grade class. Each child in the class was asked to indicate his 'friendship pattern', giving the names of three individuals in the class with whom he would prefer to work on a committee or in a real situation. As a result of these choices, seven leaders emerged, "Sociometric Stars" as Dr. J. L. Moreno calls them. These boys and girls became our team which experienced classroom role playing and sociodrama, and later, psychodrama at six Saturday workshops.[1]

This group of children was 'structured' as to:

1. age; ten and eleven years old
2. grade; fifth and sixth
3. intelligence quotients; A's
4. similar socio-economic conditions and backgrounds
5. qualities of leadership; each was a leader in his or her peer group

A second 'structured' group was involved in the experiment: the adults who were the workshop members. Their ages were comparable, and their interest and participation in role playing over a long time resulted in their being known to each other and to the children. They had been given that

---

* Presented at the Annual Meeting of the Academy of Psychodrama and Group Psychotherapy, Hotel Morrison, Chicago, May 7, 1961.

1. The workshops were organized by the Michigan Chapter of the American Society of Group Psychotherapy and Psychodrama, under the direction of its President, Dr. Robert S. Drews, Psychiatrist.

special quality of orientation by its director, Dr. R. S. Drews, so that the group warranted the designation "Therapeutic Community".

The inter-action of these two structured groups was exciting and mutually beneficial as they participated in sessions involving role playing, sociodrama, discussions, buzz groups, brainstorming, films, and psychodrama. Themes of the workshops were: "Loneliness", "Self-Fulfillment", "Conscious Roles for Creative Living", "Living in the Space Age", "The Therapeutic Community", and "Problems of Everyday Living". Situations arising from the various group 'springboards' indicated that there was ample idea material for action.

The children had shared their worries with the director in several 'warm-up' sessions:

1. how to get along with brothers and sisters, as well as parents
2. how to make friends and keep them
3. stuttering, being shy, exaggerating, and daydreaming
4. taking risks and dares
5. how to have fun with other people's games when it is their choice
6. keeping healthy, looking nice, having the right clothes
7. going to a show with a boy or girl, alone
8. earning money
9. having 'bad' thoughts; staying up late; thinking 'older' than you really are; 'growing up' too rapidly
10. doing well in school, especially in 'arithmetic'
11. having your own way; self-control
12. having your ideas accepted or rejected

These were some of the ideas used to structure the psychodramas, fitting them into the workshop theme. The adults shared their problems, and situations were constructed on the basis of their common aspects. The children were adept at suggesting the protagonists and auxiliary egos involved. Their spontaneity was delightful after they had learned some of the procedures: warm-up, role reversal, double ego, auxiliary chair, and the 'ego' chair. They learned to take mother, father, brother, sister, career, and leader roles effectively and easily. They were sometimes shy, angry, baby-ish, lonely, agressive, and usually highly competent role takers. Feelings were freely expressed instead of being denied.

As the degree of personal involvement increased, to that degree did we consider the psychodrama successful. We watched, and were involved in scenes showing families dealing with such problems as: planning for

a vacation, caring for Grandpa in a crowded home, managing a party of young people with and without a parent sponsor, living with a younger brother who 'tagged' along or interfered, and living in a home where both mother and father worked.

These children helped us to learn of their hopes for careers as teachers, nurse, engineer, salesman, and astronaut. With them we took the first ride into space, and gathered around the council table as they debated the merits of funds for missiles or hospitals.

We felt *with* them the joy over a well-received report card, or feared *with* them when the marks were poor. They *shared* their thoughts, their feelings, their forward-looking ideas about areas of living normally confined to adult discussion. We were impressed with their composite candor and warmth; with their authentic feelings for one clasmate who was really quite alone, of for another who created her own problems which made her difficult to accept. we were constantly impressed by their insights about their own behavior, and that of the 'grown-ups' they knew.

It was a pleasure to note the growth in ease and spontaneity among these young leaders, as they learned to speak and to hear the qualities they liked about themselves and each other, *or heard others commenting on their outstanding qualities.* In turn, they shared these techniques with their friends and teachers at school. As our director commented, "They self-i-cated and ipsi-fied themselves."

Following the psychodramatic action, there was opportunity for assessment by expression of the feelings and ideas aroused by the action-situation. They listened and responded with astute observations to the Axiodrama, which is our leader's brilliant way of synthesizing a session. The children shared in the total procedure, *as well as their parents,* who also became participants.

We literally *lived with* these seven children in an adult setting, and came to know each of them as distinct, unique, and lovable personalities. This was their *first* experience of being so totally accepted as complete selves, and so genuinely welcomed into an adult group. "It was their time", said Dr. Drews, "and they made the most of it for all of us".

It was our hope that this exciting and close relationship could have continued until such time as scientific evaluation could be made. The writer's transfer to another school department, and promotion of the children to a different school unit made such a scientific appraisal impossible.

Certain assumptions had been made at the beginning of this experience with a 'living laboratory:'

1. that role playing, sociodrama, and psychodrama were lively and exciting methods of learning
2. that normal and highly intelligent children who have marked qualities of leadershp should have, and indeed must have an opportunity to benefit from these methods as well as those with severe problems
3. that leaders, whether children or adults, need encouragement in spontaneity to exercise their originality and creativeness
5. that an accepting, therapeutically-oriented adult group can be invaluable for launching a pre-adolescent group into the mysteries and pleasures of experiencing a 'grown-up' feeling.

From their directly stated and written comments about their feelings as they participated in the workshops, children and adults, participants and observers, directors and directed—all gave evidence of the joy and authenticity of our experiencing together. The mutually shared benefits were exciting and rewarding to the children as well as to the older members of the workshop. This was a truly human adventure in group dynamics, where people of all ages *could be themselves* more freely, could inter-relate, gain personal insight, and see and feel another's point of view. Such an experience was succinctly expressed by Sammy who likened his participation to a Sioux Indian's prayer: "Great Spirit, help me never to judge another until I have walked two weeks in his moccasins".

We felt that these children had received unconditional, non-critical acceptance *as never before* in an adult group. Did we contribute to their growth as creative, spontaneous leaders? We believe so. We felt we had assisted in the creative process, each of us learning new ways of dealing with people and their problems. Adults and children had learned to take roles more consciously, contributing to a greater awareness of self and of others.

We not only saw and heard, we felt the validity of these spontaneous sessions lived together for an entire day. Each gave expression to his own individuality through the group. Each enriched all the others. Here were new dimensions in learning, knowing, feeling, and leading, a never-to-be-forgotten series of adventures in experiencing the healthy and spontaneous excitement of each moment. This we agreed, was a valid confirmation of evolutionary doctrine: this was, indeed, *social symbiosis!*

THE USE OF PSYCHODRAMA IN PASTORAL THERAPY*

ALLAN N. ZACHER, LL.B., B.D.

Christ Church Cathedral Counseling Center, St. Louis, Mo.

A surprisingly large number of Church-related Counseling Centers have sprung up all over the United States in recent years. These Centers attest both to the need the Church sees to help people with emotional problems, and also to the lack of standards in the field of Pastoral Therapy. The Cathedral Counseling Center in Christ Church Cathedral, St. Louis, Missouri, is in its third year of operation, and is working with several other Centers now to establish criteria for Pastoral Therapists.

Referrals are made to the Cathedral Counseling Center by the St. Louis County Domestic Relations Courts, lawyers representing parties in a divorce, by psychiatrists and clergy in the St. Louis area, and by individuals who have been helped by the Center. People come to the Center from a wide variety of religious backgrounds. Each case is carefully reviewed, after the initial interview, by myself and the psychiatric supervisor; a decision is made to work with the individual in the Center or to refer the individual to other psychiatric resources in the community.

A CLERGYMAN'S ROLE IN THERAPY

A number of individuals come to the Cathedral Counseling Center because they want to see a clergyman and will not consider seeing a psychiatrist. We make a diagnosis and help the individual work out a realistic therapeutic plan. If referral is indicated, in practically every instance we have been successful in making a referral to a psychiatrist after a series of interviews. Often individuals need help from a clergyman to see that "religious people" do have emotional problems and that God has provided professionals, equipped to treat emotional problems. It is just as appropriate for a Christian to go to a psychiatrist as to a surgeon or a dentist. The pastoral therapist then is often in a position to help an individual make much more creative use of the strengths found in that individual's own religion.

We have received several referrals from psychiatrists who perceive that there are some kinds of help that a clergyman may be best able to give.

---

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

An individual who is troubled by his relation with God may find it almost impossible to speak of this to a psychiatrist if he feels the psychiatrist does not share his religious conviction. The case of a young woman is a specific example of this. Her mother died when she was eight. Members of her family told her that the mother's death was God's will, that God had called her mother to Him. She became resentful and bitter toward God. In her adolescence she became quite depressed, and on several occasions had attempted suicide. She believed that her hatred of God was a religious problem. She had attempted to work through this problem in college where she had a number of conversations with a clergyman, who tried to help her understand a God who didn't punish and a scientific view of the world which was more acceptable. Unfortunately, she had been able to seduce the clergyman, and this intensified the problem. As she talked of what she believed about God, she began to suspect that she equated God and her father. Her father was withdrawn and difficult to be close to; he had often punished her severely. She believed his indifference had hastened her mother's death. Gradually she developed the desire to learn about the God I knew, who was concerned and loving toward His children. In this process she developed deep attachment for me. At times I was father, yet a father who could love her. It seems that a clergyman, because of his vocation, is sometimes in a unique position to teach through a transference relationship. She also learned her sexual feelings were God-given; she found she could trust herself and others enough to be close to them. She was a very sick girl several years ago; today she is well, happily married, and a mother herself.

An older woman, referred to me by a psychiatrist, is another example of a person who was troubled by her relationship to God. She said she had angry thoughts about God, and she felt God surely condemned her for this. As a result of several interviews, she began to see that this was a symptom of her depression, and she began to feel much more relaxed. She also believed that if God truly loved her, He would cure her depression in a miraculous way. I suggested that God was using me and others around her as channels for His healing powers. Within her religious framework she gradually began to deal with the emotional problems in her life.

The Use of Psychodrama In Pastoral Therapy

I have found psychodramatic techniques useful in diagnosis. If both husband and wife in a marriage problem agree, I have them come in for a first diagnostic conference together. Often they are both active in the

discussion of their problem. Possibly they remember the crisis which precipitated their going to a lawyer for a divorce; in many cases this is a violent argument, and with a little encouragement from me they begin to re-enact the argument, not just tell about it. I find this is a very helpful technique to use to begin to diagnose the emotional problems in each—the husband and the wife.

When an individual in therapy resists going into certain material, I find they can be stimulated by a modified action technique. One example of this: a young woman was describing feelings she had while lying on her bed; she had left her husband for another man and then decided she didn't like the second man. She wanted to be married and found herself caught between the two. She was living by herself in a women's residence; occasionally she would call one man and and then the other, completely torn and divided between the two. While she was lying on her bed close to the phone, she experienced a lot of fantasy which was important for her to discuss, but she didn't seem able to go into this material. I asked her to describe her room and to recline in her chair as she had in her bed. She began to relive the experience and was able to remember exactly the fantasy material.

I use "role reversal" to help individuals understand what others are thinking or feeling. Several times when husband and wife were acting out a conflict, I have asked them to reverse roles. We would do this by having them change chairs and assume the identity of the other person in the action they were re-living. If they are able to get into the spouse's role, I stop the action and ask them to describe their feelings as they played the role. I found on a number of occasions that this technique enabled the husband or the wife to gain insight into the other's feeling, in a dramatically quick way.

I have used role reversal more frequently in individual sessions where an individual cannot speak of his or her feelings about me, or where I sense that the individual has a very unrealistic view of me, but is not able to talk about who he or she perceives me to be. In one case, a young woman employed as a psychologist had begun to discuss an extra-marital affair. She seemed to feel that I was very judgemental. I suspected that she was attributing to me many of the feelings she believed her parents would have. I asked her to change chairs with me. I acted as she had been acting, assumed the same position, spoke in the same manner, showed defiance and resentment, yet blocked in an attempt to describe feelings. This woman, who had taken my role, began to feel the way I had felt. She began to

view herself not as a person who needed moral lectures or punishment, but as someone who had problems, someone who was working at cross-purposes with herself. (No doubt experience she has had treating others helped her to assume my role.) Her ability to gain insight into my feeling was remarkably quick. Then we switched back into our original roles, and I asked her to think about why her first perceptions of me had been so far off. She was able to perceive her transference of feelings from her father to me. In our next hour I asked her to describe her feelings about changing roles with me. She said she didn't realize how blocked her ability to describe her feelings was until we reversed roles, and she saw me "working" at trying to encourage her to talk about these things she found difficult to reveal.

Training in Psychodrama helped me develop a broader view of the therapeutic relationship than that gained in other psychiatric training. This broader view is very helpful to the pastoral therapist. I remember one young woman who was so depressed she could not speak. I said, "Let's go down to the Coffee Shop and get a cup of coffee." There we had an opportunity for a significant meeting that had not been possible in my office* Occasionally I ask a person to take a walk in the park with me. On two occasions I have asked people I was working with if they would like to live in our home.** In one case my invitation was accepted and it worked out quite well. The person who came to us was a very fine and talented person; she was having marital trouble which had finally precipitated hospitalization. I was quite conscious of the interaction of the members of my family and how she participated in this. Within six months she was able to return to her own home and successfully resume her married life. In the other case, although the woman did not accept my invitation, she said it was a turning point for her. She felt for the first time the reality of my concern for her. She felt she was "worthwhile." She also re-evaluated her home situation; previously she had felt many of her problems were caused by conflicts at home. After my invitation she saw more clearly her difficulties were within. In both cases these people had not gotten all they needed from normal psychiatric procedures after a considerable period of time and my invitation seemed to open the way to further healing. Quite obviously there will never be more than a small percentage of clergy specializing in pastoral counseling and pastoral therapy. Although psycho-

*Editorial Note: Informal psychodrama.

**Editorial Note: Psychodrama in situ.

dramatic insights and techniques are useful to the clergymen involved in this work, I feel these insights and techniques have much broader application in the Church. Members of the Panel on Psychodrama and Religion[1] have pointed to a number of instances where psychodrama was used to help individuals in a congregation know themselves better, become more effective in their relations with others, and to help them understand at deeper levels the social issues of our time. The Church is a place where people really *live* together. If we can use psychodramatic insights to shape the worship and group life of our congregations, where life is lived, there will be less sickness in the world and less need for Counseling Centers.

---

[1] Panel on Psychodrama and Religion (Chairman: James Enneis; Speakers: Allan N. Zacher, John R. Green, Dale A. Anderson, and David J. Greer), held at 20th Annual Meeting of the American Society of Group Psychotherapy & Psychodrama, New York City, N. Y., March 24 and 25, 1961.

PSYCHODRAMA AND THE NEW ROLE OF THE SCHOOL PRINCIPAL*

LAURIE MAE CARTER, MA

Oakland Heights School, Meridian, Mississippi

Our school has 550 elementary school pupils. Once every year we give what we call a Festival, for want of a better name. It is really a Social Studies project. We have dramatized the Industrial Festivals of our State in miniature on our stage. (You have no doubt heard of the Shrimp Festival at Biloxi, Mississippi, and the Pilgrimage at Natchez, Mississippi.) Another time we gave, "What Goes with Your Tax Dollar?" Still later we gave "Americans All," and "The 100th Birthday of Meridian." This year we are giving Franklin Delano Roosevelt's "Four Freedoms of America." This latter one gives us a chance to stress freedom from fear and the psychological reaction to fear. We will bring our particular fears out and represent them on the stage in figures and color. Perhaps we shall use the witch for superstition or fear of darkness. Each time we create a pageant, children, teachers, and parents do research, think, and build it gradually into a thing of dramatic beauty. It is a result of the efforts of the total community. In 1959, we won a Freedoms Foundation Award for this work.

In individual classes and in groups we discuss our fears and act them out psychodramatically. One day I was explaining to fourth graders the crippling effects of fear. I very dramatically shook my hands to show the effects of it. One little boy said, "But, Mrs. Carter, I don't do it that way. I just shake to myself." This, of course, is the worst way to shake.

I have a reading circle when it is possible for me to get away from other pressing administrative duties. I set the environment with many, many books of all reading difficulty and interest. Children are free to choose the book they want regardless of its simplicity or difficulty. We keep a list of the books each child reads. They love the power of choice and read ravenously. One mother and father reported that their son had not ever wanted to read books before, but how they couldn't get him to

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

put the books down. One day they let him come to school without a bath because there had been such a change in his reading habits. He tenaciously held on to his book.

Besides the reading we dance out our feelings, using different kiddie band instruments to make the music. We play out our happy feelings and our sad feelings.

When children are shy, I use the mirror technique. I have also found that the Magic Shop appeals to children, and they will be very serious about the things they buy.

I have worked with classes in my own school and have been invited to other schools to talk about human beings. A teacher from another school said. "You showed such inderstanding, and that is what we need most."

In our school parents are free to choose the teacher of his or her child. We have three sections of each grade-three firsts, three seconds, and so forth. A child works with the teacher of his choice.

Parents develop leadership. There are many Boy and Girl Scout Troops, and a good P.T.A. Parents think, express their ideas freely; then come to conclusions on actions to be taken. Parents last year and this year have mended 1600 books because they love the school. They do not feel that any worry of theirs is too small to bring to the principal. We emphasize with parents, too, that a person's picture of himself is the most important thing he has. At P.T.A. meetings we have guidance-minded speakers.

All the principals in Meridian met with us at Christmas time for a Christmas party. I demonstrated musical therapy and psychodramatic methods.

Once when all the teachers of the city met for assembly, I had the devotional period. I tried to show that in using psychodramatic methods with people it becomes more than any other type of work, what we call God's work in the world. President Kennedy ended his inaugural address with, "God's work in this world is but our own."

I have taught counseling to ministers and civic workers in our community. Dr. Ralph White, Student Teacher Instructor from Mississippi Southern College, spends one-half day with us at Oakland Heights School about every three weeks. He had this to say after observing in many rooms: "I make no bones about it. This is the best teaching I have ever seen in my life. This is the kind of teaching we read about in books—the kind that should be done, but is found seldom in reality—but here it is.

Why haven't I seen this school before? How do you get all the teachers to do such 'top-level' teaching, *So Alive!*

"May I bring all the teachers in my student teaching group here to see what you are doing?

"You needn't say you don't have any turnover of teachers in this school, for I know you don't."

Later he added: "Now that I know the spirit of the school, I want more and more of our student teachers trained here."

I have talked about Child Growth and Development and Mental Health to Four H. Club Conventions, Civic Clubs, D.A.R. Meetings, faculty meetings, P.T.A. meetings, and prayer meeting. Not long ago for two nights I led Negro parents at a Negro school in discussion for one hour each night and lectured for forty-five minutes the second night.

We try at Oakland Heights to develop faith in everybody with whom we come in contact—in each teacher, each child, and each parent. We believe with a writer, whom I cannot name, that "Faith is reflected in a person when he considers himself to be an important person, someone who has something to offer to himself and others. The person who has faith in himself believes in himself. He has convictions that are an integral part of him. He makes decisions for himself and carries them out. He expresses himself freely and fully and does not fear that he will be condemned for his feelings or his beliefs. The person who feels faith knows what he wants to do, what he can do, and what he will do. He trusts his own feelings."

Michelangelo was one day walking around the yard of a builder. He saw in the corner a misshapen block of marble. He asked the builder what he was going to do with it and received the answer that it was useless. Michelangelo replied, "It certainly is not useless; send it around to my studio. There is an angel imprisoned within it, and I must release it."

This story exemplifies what I feel psychodramatic methods of education in our school do for the individual teacher, child, or parent. There is a much greater person beneath the skin of each one of them. These methods can bring the greater person into being.

BIBLIOGRAPHY

R. B. Haas (Ed.): Psychodrama and Sociodrama in American Education, Beacon House, Beacon, N. Y.

TEACHING GROUP, A THERAPEUTIC GROUP?*

CLARISSA JACOBSON, M.S.W., JOSEPH MANN, M.D., EDNA RAINEY, R.N.
Ypsilanti State Hospital, Ypsilanti, Michigan

As the title already indicates, this article deals with the problem: Should a psychodrama group which is serving for teaching purposes in a state hospital be at the same time a therapeutic group? It this possible? The following gives an account of our experiences in this matter and tries to answer the question.

The beginning of psychodrama at the Ysilanti State Hospital dates back to June of 1959 when Jacobson and Mann formed a group with five patients in the female admission ward. The patients enjoyed this, and their reaction to their roles was interesting, and in most cases quite therapeutic. Certainly other factors in their hospitalization played a part in their progress, but the fact remains that this group did very well. This experiment was far from the classical form of psychodrama, but its success predisposed us to accept the method. The rather promising results obtained with this small group of patients was the deciding factor for sending the writers to Moreno's Institute in Beacon by the hospital authorities. The rich program and the association with others who were already familiar with and using the psychodrama method in the state hospital structure, all helped to convince us that this had a value for our hospital. On our return, we felt that an immediate demonstration for the staff was necessary to introduce psychodrama to the hospital. We knew that psychodrama had once been started at the Ypsilanti State Hospital and had faded, but we knew none of the factors involved. We knew that other members worked in psychodrama in other settings also, but we were unaware of their real feelings about the method. We were unsure of ourselves about our skill, and each had his own individual doubts and convictions about the method. The staff came and filled our staff room to overflowing. We had deliberately disrupted the room arrangement in order to take command of the group more fully. The reactions varied. People were alarmed, excited or critical. Many asked us what it was about the method that had so moved us, as it was obvious to them that we had been deeply touched during the time that we were away from the hospital.

* Read at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

The demonstration created a fascination, and many asked to learn more about psychodrama. A few staff members were impressed by the power of the method, were concerned about our ability to use it therapeutically and control it. This, of course, echoed our own concern, and we could only assure them and ourselves that we would try and that we could learn more by forming a staff group. We issued an open invitation to all treatment groups in the hospital and ruled out all spectators. Our initial group consisted of physicians, nurses, attendants, psychologists, social psychologists, social workers and recreational therapists. We self consciously banned use of titles and last names and attempted to form a group.

Our first session was a fruitful one that allowed the resolution of a conflict between two group members which had been based almost solely on poor communication. We were all moved to realize the superficiality of our contacts with the people with whom we worked as we got to know each other through the group. We haltingly began to struggle with sociometry, made our mistakes and at the same time learned a lot about ourselves. Other problems developed. The group had been designed originally as a training group, but it now assumed the quality of a therapeutic group as well. Members began to have strong feelings about each other and sought each other out during their time at work. We began to evaluate ourselves and others. The group had several members who appeared to us to have joined mainly to do their own "private research", and who continued to intellectualize to the point where their presence was a disturbing factor to us, although the group itself seemed to embrace them. After several emotional and anxiety producing sessions, the group began to demand rather angrily to know what was being done to them and to talk about their need to have more theoretical discussions concerning the techniques of psychodrama. At the same time, intense discussions were held around the subject of confidentiality and responsibility of group members to each other. The group by this time had developed an identity in the hospital, which was recognized also by non-members who were interested in knowing what was happening in the group. Some group members then asked us to direct sessions, but we were frightened to let them. However, at this time, pressure developed from the hospital to utilize this method with patients, and therefore it became obvious that others would also have to direct. We also feared the group would become out of control if others directed and the outline, however inadequate, that we had thought out, would fall aside.

About this time we had a tumultous evening session, at which time

the group severely attacked us for our method of running the group and indicated that our aura of "knowing so much" and our constant reference to Beacon and our simultaneous saying that we really did not know so much was very irritating to them. We had previously confided in others our concerns and leaned on each other for support, and this alliance was criticized by the group who accused us of having "secret meetings" and of being "a group within a group." They demanded that we step down as leaders and that we share more with them. We felt overwhelmed and unhappy and distinctly unappreciated. We thought of disbanding the group or beginning a new one, but could not ourselves leave the group as we were too involved. This appeared to us as a complex phenomenon which we could not totally evaluate. About this time Dr. Moreno was expected in our hospital for a seminar, and all of us had almost magical expectations that he and Mrs. Moreno would cure our problems.

Instead it soon became obvious that he regarded us as a group in no way unique and that we would have to somehow find our way out of our difficulties. The group became more realistic at this point and began to see pychodrama as a therapeutic technique that had power, but also made demands on all involved in it. At this time enough was being done of psychodrama and role playing outside our group to convince everybody of its value. This, however, only accented the awkward situation in our group which now had no leader. The group itself saw this as their resistence to the method, and wanted us again to take steps forward, but they could not reinstate us. They had "resented the monarchy, had a revolution but had not elected a new government." Other difficulties arose. Members of the group were forced to leave us. Their work areas were changed, and they were put on different shifts. Staff meetings were held that involved our members at the same time as our meeting. Anxiety was aroused whenever a new member joined the group or one left. We began to see the importance of having people present for a reasonable length of time so that their perception of the process was an accurate one.

In the evolution of our group, we have since had many directors (previous protagonists) who chose now the protagonists themselves, and from this we have come to the realization, that just as any psychoanalyst has to go through analysis himself, no one can direct the psychodrama without having been a protagonist. Simultaneously the members of our group began to work: 1) Directly with patients (in chronic and rehabilitation wards, children's groups), utilizing psychodrama techniques in rearrangement of ward personal structure (exchange of ward psysicians,

nursing personnel etc.), 3) in work with alcoholics, 4) in work with a group of ministers, who were in the hospital for a course of institutional ministry. All these efforts can be described as satisfactory, and at the time this report is given further steps are in planning.

In addition, Jacobson and Mann are using some psychodramatic techniques such as a role reversal, in the treatment of families.

The experience in our own group lead to the following conclusions: (1) In order to use psychodrama in working with patients it is necessary to start with a group of the hospital personnel. (2) Everybody, who has to deal with patients professionally can be involved in the group, but the responsibility for the group must rest in the hands of professionally trained therapists. (3) This group should be formed in such a way that administrative changes in the hospital structure will not involve the group. (4) The teaching core group has to be a therapeutic group at the same time, otherwise the experience of psychodrama will never be complete, and only theoretical elaboration within the group will lead to superficiality. (5) The use of psychodrama in working with the hospital personnel can be a vital factor in producing better staff relationships and (6) Can be a liberalizing factor in terms of therapeutic goals.

PRINCIPLES OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA AS APPLIED TO MUSIC THERAPY*

LEO C. MUSKATEVC, R.M.T.

Milwaukee County Hospital for Mental Diseases

There is a peculiar phenomenon about most lectures concerning music. That is, they are usually all lecture and no music. I would like to remedy this peculiarity to some extent today by listening to music first and then talking about it. At the same time, I would like to "kill two birds with one stone" by asking you to participate in a little study I am doing on Musical Preference while you listen to the music.

You will notice that the sheet which has been passed out to you contains a form consisting of two enumerated columns headed by the single words "yes" and "no."

(Facsimile of Form)

Age _____ Occupation _____

Nationality _____ _____

Education _____ City _____

Sex _____

MUSIC PREFERENCE INVENTORY

	YES	NO
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

---

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

The purpose of this test is twofold; the first to determine the acceptance or the rejection of various types of music. The second purpose I will discuss later. Before I explain the procedure of this test, would you please fill in the blanks at the heading of the sheet. It is not necessary to identify yourself, and those of you who find the age bracket somewhat threatening may mark an arbitrary "29" or "39" and I will tabulate the results accordingly.

The procedure in taking this inventory is quite uncomplicated. I will announce the numerical order of the compositions being played, and after a few moments of listening, you are to place a check mark in the appropriate box under either column "yes" or under the "no" column, but not in both. You will place a check under the "yes" column if you find the music acceptable, enjoyable and pleasing to you. However, should you find the music displeasing, unenjoyable and generally unacceptable to your ear, you will place a check mark under the "no" column in the appropriately numbered box. It is entirely possible that you may have ambivalent feelings regarding some of the compositions due to various factors; associative, acoustical, or aesthetic. In any case, one reaction must take precedence over the other and a decision must be made. Thus, if you like the song but dislike the singer, the appeal of the song may overpower the distaste for the singer and you place a check mark under the "yes" column. On the other hand, if the distaste for the singer overshadows the song's appeal, you will place a check mark in the "no" column.

I will play only a portion of each record. (This is not a test involving a grade for passing or failing, so please do not copy!)

Record Played	Manuf.	Number	Title	Performer
1	DECCA	9-40201	The Waltzing Cat	LeRoy Anderson
2	RCA VICTOR	447-0174	The Glow Worm	Spike Jones
3	DECCA	9-30704	Tea for Two Cha Cha	Tommy Dorsey Orch.
4	RCA VICTOR	EPA 821	Heartbreak Hotel	Elvis Presley
5	RCA VICTOR	447-D123	Star Dust	Tommy Dorsey
6	CAPITAL	EAP 1-538	Anybody Hurt	Gloria Wood
7	LONDON	45-1358	Ebb Tide	Fr. Chacksfield
8	DECCA	ED 2483	Helena Polka	"Whoopee" John Wilfarht
9	SUE	706	Itchy-Twitchy Feeling	Bobby Hendricks
10	RCA VICTOR	447-0181	La Golondrina	Connie Francis
11	M-G-M	K12683	Stupid Cupid	Wayne King
12	CAPITAL	F3507	True Love	Bing Crosby

(Test Administered)

I would like to present some general preliminary observations before we determine whether this group follows the general pattern of previous results. The popular responses are distributed in this manner:

Numbers 2-4-6-9 and 11 are heavily weighted in the "no" column.
Numbers 1-5-7 and 12 are heavily weighted in the "yes" column.
Numbers 3 and 10 are somewhat evenly distributed with a slight edge in the "yes" column.
Number 8 is also somewhat evenly distributed with a slight edge in the "no" column.

Results tabulated from this group indicate the group to be atypical and not a reliable criteria for musical preferences of the general population. This is probably due to the high degree of homogeneity in the cultural constructs of this group.

The second purpose I spoke of prior to the administration of this inventory deals with the use of this device as a projective technique. You are all familiar with the Roschach, the Thematic Apperceptive, the Mosaic, the Szondi, and other projective devices for personality evaluation. You will note that all of these measures involve responses to visual and motor stimuli as vehicles of impression and expression. There are, however, no projective techniques utilizing aural involvement for this purpose. I feel that the expansion of projective techniques into this functional area would offer an additional dimension to personality evaluation which would serve to reinforce existing measures, increase the quantity of material expressed, and enrich and refine the quality of responses.

Let us look at this Musical Preference Inventory in this light; that is, as a projective technique for personality evaluation. First of all, let us refer to the popular response profile: If you have marked numbers 2-4-6-9 and 11 as "no," and the others as "yes," you are in the so-called "normal range," which while being reassuring is not necessarily flattering since it categorizes you as one of the common herd."

If you have ten or more "yes" responses, this is an indication of the extrovertive personality. One having strong social needs, an affective "acting-out" type of person.

If you have ten or more "no" responses, you have an introvertive type of personality. You are very selective in your choice of friends, somewhat narcissistic, controlled in your thinking, excellent in abstract conceptualization.

If you have checked "yes" for numbers 2-3-4-9-11 and 12 you are immature.

If you have checked "yes" for numbers 1-5-7-10 and 12 you have the geriatric tendency of looking backward and reflecting upon the "good old days," lack spontaneity, show little initiative, and experience mild depression.

If you have checked "yes" on numbers 3-8-9-10 and 11 you are the physical type who find expression and catharsis through activities requiring bodily movement.

If you have numerous double checks, having checked both yes and no on identical numerical levels, you are anxiety-ridden and are not as happy as you could and should be.

If you have alternating checks, you are merely facetious, a "practical joker," the clown type, often times difficult and obnoxious.

If you have checked yes on numbers 1-3-5-6-7 and 12, you have a high level of aesthetic appreciation; strong musical interests.

And, finally, all of you who have submitted yourself to this personality evaluation are urged to take these reults with a very large grain of salt for these findings are purely *fictitious* and *hypothetical,* having *no basis of validity* and *reliability.*

What is much more important is that I had hoped you would become highly "involved" on an affective level and would have experienced some "spontaneous" reactions to my "warming-up" device; from your reactions, I am pleased to see that these goals were accomplished.

Really, I am here to discuss something totally different than testing devices. As the title of my subject implies, I am to speak to you about "The Principles of Group Psychotherapy and Psychodrama as Applied to Music Therapy." In this respect, I am primarily interested in presenting and discussing some basic precepts which we can establish as denominators which are common to both media.

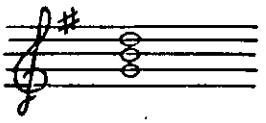
Now, let us look at Group Psychotherapy and Psychodrama and Music Therapy in the light of this consideration.

POINT NO. 1. ARCHITECTURE OF PSYCHODRAMA

The Warm-Up
The Psychodramatic Action
The Analysis and Discussion

It is apparent as we perceive the formal structure of Psychodrama that

it assumes a triadic characteristic so like the basic architectonic characteristic of the complete harmonic unit in music, that of the triad; for example



A further consideration, even more closely related to this structural consideration lies in the nature of the classic sonata-form and fugue; that is,

Exposition
Development
Recapitulation

More directly significant in this generic relationship is the actual organization and development of a musical activity.

As our example of the psychodramatic situation as applied to Music Therapy, let us assume our setting to be the organizational rehearsal of a choral group and its subsequent development to the point of performance. The initial efforts are necessarily directed toward "warming-up" the group, attempting to arouse "spontaneous" response to the efforts of the conductor. The next phase shows the choral group moving into action increasing its "involvement" to the point where it is ready for performance, much like the "protagonist" moving out of the group to the various levels of elevation until he finds himself on the stage, ready for psychodramatic action. Once the actual performance has been completed by the choral group a significant reaction can be noted, that of a need to "cool off" after intense emotional involvement. Analysis and discussion are an inherent part of the "cooling off" period, whether the cooling off process follows a performance on the concert stage, or in the "psychodramatic" theatre.

POINT NO. 2. THE ELEMENTS OF PSYCHODRAMA

The Encounter	Tele
The Moment	Nunc
The Place	Locus Nascendi
The Situation	In Situ

Dr. Moreno's discussion in his "Principles of Psychotherapy" clearly explains the essence of the encounter:

> "Begegnung conveys that two or more persons meet not only to face one another, but to live and experience one another—as actors, each

in his own right. . . It is a meeting on the most intensive level of communication."
The Encounter involves "Zweifühlung (Tele)—Togetherness, sharing life. It is an intuitive reversal of roles, a realization of the self through the other; it is identity, the *rare unforgotten experience of total reciprocity*. . . Begegnung is the sum total of interaction."

The musical act, in our example of the chorus rehearsal, requires the complete interaction implied by the term "Begegnung." There must be a total reciprocity between conductor and singer; between singer and singer; between section and section; or there can be no aesthetic experience. Any resistance on the part of the choral member to the conductor's wishes results in an impasse, a total lack of spontaneity and a sterility of the creative process. By the same token, any rejection by the conductor of the group will also produce such an impasse. There must be, of absolute necessity, a meeting of I to I, the intuitive reversal of roles, and the realization of the self through the other.

A factor common to both facets of human action has been never more clearly portrayed than in the element of time. In psychodrama we are concerned with the "moment"—for it is the "here" and "now" of the encounter which serves as the framework of the meeting. And so, too, the processes of music, which is a temporal art,[1] find their realization only in the moment.

Moving back into the psychodramatic situation of the chorus rehearsal we observe that it is the immediacy of creative productivity which makes the chorus a vital spontaneous organism. Again answering my position as chorus director, I ask you to sing with me the tone which I have sung for you, in the effort to produce a good unison tone; the response must be an immediate one, and the efforts sincere and unrestricted or we do not have "an experience." It must happen, not tomorrow, nor next week, but now and without reservation.

The element of place, in view of our discussion of the elements of "encounter" and "moment," is self-evident. If we are to meet now, it must be and obviously can only be "here." The "locus nascendi" is determined by the "nunc" (Hic et nunc). It is this presence at a place at a

---

[1] Goetchius, Percy, Mus. Doc. The Theory and Practice of Tone Relations, G. Schirmer Co., 1900, New York., p. 13

#35 The images of musical art, unlike the stationary creations of the arts of painting, architecture and sculpture, are progressive; as in the art of poetry, the impressions in music succeed each other by progressive motion. Therefore, time is absorbed in the expression of musical thought.

specific time which assures us of the protagonists availability for involvement in a psychodramatic situation. As a choral director, I could not possibly create a musical experience if the presence of the choral members was not assured at the time and the place of encounter. It is apparent as we scrutinize each of the elements that they are intimately interrelated and inseparable. The final element of this finely woven tapestry is the psychodramatic situation—(In Situ), the specific experience serving as the vehicle for the cathartic action of the protagonist. While the psychodramatic situation calls for complete spontaneity upon the part of the protagonist, the choral rehearsal is a more structural vehicle, but nontheless, requires a certain amount of spontaneity. (Here lies a basic difference between the psychodrama and Music Therapy. Music Therapy, as a group therapy, is an indirect form of action for group catharsis, while psychodrama involves itself directly with the specific needs of the protagonist; music in its many forms offers a more subtle approach to the therapeutic needs of the patient, approaching, sometimes, very closely the apex of the individuals conflictual needs, more often skirting its periphery in mild involvement.) Just as at today's chorus rehearsal when we used the major triad with the good Doctor,* singing the root of the chord—Leon* the third of the major triad, and Calvert* the fifth (no pun intended), we were able to create a mood of serenity and warmth by having them sing simultaneously, their own special tone with the vowel sound *oo*. An affective reaction was displayed by the entire group in that through the singing of the trio they had an aesthetically satisfying experience, a feeling of unity, and a genuine group experience. To the trio, the involvement through the performance was great, to the rest of the group, through listening, the involvement was less intense, and yet no less a group experience.

POINT NO. 3. MOTIVATING FORCES OF PSYCHODRAMA

Creativity

Spontaneity

Anxiety as a necessary factor in maintaining the spontaneity-creativity movement.

Music is an art. All artistic forms are a product of the creative process. There can be no creative processes without spontaneity, and anxiety is necessary for the continuation of the spontaneity-creative process.[2] Music

* Doctor J. L. Moreno - Dr. Leon Fine - Dr. Calvert Stein

[2] Moreno, J. L. "Who Shall Survive," Doctrine of Spontaneity-Creativity, p. 41-49

in its progression from tone to tone, chord to chord, key to key, and movement to movement, is a pure manifestation of the function of anxiety in the creative process. Once again, using the choral rehearsal as an example, the creative process was set into motion through the production of the major triad by three members of the group. This was a spontaneous reaction which resulted in a creative experience—limited to one chord. The necessity for the presence of anxiety for a continuing process was beautifully exhibited by one of the nonperforming members of the group who challenged the validity of the claim that this single chord was a creative process by declaring "That's not art, it's only one chord. How can you justify the statement that you have created something?"—True, unless anxiety caused by melodic succession, harmonic progression and rhythmic pulsation motivated further spontaneous activity, we could not have a creative process. This precise circumstance confronts the director of a psychodramatic situation wherein the protagonist refuses to enter the psychodramatic action spontaneously because he wishes to avoid the anxiety of the occasion—no anxiety—no spontaneity; no creative process; no creative process—no catharsis.

POINT NO. 4. NECESSARY STATE OF PSYCHODRAMATIC EXISTENCE

Involvement

Rule: The degree of involvement is directly proportional to the expenditure of spontaneous energy and the intensity of the creative processes of the psychodramatic situation.

The psychic blocking, the negative relationships, and other form of resistances which are set up by the protagonist must be recognized by the psychodramatic director and removed to insure sufficient "entering in to" the psychodrama, for without involvement there can be no catharsis. These resistances, in order to be dealt with, must be recognized by the director through a high degree of sensitivity of perception to "clues" given by the protagonist and then, the director must be able to use these "clues" for development of the psychodramatic situation and the intensification of involvement of the protagonist. The very same circumstances surround the choral rehearsal—psychic blocking, negative relationships and other forms of resistance are set up by the individual members as well as the group as a whole. It is imperative that the chorus director: (1) Not only become aware of the many clues which indicate these resistances to him, but; (2) that he is highly sensitive to the nature and characteristics of these resistances and; (3) that he has adequate psychic equilibrium

to use these clues for the development of group cohersion, group unification and group movement toward a goal. Thus, when the chorus sings out of tune, attacks poorly and releases badly, and is generally inflexible, the director must have the sensitivity to recognize which of these are resistances to involvement, and how to resolve these resistances.

POINT NO. 5 NATURE OF THE PSYCHOTHERAPEUTIC GROUP IN PHYCHODRAMA

> The psychotherapeutic group is a miniature society wherein all members are accepted and all members find opportunity for expression.

All one needs to do is substitute the word chorus for the words psychotherapeutic group, for the chorus is truly a miniature society wherein *ALL* members are accepted and *ALL* members find opportunity for expression. There is no other activity which is so completely a total group experience as is the music performing group. Each one of its members is expressing himself, but only in terms of his harmonious relationship with all of the other members of the group.

POINT NO. 6 COMPONENTS.

The Stage
The Director
The Protagonist
The Auxiliary Ego
The Group

The musical group is directly related to the socio-drama in its "componentiality", being limited to the three basic components of the stage, the director, and the group. However, within the developmental activity of the music group there does occur the utilization of the protagonist and the auxiliary egos. This is readily discernable in the performance of musical compositions, the arrangements of which may include solo, duet and small ensemble sections as well as participation by the group's full complement.

POINT NO. 7 . GOALS

Catharsis

Mental Catharsis
Active Catharsis
Group Catharsis

To satisfy certain needs not attainable by individual therapies.
The integration of the individual against external forces.
The integration of the group through the individual's participation.

The aim of group action is catharsis by integration. The integration of the individual self against the uncontrolled forces surrounding him and the integration of the deeper personal dynamic forces within the individual into the formal organization of the groups in which he participates.

The bifocal approach is observable in all of its manifestations and ramifications in any musical activity being carried on by a group. In the chorus, each individual has his own part to sing. In some instances, it is the most important vocal line, carrying the main theme. At other times it may be assigned a subordinate theme or an even lesser supporting harmonic role. Regardless of its degree of prominence in the musical structure it's inportance as an integral element of the schematic design continues and the total effect would be marred by its absence. The creative process would be incomplete and an aestheric catharsis by the group would be unattainable.

Thus, the necessity of the individual's creative expression within the group structure is easily discernable as a prime requisite for the realization of a group catharsis through total reciprocal integration.

By the same token, the cumulative effect of the common experience of performing Haydn's "Creation" or Handel's "Messiah" affords the individual psychic support toward the maintenance of his emotional integrity.

The foregoing discussion exemplified the first two aspects of the psychodramatic architecture, that of "The Warm-Up" and the "Psychodramatic Action", the final phase of "Analysis and Discussion" by the group is all that remains.

BIBLIOGRAPHY

MORENO, J. L., "Psychodrama," Vol. I, Chapter on Psychomusic, 1945, 2nd ed., 1962.

PSYCHODRAMA WITH IN-PATIENTS*

JOHN J. HOFFMAN, PH.D.

Veterans Administration Hospital, Buffalo, N. Y.

There will be two parts to my presentation. First, I shall briefly describe the psychodrama program which I direct on the Neuropsychiatric Service of the Buffalo Veterans Administration GM&S Hospital; then, I shall engage in a bit of theorizing about some of the special virtues and potential dangers of psychodrama.

On our Service, we hold psychodrama sessions twice a week. Each session lasts one-and-a-half hours. Our group is an open-ended one, so that over a period of time the membership of the group undergoes considerable change: some patients leave, other patients join us. The number of regularly attending patients is between eight and twelve. We have male patients only in psychodrama right now, but I hope that soon we shall again have with us female patients as well. Two female volunteers and a male psychologist trainee act as my assistants; the former are present on separate days. We are particularly apt to select for psychodrama patients who are blocked in emotional expression—those, for instance, who harbor strong hostile feelings within but inhibit expression of even mild degrees of aggressiveness or self assertion, or shut out from awareness hostile feelings altogether—and patients whose problem is, in a sense the opposite, in that they experience intense feelings and are apt to act-out without sufficient control. Diagnostically, our patients are severely neurotic, schizophrenic, or suffer from one or the other of the personality trait disturbances. We do not have floridly psychotic patients in psychodrama.

The manner in which I conduct the sessions may be called, "cafeteria style." We meet, and according to the way things evolve, a patient who appears to be warmed up is selected as the protagonist. Neither the choice of a patient nor the area on which we will focus is pre-determined, of pre-planned. On a few occasions, I do try to have the patient who was protagonist the previous session continue from where we left off before. Patients, as well as my assistants, are asked to play auxiliary ego roles. When things go well, patients spontaneously get up on the stage and assume such roles for part or all of the session. I do quite a lot of "doubling" myself—a practice about which I have mixed feelings. There is considerable

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

"esprit de corps" within the psychodrama group, and patients on the Service tend to look upon psychodrama as something special.

Now, I should like to move on and discuss some of the ways in which, I believe, psychodrama is of particular benefit to patients. I will also expound on the thesis that certain features of psychodrama pose a special psychological threat to patients, calling, therefore, for utmost sensitivity on the part of the director-therapist, and that it is to these very features and to a lesser extent even to the psychological threat inherent in them, that psychodrama owes much of its unique effectiveness.

As is true of all group psychotherapies, the fact that everything a patient reveals about himself earns sympathetic attention and, instead of provoking condemnation or loss of respect for him as a person, brings forth from others obvious eagerness to understand and to help, is a frequently novel, and invariably valuable experience for the patient. It is a beneficial experience for the giver as well as for the recipient of this type of attention, especially as both are apt to be people starved for friendly interaction and for opportunities for friendly interaction with their fellowmen. Here psychodrama has a decided advantage over other psychotherapies and particularly over individual psychotherapy. It is a different type of experience to have a psychotherapist respond in an understanding, non-judgemental manner to a *mere account* of a really painful and embarrassing personal experience, from what it is to literally go through all the emotions of this experience on the stage and have people respond after having literally entered into the relived experience. Because of the intense emotional participation which psychodrama evokes, these patient-responses to the protagonist frequently are also extremely empathic. Both empathy with, and a feeling of solidarity and goodwill toward the protagonist are strongly fostered, I believe, by the fact that all members know from personal experience of what it means to go up on the psychodrama stage—each of them has felt the anxiety connected with going on stage and psychologically exposing himself. (Let us not be deceived even by the facile exhibitionist into believing that he is not beset by this anxiety!) The experiencing of this anxiety is an emotion in the here and now which is shared and co-experienced by all the patients; it establishes a common-denominator among them and, thus, makes for cohesiveness of the group, practically from the start. This is why a patient who really lets go on the stage is treated with great respect and even admiration by fellow patients, instead of with approbation for whatever weakness in himself he may have revealed in the re-enacted or psychodramatically created situation.

I have emphasized two features of psychodrama—namely, that it

tends to elicit from the protagonist and the non-protagonist participant alike, a relatively high level of emotional involvement, and that becoming a protagonist is an anxiety-producing venture. The first of these propositions hardly anyone would question who has ever witnessed psychodrama, and there is no need for me to go into the reasons for the phenomenon. Possibly, the same is true of the second proposition, but I will, nevertheless, try to spell out some of the sources from which, I believe, this *situational anxiety* about 'going on stage' as a protagonist arises. Firstly, being picked by the therapist-director to be the protagonist is in some respects akin, and therefore, similar in its impact to the childhood experience of being called upon by the teacher in front of the class, without as yet knowing what the teacher will ask. Secondly, it seems to be in the nature of psychodrama that it is relatively easy to become emotionally carried away, with the defenses, so-to-say, caught napping and the defensive guards down. Thirdly, when the defenses have inadvertently become threatened, there is no easy, ego-saving device to 'get off the hook', to withdraw from the threatening situation. I shall return to the implications of these factors later.

Just as the above threatening aspects, so also practically all of the virtues of psychodrama stem mainly from the fact that upon entering on the stage, it is so easy to reveal innermost thoughts and feelings, even if not to oneself, at least to others. These others, through emotional participation, may then empathically reveal to the protagonist much about himself that he has not realized before. Instead of an interpretation, given in a calm tone of voice as in individual psychotherapy, his auxiliary egos may speak words and express feelings which he emotionally recognizes as his own even before he had time for intellectual reflection. Now, to experience the emotional impact of and to respond to certain situations in the psychodrama setting, can help immeasurably to desensitize the person to noxious stimuli to which he had been over-reacting; it can help the cathartic process; it can slowly teach the person that it is all right for him to have certain thoughts and feelings—that to have these thoughts and feelings does not necessarily result in catastrophic consequences. Because of the very reason that the defenses do not operate so efficiently, formerly dissociated thoughts and feelings have a chance to become united again. The person's narcissistic self-centeredness may be exposed to him through such techniques as role-reversal; by the same technique or through others playing the role of important people in his life, he may learn things about the latter of which he had not been at all aware. By means of "role training", he can prepare himself for meeting

and coping with anticipated situations in the future. Lastly, in this list of potential therapeutic gains, of which there are no doubt others, I should like to mention that when a protagonist is able to be spontaneous on the stage, he thereby demonstrates to himself that he can conquer the situational or protagonist anxiety which I emphasized earlier. As a result, his very presence on the stage, and willingness to expose himself there, becomes for him an ego-building success experience.

In order that this may happen, however, we are therapist-directors must be forever aware of how greatly a breakthrough of unconscious impulses or a breakdown of emotional controls does threaten the very emotional equilibrium of most of our patients. When directing, we must remember that in psychodrama it is very difficult to mobilize defenses until after it is too late, and that once his defenses are threatened, the protagonist cannot easily shift the focus of attention onto another patient as is the case in other group psychotherapies. About all the protagonist can do when the threat becomes too severe is to go through the motions, without allowing himself to be emotionally spontaneous, or leave the stage altogether. Either of these strategems is deflating to the ego. In the former case, the patient knows that he has not been sincere with others, and that others realize this too. He also knows that he has not gotten as much out of the psychodrama experience as he should have, and partly blames himself for it. In both cases, he is apt to see himself as a weakling, and to be painfully aware of his ego deficiency. It is, therefore, the therapist's duty to safeguard the patient by means of empathic, sensitive direction of psychodrama against these ego-debilitating experiences, and to insure that the protagonist has an ego-boosting experience both because he has been able to master the situational anxiety and because his psychodramatic action has furthered his personality integration.

I have outlined our psychodrama program on the Neuropsychiatric Service of the Buffalo Veterans Administration, GM&S Hospital, and specified what I believe to be some of the special merits of psychodrama as psychotherapeutic technique. I also devoted some time to spelling out certain features of psychodrama which induce, what I chose to call, "situational anxiety" in patients, and expressed the belief that the latter plays an important role in the effectiveness of psychodrama. In comparing psychodrama with other types of psychotherapy, I merely wished to illuminate certain distinguishing features of psychodrama, and had no intention of suggesting that only psychodrama possessed distinctive virtues while other psychotherapeutic techniques did not.

SOCIAL CLASS AND VISITING PATTERNS IN TWO FINNISH VILLAGES*

KAUKO HONKALA

School of Social Sciences, Helsinki, Finland

The study of social classes forms an important and topical branch of modern sociology. The choice of the most important characteristic of a class has, however, largely depended on the investigator's prejudices and research methods. Sometimes a class has denoted an occupational group, sometimes a set of individuals with the same socio-economic status, and sometimes a group of people who are treated in the same way or who have closer connections with each other than with outsiders. But it has been found that most of the variables used in defining social class are correlative. In the class sociology of our day there is a tendency towards a coherent theory of social stratification based on empirical investigations. An example of this is Kahl's system of six operationally established variables—a first approximation to a conceptual scheme.

Interaction is one of Kahl's variables. The members of the same occupational group have the same socio-economic status and hold the same opinions; they come into contact with each other more easily. On the other hand, interaction adds to the feeling of solidarity and standardizes norms and values; thus it is likely to increase the cohesiveness of the group.

The aim of this study is to analyze the class structure in two villages in the South-West of Finland, with special reference to the interaction between the classes.

In the South-West of Finland the basic unit of rural settlement is the village in which the dwellings are clustered in the middle of jointly owned forest and water areas and arable land. Traditionally, the joint ownership called for cooperation, which together with geographical proximity made the village a cohesive social group. In our day joint ownership has almost completely ceased to exist, but nevertheless the village has remained an administrative as well as social unit. The villagers' feeling of solidarity has by no means disappeared.

Data about the classes.

The present study concerns two villages: Isola (285 inhabitants) and

* Reprinted from *Acta Sociologica.* Vol. V, Fasc 1 Copenhagen Denmark. Editor, Torben Agersnap.

Vähälä (123 inhabitants). These villages lie in the same open field and are separated from other neighbouring villages by a forest belt a few miles wide. The distance to the center of the parish, the church village, is slightly less than six miles, and to the nearest town about 15 miles. Through Isola runs a main road with busy traffic. Less than half of the villagers get their living from small-scale farming. About one third are workpeople and the rest—apart from the disabled and the pensioners—are occupied in business and transport.

The stratification of the families in the villages was carried out by using 45 inhabitants as judges. In spite of differences in the classification criteria set up by the judges and in the number of classes employed by them, there was a fair degree of unanimity in the placing of the families. The estimates of the judges were combined in such a way that four classes were established in Isola and three in Vähälä. In this manner, the final status of each family was fixed. The 74 families in Isola fell into classes as follows:

Class I (6 families), the four biggest farms in the village (arable land: 40—26 hectares) and the families of two elementary-school teachers.

Class II (24 families) 18 farms (arable land: 16—7 hectares), a master-builder, a shop keeper, two truck-drivers, and two retired farmers.

Class III (28 families). The families of seven small farmers (9—1 hectares), four skilled workmen, eleven unskilled labourers, two truck-drivers, one shop keeper, and three pensioners.

Class IV (16 families). The families of four skilled workmen, eleven unskilled labourers, and one pensioner.

The 35 families of Vähälä were classed as follows:

Class I (9 families), the eight biggest farms in the village (30—16 hectares) and one old farmer.

Class II (13 families), the families of eight small farmers (9—3 hectares), three old farmers, and two workmen.

Class III (13 families), the families of two small farmers, two skilled workmen, six unskilled labourers, and three pensioners.

The classification of the judges thus correlates strongly with the size of the farm or the professional skill of the head of the family. The correlation between a 14-item socio-economic index, based on various possessions and social participation, and the combined estimates of the judges was + .74 in Isola and + .76 in Vähälä. In general, it may be said that the higher-class families possess more books, read more daily papers, belong more often to

various organizations, are placed in communal and congregational positions of trust, and have pursued studies after leaving elementary school. With decreasing class status church-going declines, and political opinions swing to the left; those who belong to the lowest classes are almost without exception supporters of the Communist parties.

The visiting pattern.

Using a sociometric method, information was collected about the inter-visiting of the families in the two villages. The questionnaire included the names of all families in the village, and each family was asked to check one of the following alternatives:

1. We are not on visiting terms with them. We do not know them or we know them only by name or by sight.
2. We visit them at times, but rarely. We know them fairly well; we chat when we happen to meet.
3. We know each other very well. We visit them often. They are among our nearest friends in this village.

When each family stated its visiting relations with every other family within the village, 5402 choices were obtained in Isola and 1190 in Vähälä. As graphic treatment of such a great number of choices is inpracticable, the present study is restricted to a statistical analysis of the distribution of the choices.

Out of the Isola choices c. 10% were third, c. 27% second, and c. 62% first choices. The average Isola family thus visits about 8 of the families in its own village frequently and about 28 families occasionally. Tables 1 and 2 show the choices given and received by social class.

Each class gives about the same number of third and second choices, which means that there are no very great differences between the classes as regards the amount of their visiting. The evenness of the received choices shows that there is no class whose families are particularly favoured objects of visiting.

TABLE 1

CHOICES GIVEN BY FAMILIES IN DIFFERENT CLASSES IN ISOLA (%)

Choice	I	II	III	IV
3	12	9	12	10
2	31	26	27	28
1	57	64	61	62
n	(438)	(1752)	(2044)	(1168)

TABLE 2
CHOICES GIVEN TO FAMILIES IN DIFFERENT CLASSES IN ISOLA (%)

Choice	I	II	III	IV
3	12	11	11	9
2	27	29	27	25
1	61	60	62	66
n	(438)	(1752)	(2044)	(1168)

Fundamental differences appear, however, when we study the direction of the choices. Tables 3—6 show the distribution of the choices by class. Thus, in each class most families give most of the third choices and the fewest first choices to families belonging to the same class. The visiting is, accordingly, most frequent between families of the same social status and

TABLE 3
CHOICES GIVEN BY FAMILIES IN CLASS I IN ISOLA (%)

Choice	Given to families in class I	II	III	IV
3	50	10	9	5
2	43	42	26	22
1	7	48	65	73
n	(30)	(144)	(168)	(96)

TABLE 4
CHOICES GIVEN BY FAMILIES IN CLASS II IN ISOLA (%)

Choice	Given to families in class I	II	III	IV
3	8	11	9	4
2	35	30	25	22
1	57	58	66	74
n	(144)	(552)	(672)	(384)

TABLE 5
CHOICES GIVEN BY FAMILIES IN CLASS III IN ISOLA (%)

Choice	Given to families in class I	II	III	IV
3	10	12	14	10
2	23	28	28	25
1	67	60	59	65
n	(168)	(672)	(756)	(448)

TABLE 6
CHOICES GIVEN BY FAMILIES IN CLASS IV IN ISOLA (%)

Choice	Given to families in class I	II	III	IV
3	7	7	8	18
2	19	26	31	32
1	74	67	61	50
n	(96)	(384)	(448)	(240)

decreases with growing social distance. It is, however, possible that in some families the origin and preservation of its visiting pattern is due to factors which are unconnected with class attitudes and behavior. Neighbourship, for instance, may influence the visiting. This is the case in Isola; close neighbours (the two nearest neighbours of each family) on the average receive quite significantly fewer first choices than the other families in the village. A second factor influencing visiting patterns is kinship. The families of Isola have relatives (cousins or closer)

in the same class	43%
one class above or below	39%
two classes above or below	13%
three classes above or below	4%

Family connections are, then, most numerous between families in the same class or in adjacent classes. Kinship, too, seems to be a factor that preserves the visiting relations, for kindred families receive significantly fewer first choices than the families of the village on an average.

Close neighbourship and kinship do not, however, essentially influence the distribution of the choices shown in tables 3—6. Even if all the choices given to close neighbours and relatives are disregarded and the distribution of the remaining choices is re-examined, the ratios shown in tables 3—6 do not change much. The families in each class still visit the families of the same class most frequently, and the visiting decreases with increasing distance between the classes.

Visiting pairs (family A states that it visits family B, and B that it visits A) are significantly more numerous among families in the same class or in adjacent classes, as becomes apparent from table 7.

Those who visit each other are, then, more often than could be expected by mere chance, of similar social status. Unilateral visiting (family A states that it visits B, but B does not state that it visits A) is significantly less directed at such families as are of a lower class than the family that does the

visiting. The analysis of the visiting patterns shows that in Isola there are subgroups which differ with respect to their interaction behaviour. The visiting in Vähälä, however, is of a different structure.

TABLE 7
THE VISITING PAIRS IN ISOLA

Pairs	Number	Max. number	%
Within the class	169	789	21.4
Crossing one class border	245	1264	19.4
Crossing 1 or 2 class borders	103	648	15.9

In Vähälä, too, each class gives about the same number of choices. On the other hand, a fundamental difference appears in the distribution of received choices as compared with Isola. Whereas in Isola each class received a fairly equal number of both third and second choices, in Vähälä class I receives most of them and class III least, as appears from table 8. The visiting is thus most frequently directed at the families in class I and least frequently at the families in class III.

TABLE 8
CHOICES GIVEN TO FAMILIES IN DIFFERENT CLASSES IN VÄHÄLÄ (%)

Choice	I	II	III
3	31	18	12
2	34	26	23
1	35	56	65
n	(306)	(442)	(442)

TABLE 9
CHOICES GIVEN BY FAMILIES IN CLASS I IN VÄHÄLÄ (%)

	Given to families in class		
Choice	I	II	III
3	38	18	9
2	47	28	18
1	15	54	73
n	(72)	(117)	(117)

As shown by tables 9—11, in each class the families give most third and second choices to the families in class I. Thus it appears that the visiting in Vähälä is directed "upwards," at the families in class I. Elimination of the

choices given to relatives and close neighbours does not change the situation essentially.

The patterns of visiting found in the two villages have thus proved to be of two remarkably different types. In Isola visiting is mostly confined within

TABLE 10
CHOICES GIVEN BY FAMILIES IN CLASS II IN VÄHÄLÄ (%)

Choice	Given to families in class I	II	III
3	32	23	11
2	26	22	24
1	42	55	65
n	(117)	(156)	(169)

TABLE 11
CHOICES GIVEN BY FAMILIES IN CLASS III IN VÄHÄLÄ (%)

Choice	Given to families in class I	II	III
3	26	14	15
2	35	28	26
1	39	58	58
n	(117)	(169)	(156)

each class, whereas in Vähälä it is directed towards families of higher status. To make the dissimilarity between the villages even more obvious, the distribution of all second and third choices is shown once more in table 12.

A "downward choice" is defined as a choice given by a family to a family in a lower class; an "upward choice" indicates the opposite. The choices are presented as percentages of the greatest possible number of choices

TABLE 12
DIRECTION OF SECOND AND THIRD CHOICES IN THE VILLAGES

Vähälä				Isola		
Direction of choice	N	N% of greatest possible N	Difference P <	N% of greatest possible N	N	Direction of choice
Downwards	144	35.7	0.47	33.8	646	Downwards
At same class	196	51.0	0.05	43.7	689	At same class
Upwards	210	52.1	0.001	37.3	714	Upwards

in each direction. It will be seen from the table that in Vähälä the upward choices are significantly more numerous than in Isola.

As, however, study of the choices by classes only results in a relatively rough picture, the correlation between the combined estimates of the judges (the figure indicating the social status of the family) and what I call the choice status (the sum of the second and third choices received by the family) was calculated in both villages. In Isola it was—.04 and in Vähälä—.75. (P of the difference between the coefficients is less than 0.001.) The coefficients of correlation turn out negative, because the numerical value of the combined estimates of the judges rises when the status of the family goes down and because the choice status is higher the more the family is visited.

Discussion.

In Isola the status of the family and its popularity as a visiting goal are not interdependent. In this village the classes that were established by means of subjective criteria seem to form real subgroups within the village community, which differ form one another with regard to their interaction behavior. In Vähälä, on the other hand, the number of visits received increases with higher social status. Vähälä is, therefore, a more cohesive social group, in which interaction depends on the status of the member. It is hard to venture a guess at the reason for this dissimilarity of the two villages. One reason is probably the difference in size; in a larger community separate groups arise more easily. Another potential factor is the greater socio-economic differentiation in Isola. This is seen for instance in the facts that the size of the farms varies more in Isola and that in this village a larger number of people are engaged in non-agricultural occupations.

GENERAL BIBLIOGRAPHY

Kahl, The American Class Structure, p. 17.
Moreno, J. L. Who shall Survive?, Beacon House, 1953.
The Sociometry Reader, The Free Press, 1960.

USES OF HUMOR IN GROUP PSYCHOTHERAPY*

MANUEL J. VARGAS, PH.D.

Beatty Memorial Hospital, Westville, Indiana

I have seen humor in three main ways.

To Hide

The first usage is that in which humor is used to conceal some part of the personality which is considered distressing, or undesirable. Example: In a group therapy discussion a patient said that since her admission she has been trying to persuade everyone how well she is and that she should be discharged. To persuade them she must appear happy, therefore, she has sought to appear happy at every opportunity. She has clowned, tried to be the life of the party, and cut up continuously. But now, she says, she is getting tired and thinks perhaps she should be more honest with herself and others. I will not dwell much upon this use but concentrate most of the attention upon the next usage.

To Facilitate Expression

One type of facilitation is that in which the patient *desensitizes* terms and concepts. Example: In a group therapy discussion a patient was discussing a visit she had with her husband, then she acted embarrassed and unwilling to say something that he had told her. The group urged her to say this, finally she said, "My husband says I have no business here with all of you screwballs." This was greeted with laughter, the patient also laughed when she said this. The patients all then discussed this evaluation of being screwballs that they made of each other, that they knew others made of them, the superficial evaluation that people made, and the general way in which the public looked at people with mental problems and patients in mental hospitals. Example: In a therapy discussion there had been some lighthearted talk going on and a particular patient had not been taking part in it, he had been sitting quietly, just watching and listening. The therapist asked him how he felt and to tell us a little about what was going on in his head. He shrugged his houlders and said nothing. It was well known that this patient has severe stomach pains and spends

* Presented at the Twentieth Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, March, 1961.

much time in the toilet. The therapist asked, "How is your stomach?" The patient said, "Bad." The therapist said, "There are three major nerve centers, one is in the area of the stomach called the solar plexus, another is in the area of the heart, how is your heart?" The patient said, "O.K." The therapist then said, "The other nerve center is in the head, called the brain, how is your head?" The patient shrugged his shoulders. It was known that this patient would sit around, sometimes wringing his hands, sometimes with a puzzled, worried expression on his face, and this shrug therefore was an indication that he admitted his head was not well. The therapist then said, "Of the three nerve centers, two of them are out of whack, and one is well, therefore it seems that you are two-thirds whacky and one-third well, we've got to start working on the whackiness." This was greeted by laughter from all, including the patient. Some light talk was made about this idea of being whacky.

Another type of facilitating use is that in which humor brings a *simple release* of tension. Example: A nurse came on a ward and saw a group of patients gathered together and looking down. When she approached them she saw one patient sitting on the floor with two aides around her trying to get her to take her medication. The patient was unwilling and appeared frightened. The aides were urging her to take the medication and that this would make her feel better, but the aides were obviously flustered also. The patients gathered around were watching this and were showing a high degree of anxiety. The nurse looked about, then said, "Gee, I'm glad all you other girls take your pill without any trouble." This was greeted with much laughter from the patients watching, the aides, and the patient who was refusing the medication. The patient then did accept the medication.

A third facilitating usage of humor is that in which patients *show* their *judgment* of important events and conditions, in their hospitalization. Example: In a group therapy discussion about "therapy" a patient said, "There is so much 'therapy' going around here that if you clean up or even mop, they call it 'mop therapy'." Then another patient said, "Brief psychotherapy is when somebody shakes your hand and says good morning. Long-term psychotherapy is when that person waits long enough to hear you reply." Another example is the following: One patient in a group described how dependent he had become upon the electroshock treatments. He said that whenever he began to feel upset or worked up in some way, he kept wanting to have the shock treatments and since these have always helped him, he feels very dependent, that he cannot live without them. The

other patients began to discuss this in a humorous fashion. He was asked what would he do when he got out of the hospital. Would he strap on his back the "buzz box", looking for a place to plug it in? In a continuing humorous fashion, the uses of the "buzz box" were discussed.

Another facilitating use of humor is when *continuing* humor helps in the *expression and discussion* of that which is potentially frightening. Example: In a group discussion a woman revealed how she had used the "menopause" to get away with some of her complaints at home. Others in the group were much amused and they also began to reveal how they had misused the "menopause" as a way of getting away with things that they didn't think they would be permitted otherwise. As each woman stated her use of the "menopause" more and more serious problems were revealed, and more and more injustices and disturbing conditions were explored and yet each deeper revelation was greeted with increasing hilarity. It appeared to the therapist that as the depth and seriousness of the revelations increased, the hilarity also increased, and that the increase in the gales of laughter was necessary in order to reveal the deeper problems.

Another form of facilitating use is that in which humor is the *doorway* by which a patient can enter into a serious, sober, non-humorous discussion of a deep problem. Example: In a female group therapy discussion the patient was talking about her problems with her husband. To present this in a psychodramatic form, she was asked to choose a "husband" from the group. This was greeted with some laughter and one of the other female patients was chosen. The two women then bantered somewhat as to how they would greet one another, whether they would kiss the way a husband and wife would, whether they would embrace or just how they would talk to each other. The whole group thought all of this was very funny and participated in this initial "silliness". They did go on with the skit, however, although as it started they could not fully take the roles and there was some laughter and interruption with side comments from the audience and the two actors in the skit. But as the skit proceeded, the original patient who had presented the problem began to lose her gaity and finally got to the point where she was very angry and worked up and began to express intense fury at her husband. This of course surprised the other patient and the group whereupon they became serious and the psychodramatic presentation and the discussion which followed proceeded in a very earnest mood. Another example: In a group therapy meeting nothing was being said from the very beginning. There was some tension in the group, the therapist became very tense. He was hoping something

"worthwhile" would be said by somebody. There was some apparently irrelevant comment made. Finally, he decided to tell a joke. "Two boys went out to the country to pick some hickory nuts. They filled their pockets, then they tied strings around their pant legs and filled up the legs with hickory nuts. On their way back they passed near a graveyard, and feeling tired, also being somewhat devilish by nature, they decided to climb over the fence and rest in the graveyard, sitting on some of the gravestones. They did this and then emptied out all of the hickory nuts on the earth, making one great pile, and proceeded to divide them equally. One boy would say, '1 for me and 1 for you', and the other boy would say, '1 for me and 1 for you'. One of the boys said, 'When we climbed over the fence, two of the hickory nuts dropped out of your pocket, we'll pick those up when we are through here.' They then continued saying, '1 for me and 1 for you', '1 for me and 1 for you'. A rather simple farmer by the name of McNutty who lived nearby was walking down the road. When he came near the graveyard he heard some voices, stopping, he heard one voice saying, '1 for me and 1 for you', another voice saying, '1 for me and 1 for you'. He became frightened and ran as fast as he could down the road. About a quarter of a mile farther down there was a church and the minister happened to be outside at the time. The minister called him, seeing him running by so fast, and the man stopped and coming up to him pantingly he told him, 'Pastor, I just heard the Lord and Satan dividing up the souls in the graveyard'. The minister was amazed and said, 'Oh no, Mr. McNutty, this can't be.' The man said, 'Yes, sir, Reverend, I just heard them and I know this is what they were doing, I heard it with my own ears.' The minister then said, 'It can't be, let's go back together and I'll show you that this is not true.' The farmer then said, 'All right, you lead, I'll follow behind you.' So they did walk up the road to the graveyard. As they came close and stopped, both men sure enough heard one voice saying, '1 for me and 1 for you', and another voice saying, '1 for me and 1 for you'. Then one voice said, 'These are the last two, 1 for me and 1 for you, now let's go and get the two that are on the other side of the fence.' The two men ran as fast as they could down the road, and the villagers down aways were surprised to see the pastor and the farmer having a race down the main road of the village . . . . Incidentally, it seemed that neither the farmer nor the minister were sure as to who would be chosen by the Lord." The entire group laughed uproariously at various points along the joke, especially at the end. They began to talk about death and got involved in a very deep and sober discussion about their loved ones who

had died, those whom they feared would die, the possibility of their own death, and their own feelings of grief.

Other varieties of facilitating humor could be found.

To Disguise Yet Express

Sometimes a person may wish to express without a strong commitment an idea or an attitude in a tentative manner such that he could not be held fully responsible for what he says and yet he does want to communicate partially what he is saying. For example (taken from individual therapy): A patient was making small talk with his therapist, obviously having a difficult time trying to express himself, wanting to talk and yet being unable to get on to anything of importance. Finally he asked the therapist whether or not he had some chess they could play. The therapist said no but that he had a deck of cards. These were brought out and the patient shuffled them, dealt them and they played the first game. Then the therapist shuffled the deck and gave them to the patient to cut. The patient said, "I trust you" and laughed. The therapist replied, "You do that", and laughed, too. It seemed to the therapist that both were referring to a trust that was much wider than the card game, the patient was saying, in other words. "I trust you not to cheat me at cards, but I trust you more fully as a man whom I can depend upon and who will be good to me." The therapist was saying, "You can trust me, I want you to trust me—for I will try to be and want to be dependable and good to you". Although these are seen as some of the implications of the statements made yet this patient would not be willing to say these things in a sober, fully explicit manner. He is only tentatively expressing his growing trust and the therapist is only tentatively likewise recognizing it.

The Spirit of Humor

In humor what is important is not so much what is said as the way it is said. It is as if in painting a picture which necessarily is going to include much darkness, it is necessary to bring in some lightness so as to relieve and make clear some of the darkness. It is as if in expressing an idea or a feeling of disturbance or disorder, it is necessary to bring in a feeling of ease and of superiority and tolerance of the disorder. Humor implies then, a perspective of wholeness, ease, and elevation while facing the distressing and fragmentary.

THE EFFECTS OF SOCIOMETRIC REGROUPING ON PSYCHOLOGICAL STRUCTURE IN THE SCHOOL CLASSES

KUMAJIRO TANAKA, PH.D.

Tokyo Gakugei University, Tokyo, Japan

To educate in one class pupils who have various individual differences in every developmental process offers many problems. Therefore, in our country, for instance, large school classes are felt to be a limitation of education and sometimes the individual differences are regarded as barriers to effective education.

However, the persons who are the object of education are formed by the group in the group (3). We should break through the barrier to education in spite of the prevailing limitations of the large school class and try to provide the best possible learning environment for each child. In order to encourage children to engage in spontaneous-creative activities, we should study the fundamental mechanisms of their group structure.

The fundamental basis of group structure is the formation of interpersonal relations. The most important factor in interpersonal relations is mutual sympathy. Thus we try to foster this mutual sympathy between children in their group.

Accordingly we applied the new methods of sociometric regrouping (4) so as to reduce tensions in interpersonal relations and promote a warm socio-empathy in the classrooms.

The following describes this experiment and its effect on the psychological structure in the class group.

SUBJECTS

The subjects used in this study are two classes in Edogawa Elementary School in Tokyo. They consisted of approximately 50 children each.

This study began September 1956 (the 4th grade at that time) and ended in March 1959 (the 6th grade at that time). One class was designated as the experimental class (E); the other class served as the control class (C) during this study.

EXPERIMENTAL PROCEDURE

We started the experiment with a discussion between the experimenter and the class teacher.

Each term, we organized 9 small groups of 5 or 6 members in the

class according to the results of the sociometric test which was unlimited in choices and rejections. The criterion we used for this test is a small group arrangement in the classroom for school work and group activities.

To organize these small groups, the following rules (4) were carried out.

(1) First we considered into which small group we should put the rejectees and isolates.
(2) In each small group we endeavored to avoid rejections within the fifth order.
(3) The total amount of choices in each small group was equalized as possible in inter-groups.
(4) Each small group consisted of boys and girls. In E class, we took advantage of these small groups not only in regrouping by sociometric test but for studying in school and special educational activities.

The series of sociometric regrouping took place as follows.

The 1st ..... Sept. 1956 (the 2nd term in the 4th grade)
The 2nd ..... Jan. 1957 (the 3rd term in the 4th grade)
The 3rd ..... April 1957 (the 1st term in the 5th grade)
The 4th ..... Sept. 1957 (the 2nd term in the 5th grade)
The 5th ..... Jan. 1958 (the 3rd term in the 5th grade)
The 6th ..... April 1958 (the 1st term in the 6th grade)
The 7th ..... Sept. 1958 (the 2nd term in the 6th grade)
The 8th ..... March 1959 (the 3rd term in the 6th grade)

C class was tested at the same time in order to compare it with the E class, but we did not have the special consultation.

Results and Discussion

1. *Distribution of the Choice Score*

Had the interpersonal relations been ruled by chance, the results of the sociometric test could be shown by the binomial distribution (2). However, in the case of the school class group, these distributions of the choice scores expand on both sides, but especially to the left. The psychological phenomenon of interpersonal relation in the group will be shown in this tendency.

Now, we picked up the choices to the fifth order and calculated the choice scores in each grade for the results of the sociometric test. Table I gives the comparison of the distributions for the two classes based on a contingency table by the median 3.

As shown in Table I the E class varied considerably from the C class—the percentages above median 3 in the former are increased as the grade is promoted, while the percentages above 3 in the latter are decreased as the grade was promoted. We may say, therefore, that the distortions in interpersonal relation in the class group are somewhat relieved by the sociometric regrouping.

TABLE 1

COMPARISON OF CHOICE SCORE DISTRIBUTIONS

(Within the 5th order choice)

Class	E				C			
Grade	4	5	6	Total frequencies	4	5	6	Total frequencies
Percentages								
less than 2	44.96	38.65	36.81	172	35.05	40.51	47.02	169
more than 3	55.05	61.34	63.18	263	64.94	59.48	52.98	237
Total frequencies	109	163	163	435	97	158	151	406
C. R.	1.05	2.37 *	2.76 **		3.13 **	1.99 *	0.62	

* Significant beyond the .05 level of confidence.

** Significant beyond the .01 level of confidence.

2. *The Tendency Toward Reciprocation of Choice*

The tendency toward reciprocation of choice in the group is judged to be an index of the group cohesiveness. L. Katz and J. H. Powell described it in a formula (1). According to this formula, the comparison of the two classes is as in Table 2.

TABLE 2

COMPARISON OF THE TENDENCY TOWARD RECIPROCATION OF CHOICE

(Within the 5th order choice) $t_a = \dfrac{2N(N-1)m-T^2}{T[N(N-1)-T]}$

Class		test order I	II	III	IV	V	VI	VII	VIII
E	N (number of children)	55	54	56	53	54	53	55	55
	m (number of mutual choices)	34	33	45	47	40	45	54	52
	T (total amount of choices)	249	259	258	232	253	253	255	270
	t_a	.207	.181	.289	.350	.250	.291	.369	.321
C	N	50	47	51	53	54	51	50	50
	m	48	37	44	44	50	43	41	33
	T	219	205	235	248	252	243	234	215
	t_a	.383	.294	.311	.291	.339	.286	.282	.240

TABLE 3

COMPARISON OF SOCIOMETRIC STRATA (WITHIN THE 5TH ORDER CHOICE)

Class	test order	I	II	III	IV	V	VI	VII	VIII
E	Number of sociometric strata	6	7	7	5	5	5	5	5
	Number of subgroups	5	5	8	6	3	3	3	4
	Size of subgroups	b18 g10	b13 g11	g11,g2 b9,g2	{b11,b2 {g4, b2	{b19 {g6	{b18 {g12	{b20 {g1	{b25 {g11
	b = boy	g3 b2	b4 b3	b9,g2 b3	g11 b6	g5 b3	b5 g4	g16 g4	g4 g4
	g = girl	b2	g2	b2	b4				g2
	Number of fringers	13	14	9	7	14	6	8	6
	Number of isolates	7	7	7	6	6	8	6	3
	(do. unlimited choices)	(4)	(2)	(2)	(4)	(1)	(0)	(0)	(0)
C	Number of sociometric strata	7	6	7	8	7	7	6	6
	Number of subgroups	6	6	7	8	6	10	6	8
	Size of subgroups	g14 b11	g17 g6	b16,b2 g9	b12,g3 b6, g2	b20 g12	b16,g2 b9, g2	b18 g7	b10,g2 g5, g2
	b = boy	b6 g4	b3 g3	g5 b3	g6 g6	g4 b3	b5, g2 g3, g2	g5 g2	g4 g4
	g = girl	b2 g2	g3 b2	b3 g3	b5 g4	b2 g2	b2 b2	g2 g2	b2 b2
	Number of fringers	4	7	4	5	5	4	7	4
	Number of isolates	7	6	6	4	6	2	7	15
	(do. unlimited choices)	(3)	(1)	(2)	(1)	(2)	(1)	(4)	(3)

As shown in Table 2, the tendency toward reciprocation of choice in E class is increased as the grade was promoted, while the rate of increase in C class is not clearly perceptible. We may assume, therefore, that this is an effect of sociometric regrouping.

3. *The Sociometric Strata in the School Class Group*

It is not enough to consider group cohesiveness only by the index of the tendency towards reciprocation of choice, particularly in the case of the school class group in co-education (4). Therefore, it is necessary to consider a sociometric matrix. As there is no space for drawing the sociometric matrix in detail, we are going to compare it with a skeleton—number and size of subgroups, fringers and isolates in the two classes. This skeleton is expected to express the essential factors of the sociometric strata in the school class group. See Table 3.

According to this table, the E class has decreased in number of sociometric strata and in number of subgroups, but increased in the number of pupils involved in the subgroups. Moreover, the number of isolates has decreased as the grade was promoted.

Considering the tendency towards reciprocation of choice, we shall be able to conclude that group cohesiveness was increased by sociometric regrouping.

4. *Choice Relations Between Boys and Girls*

In the case of large school classes in co-education, group cohesiveness is to be evaluated especially in terms of the choice relations between boys and girls. Table 4 shows the comparison of the ratios of choice relations

TABLE 4

CHOICE RELATIONS BETWEEN BOYS AND GIRLS
(Within the 5th order choice)

Class		grade 4	grade 5	grade 6	x^2
E	Percentages				
	choices between boys and girls	8.86	13.73	17.97	21.151
	choices between the same sexes	91.14	86.27	82.03	**
	Total frequencies	508	743	779	
C	Percentages				
	choices between boys and girls	9.43	7.89	6.94	2.254
	choices between the same sexes	90.57	92.11	93.06	
	Total frequencies	424	735	692	
C. R.		0.95	3.69	6.39	
(Significance of differences between E and C)			**	**	

** Significant beyond the .01 level of confidence.

between boys and girls. The ratios are computed within the fifth order choice to make the calculation as simple as possible.

According to this table, in the E class the ratio of choice relations between boys and girls has increased as the grade was promoted. Moreover, this tendency is significant at the 0.01 level. On the other hand, in the C class the ratios of the choice relations between boys and girls has decreased rather than increased as the grade was promoted. And in the higher grade the E class has a ratio significantly higher than the C class.

It must be noted, above all, that the sociometric regrouping as here used has resulted in increased positive attitudes between boys and girls in the school class.

Keeping in mind the hazards of generalizing from this small scale study, these results suggest that the new method of sociometric regrouping is effective in reducing interpersonal tensions and promoting a warm socio-empathy in the classrooms of elementary school children.

REFERENCES

(1) Katz, L. and J.H. Powell. "Measurement of the Tendency Toward Reciprocation of Choice." Sociometry. *1955, 18, 659-665.*

(2) Moreno, J. L. Who Shall Survive?—Foundations of Sociometry, Group Psychotherapy and Sociodrama—New York: Beacon House Inc., 1953.

(3) Tanaka, K. Child Group Psychology. Tokyo: Meiji-tosho Publishing Company, Inc., 1957.

(4) Tanaka, K. Theory and Method of Sociometry—The Study of Psychological Technique for Human Education—Tokyo: Meiji-tosho Publishing Company, Inc., 1959.

GROUP PSYCHOTHERAPY WITH CHRONIC SCHIZOPHRENICS[1]

RICHARD C. COWDEN, PH.D.

VA Hospital, Pittsburg, Penna.

GROUP VS. INDIVIDUAL THERAPY

There can be little doubt about the fact that group psychotherapy is much more economical in terms of time and expense than individual therapy. However, economy alone is not the deciding factor in choosing group therapy over the usual individual type.

It has been argued that individual therapy is much more effective than group therapy. This has never been proved outside of statements made by the therapists personally involved.

People essentially oriented toward individual therapy state that group therapy does not permit the deep insights and perspective that occurs in individual therapy. But then it is this therapy that is more fantasy oriented than reality oriented.

The group approach has several inherent factors which the individual sessions lack. There is the opportunity to use one patient's symptoms to "soften up" another patient. In a careful study of the clinical records of the patient, certain similarities in the symptoms and developments of the illness, will stand out. In situations like this, it can be arranged so that in discussing one patient's symptoms you are indirectly preparing another patient to accept and voluntarily present his own problem at a later date. This is especially so when you have an on-going group where new members are constantly being added and old ones discharged. Here is a situation in which the new patient is going to feel considerable anxiety. The anxiety will stem not only from being in a new situation, but also from being expected to expose himself to people other than professional ones. In the group situation, the patients also note movements out of the hospital of other patients. This observation tends to offer encouragement and support in that it shows that it is possible to recover from a mental illness and to return to society and be a useful citizen.

Another important major element of the group situation is the fact that it breaks up the pattern of isolation. In the group therapy situation,

[1] The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

almost invariably there is established some degree of friendship among various members of the group. This friendship carries over after the group situation and develops into a kinship which can be noted in the ward, and in various hospital activities. Also, there are those types of patients who seem to respond in a very therapeutic manner to other patients, in that they tend to take a sicker patient "under their wing" and offer assistance to them. This, at the same time, enhances their own ego and gives them considerable satisfaction.

Techniques

Techniques used to induce behavioral changes vary widely. But we must not deviate from the idea that psychotherapy is essentially instruction as to what a schizophrenic's behavior is, how it deviates, its effect on society, and the fact that this instruction removes confusion from the patient. And schizophrenics are extremely confused. They do not understand their illness. They are extremely ashamed of it.

The first step in group psychotherapy is to get the patients to realize that some of their behavior is disturbing to society and that is why they have been placed in the hospital. To correct deviant (psychotic) behavior the therapist can (1) remove the need for psychotic defenses or (2) provide a new defense for the old psychotic ones. Regular hospital routine usually satisfies the first. In other words it removes the need for the psychosis by reducing current stress. Psychotherapy attempts to accomplish the second. Frequently it is necessary to shatter old psychotic defenses by direct methods. It is when the patient seeks a new explanation for his feelings and actions that the most critical phase of treatment occurs. This occurs almost immediately after the problem has been defined to the patient. In other words, after his psychosis has been defined to him, described to him and made explicit; that is when the patient accepts the fact that he is ill. The minor secondary symptoms such as hallucinations, delusions, homosexuality, somatic symptoms, etc., are sometimes best handled through teaching the patient to be discrete as to where and when he responds to the voices or delusions or other deviant stimulants. It is not uncommon in psychotherapy to find many patients very willing to discuss their symptoms. What is overlooked is the fact that the patients frequently flee into therapy and use therapy itself as a defense.

Another factor overlooked is that psychotherapy frequently makes a patient acutely aware of the deviations he has been engaged in for his entire life which have always been acceptable up to the present moment.

Once a patient is tagged with the scarlet letters *NP*, he becomes acutely aware of his feelings, his actions, his thoughts and his ideas. What three months before his illness was accepted by himself, perhaps smiled at, perhaps shrugged off, now becomes a source of worry and requires constant concentration. It is almost as if his mental illness is iatrogenic. This is not an uncommon thing in physical illness and it is not an uncommon thing in mental illness either, but the fact that these things can be iatrogenic in nature is often overlooked.

Before any patient is admitted to the group for treatment purposes, a complete review of his records, history, and examinations should be made so as to determine the feasibility of treatment and also the level of improvement which can be expected. There are those patients where there is hope for a complete remission and a return to near normality, whereas there are other patients who are so regressed the only goal of treatment is the possibility of self-care and a better ward adjustment. Of course, these goals are not a rigid, nonadjustable thing, but rather are highly flexible and subject to constant review as the patient improves from one level to another.

It is essential to establish contact with the patient when he first enters the group. However, this contact should be of a very superficial nature until the patient achieves some sense of comfort and ease while in the group situation. It is also necessary to establish the fact early in treatment that the patient is sick. Until the patient is willing to accept the fact that he is mentally disturbed, it seems almost impossible to effect any change. This establishing of the fact that the patient is sick can be done in various ways. By using the other members of the group to disclose this to the patient, or by the therapist himself directly presenting the deviant behavior which led him to be hospitalized. This will, at times, arouse considerable anxiety in a patient, but anxiety is an extremely effective motivating force for getting better. As stated before, this is one illness where in order for the patient to get better, he must be presented with those elements which made him sick. This also reveals to the patient that the therapist accepts him. Even though he is sick, even though he engages in deviant, unusual and perhaps wrong behavior, the therapist still accepts him on the level at which he is functioning. However, the therapist should never imply that he accepts the behavior which is deviant, as this is what must be changed and is the goal for which the therapist strives. The therapist accepts the patient but is highly rejecting of the patient's behavior.

Another early goal of therapy is for the therapist to establish control over the patient. There will be considerable argument about this, but the

writer feels it is the therapist's duty and obligation to control the patient. It is obvious that the patient is unable to do so. If he was able to do so, the odds are that he would not require hospitalization. This control can be established in various ways by granting or denying privileges, by placement on various wards, by assignments to various activities or therapies and by simply establishing absolute control over the patient. The patient has no contacts with anyone but the therapist without the therapist's approval. In this respect it is very necessary to establish an extremely close working relationship with the aides and nurses. It behooves a therapist to realize that he is one of the most unessential factors to the recovery of the patient if he confines his activities solely to the one hour therapy session. Close working relationships can be established with nurses and aides if the therapist is able to transmit to them the importance of their tasks. These personnel should be confided in and the treatment program for each patient should be outlined to them along with the therapist's expectation of their role. Patients are aware of the nuances that exist in personnel relationships and take advantage of a poor relationship. On the other hand, when a patient perceives a close harmonious relationship he realizes that the therapist is the real controlling force in his life. This tends to increase his dependency on the therapist and at the same time to relieve the need for the patient to attempt to conceal his symptoms in the actual therapy session.

Early in the therapy an effort should be made to destroy the gross psychotic symptoms; in other words, destroy the patient's defenses. The therapist establishes a set in the patient that his symptoms are no longer acceptable, even in the hospital. It is the writer's belief that many patients get better simply because the therapist expects them to improve. Two important factors exist in the improvement of psychotics; utility and expectation. The therapist must convey to the patient the idea that it is worth giving up his psychosis and the idea that he can expect to improve. A repeated statement of patients is, "what's the use. I'll never get better." In the severely ill it is necessary to teach socially acceptable behavior just as one would a child, rewarding good behavior and punishing bad. Actually when one does this he is orienting the patient to reality.

A chronic error of many therapists is an attempt to convey to a patient the idea that his illness is the same as any other and is nothing to be ashamed of. The therapist himself does not really believe this. In this regard it is felt that the words "crazy," "nuts," etc. should be returned to the therapist's vocabulary. The euphemism "mentally ill" tends to conceal

and condone too much. It is comforting to a patient to be called "mentally ill" and removes some of the motivation to give up the sickness. When a patient accepts the more dramatic terminology he tends to be more accepting of what it implies.

One of the dangers of a direct therapeutic approach of this nature is a tendency for the patient to become too dependent on the therapist. Actually the patient has invested all his eggs in one basket, so to speak. The therapist has taken a highly disturbed individual and completely controlled and manipulated both him and his environment, deliberately fostering an attitude of dependency and trust. However, the same technique can be used to wean the patient by gradually authorizing more privileges, passes, and responsibility along with continuous praise and encouragement. Some therapists feel it is a sign of a good job when, upon leaving a hospital, the patient expresses his deep gratitude, along with tears, etc. Rather, the good job is evidenced when a patient can calmly shake your hand and then dismiss you. He no longer needs the therapist.

Role of the Therapist

The therapist must have a basic respect for the patients, accepting them as they are, for the most part inadequate troubled individuals. He should learn as much as possible about the patients before beginning treatment. It is quite pleasing to them to find you know so much about them and are interested enough to do so. Upon receipt of all available information the therapist should establish a goal admitting the limitations of the patient. The therapist himself should remain aloof. It is not wise to treat patients as your equal. They are not such and do not want to be treated as such. They primarily want self-respect and can gain it only by first realizing you respect them. Treating a patient as an equal or a buddy is dishonest and the patients know this and distrust it. Further, behavior of this type negates the stereotype people have of the doctor as being a source of healing and helps destroy the expectancy of getting well. Friends do not heal people, doctors supposedly do so.

There are various techniques available to an active therapist. It has been noted that in a group situation a simple thing as the therapist walking around the room instead of sitting leads to increased activity and participation of the patients. Levity has considerable value in removing some of the mental anguish associated with certain ideas. It is difficult to maintain a fear of something when you can laugh at it. Simple instruction in how to cope with a situation is quite therapeutic. Schizophrenics are often

quite ambivalent and indecisive and frequently seek control and direction. One of the most effective techniques is role playing, which in this case is not equated with psychodrama. Many chronic psychotics are physiologically flattened. With this type of patient it has been noted that after given instructions to stand and shout as loud as possible they remark that they feel better. Physiological arousal can be achieved through shouting, working, creating anger, forcing tears, etc. Since patients develop an extreme interest in their therapist it is sometimes wise to take advantage of this. When a patient is wondering about his therapist he can not very well be ruminating about his own problems. And finally, establish the idea they are special and privileged to attend the group. One punishment for unacceptable behavior is to be dismissed from the group.

A group therapy program should have at least two groups going at the same time. Each group for different degrees of illness, with one group acting as a "graduate" group for patients who improve in the other group. This maintains continuity of treatment and at the same time shows the patient he is getting better.

BIBLIOGRAPHY

BINGHAM, D.S., (Unpub.) Two Consecutive Half Year Admission Samples to a VA Mental Hospital followed administratively for Twelve and Six Months respectively.

BINGHAM, D.S., (unpub.) Patient Movement into, out of, and among various units of a Metal Hospital as indicated by Gains, Losses, Dispositions (Non Losses) and interward transfers.

COWDEN, R.C., ZAX, M., & SPROLES, J.A., (1955) Reserpine: Alone and as an Adjunct to Psychotherapy in the Treatment of Schizophrenia. Arch. Neurol. Psychiat. 74: 518-522.

COWDEN, R.C., ZAX, M., & SPROLES, J.A., (1956) Group Psychotherapy in conjunction with a physical Treatment. J. Clin. Psychol. XII: 53-56.

COWDEN, R.C., ZAX, M., HAGUE J.R., AND FINNEY, R.C (1956) Chlorpromazine: Alone and as an Adjuct to Group Psychotherapy in the Treatment of Psychiatric Patients. Am. J. Psychiat., 112: 898-902.

COWDEN, R.C. & BROWN J.E., (1956) The Use of a Physical Symptom as a Defense against Psychosis. J. Abn. Soc. Psychol., 53: 133-135.

COWDEN, R.C. (1957) The Psychophysiology of Schizophrenia. Am. J. Psychiat., 113: 709-716.

Statistical Abstract of U.S. Dept. of Commerce, Bureau of Census. Williams Roger J. (1958) Amer. Scient. 1: 1-23.

PSYCHIATRIC AND CULTURAL ASPECTS OF THE OPPOSITION TO PSYCHODRAMA

HANS KREITLER, PH.D. AND SHULAMITH ELBLINGER

Haifa, Israel

It was Casanova who said that people who had read only one book were extremely dangerous. What he meant, of course, was that those who had had their schooling at only one single institution were bound to put up a stiff opposition to ideas that differed from those they held. A drastic example for this are the advocates of pharmacological monism in psychiatry on the one hand and the inflexible adherents of this or that psychotherapeutical sect on the other. Once upon a time they, too, had been fighting for the establishment of a new idea, but once their idea had become accepted they turned orthodox. The phenomenon is too well known to make it worth while writing an entire article about it; yet an analysis of the opposition put up to psychodrama reveals more than mere mental inertia and pusillanimous rejection of what is new and strange. Opposition to psychodrama not only reflects the direction taken by conventional psychiatry and by clinical psychology, it points to distinctive tendencies in the development of our culture.

The triumphant progress of tranquillizers both within and without the psychiatric wards of our hospitals is a tell-tale characteristic of modern psychology. The patient must be calmed down or, better expressed, should be kept in a state of calm as far as possible. There is no denying the advantages of this method, particularly if the superficial tranquillisation of the patient is made use of for psychotherapeutical purposes. But more often than not the lonely frenzy in the padded cell is relieved only by the no less lonely apathy of the ensuing numbness. Quiet has become an end in itself. Small wonder, therefore, that psychodrama, which puts the accent on acting-out and opens the way to dynamic explosions, was regarded as a troublemaker and totally unsuitable, all the more so as it permitted, in sharp contrast to verbal psychotherapy, not only free speech, as it were, but free action as well. Psychodrama is regarded as the antithesis of the tranquillizer. What is disregarded, of course, is that the psychodramatic outburst is what is called by Moreno—with complete justification a "therapeutic acting-out"; and both the discharge of tension and its psychodramatic interpretation serve to calm the patient and furnish deeper understanding. Moreover they enable dramatic acting to form a bridge between uncontrolled explosion and controlled action. Precisely speaking, however, it is not the

purpose of psychodrama either to calm or to induce controlled acting, but to bring about free action in which intellectual control does not govern emotions but merely guides them. A strong emotion is not merely an instrument of the psychodrama—it is its very idea. Comparing psychodrama with the tranquillising therapy one is reminded of an episode in the life of Gustav Mahler, the great composer. When his little daughter saw a giant ocean liner for the first time in her life, she got tremendously excited. Her Nanny admonished her sternly: "Don't get excited! Don't get excited!" Angrily her father snapped the child up into his arms and exclaimed: "Do, do get excited, child!" Here we have the clash of two fundamental attitudes. The artist registers his protest against artificial understatement. Our society, however, decided against violent emotions, oblivious of the fact that the price for understating emotions in the private sphere are excesses in public life. There is a direct connection between sobriety in love and the arts and highly emotional politics, but it seems that so far this connection has escaped the notice of the advocates of psychiatric and non-psychiatric methods of tranquillisation. Psychodrama purports to educate a person to experience genuine drama without being broken by it, and this makes inevitable the opposition of all those who hold that drama can be permanently eliminated from human life.

Psychodrama, however, is not only a drama, it is a kind of game, too. This provokes its rejection by all those who identify science with immutable seriousness. The usefulness of computers, the mechanisation of much of the research practised in laboratories, the barrenness of university life brought about by progressive specialisation—all these have caused even psychologists and psychiatrists to regard playing as something frivolous, even dangerous. Yet it was present-day psychology that showed up the vast importance of play not only for the mental development of the child, but for any kind of productive activity. It also showed that there is only a thin dividing line between reality and fiction. Nevertheless, time and again the argument is trotted out that those taking part in a psychodrama know all the time that they are only playing, so that they could never be fundamentally influenced by the scenes enacted.

The stubbornness with which this argument is raised even by those who ought to know better on the strength of their studies gives rise to the assumption that it is rather the common, middle-class contempt for the theatre that is hiding behind the facade. For centuries the stage was the only place where repressed wishes could be displayed and satisfied publicly and for all to see—and society sought to protect itself against the fear engendered by a

return of the repressed by degrading the theatre to a socially unaccepted status, by not taking it quite seriously, even finding it slightly scandalous. In modern society this attitude has all but disappeared; but in the assessment of the psychodrama voiced by many psychiatrists and psychologists it has left recognisable traces, even bringing it about that the same argument is used in a diametrically opposite direction! Some psychiatrists claim that the danger inherent in psychodrama, and especially where schizophrenics are concerned, is to be seen in the circumstance that its fictional character removes the patient even further from reality. Moreno, in his work entitled "The Psychodrama of Adolf Hitler," has shown that the exact opposite is true, and his experiences have been verified by many psychodramatists. But the excessive value placed on physical reality already mentioned as a characteristic of our times is so great that the significance of day-dreaming and dramatic play as a bridge to reality is overlooked. Banning the day-dreamer into the realm of art and the strict separation between the arts and life do not reconcile man and reality, but merely lead to a double existence in an empty, mechanised every-day life and in a mendacious and fanciful film world. The Teddyboys in the streets and in the parliaments are a pathological symptom of this attitude.

Another objection that is sometimes raised against psychodrama points in a different direction: The strong dynamics of the psychodramatic scene cause the sudden eruption of anxiety producing material without the therapist's being able to brake and calm to the same extent as in single or group therapy. This objection exactly coincides with the real state of things, but it does little to invalidate the therapeutic value of the psychodrama.

In the past twenty years much has been said of the pathogenic character of anxiety, and many psychotherapists attempted, therefore, so to direct their therapy as to spare the patient violent experiences of anxiety as far as practicable. Unfortunately this endeavour, by itself entirely praiseworthy, led to what can only be termed a superstitious apprehension of inducing anxiety in the patient, especially among the disciples of Sullivan. What was disregarded was the fact that the refashioning of the patient's anxiety into fear, which is of primary importance in this restoration to health and consists of the transformation subconsciously into consciously controlled defence mechanisms, is possible only if the experience of anxiety actually makes an appearance in the therapeutical situation, to be dealt with in all its aspects by the patient in collaboration with the therapist. Only if the patient realises that even in the extremities of an anxiety situation the contact between him and his therapist is not interrupted, will he develop

a confidence in his therapist and later on in his own ego, that confidence which enables him to get over his anxiety. For this psychodrama is expecially useful, provided only that the therapist is not driven into anxiety himself by that of his patient and by his suddenly being confronted with unexpected and to him entirely new material. When all is said and done it is not so much the patient's but the simultaneous anxiety of his therapist that brings about the sudden breaking off of the psychotherapeutical contact. In our experience all the scenes which caused harmful anxiety were to be blamed on that of a therapist or of an auxiliary ego. It seems to us that exaggerated warnings against anxiety played some part in this.

This psychiatric attitude, however, is but an expression of a common tendency of our civilisation. It is not to be wondered at that anxiety has become a problem of our times, if we consider that each single worker knows as little of production as a whole, in which he is taking part, as, say, the taxpayer of the intricate machinery of the state. Even scientists and philosophers lack a comprehensive view of things; isolated in their special fields they know but little of other fields of endeavour, cannot even foresee the consequences of their own activities. To be precise people in former periods knew even less of the forces that shaped their lives, but they filled the gaps in their knowledge peopling them with gods and demons, believing at the same time that they were able to influence these by means of prayers or black magic. Scientific progress destroyed this belief, but the accretion of knowledge made it impossible for the individual to find his way about in the world by his own exertions. More than at any time previously it is the group, the team, not the individual that knows. Thus the I-you and the I-we ties became the strongest rampart against the anxiety of modern man. Frequently one has the impression that the group tie is beginning to take the place of religion. Here, too, the evil consists in exaggeration, similar to the situation in the purely psychiatrical sphere. The group becomes a danger and is itself endangered if the individual member loses too much of his individuality.

Anxiety is not only the experience of suddenly lost contacts, it is the most individual, most personal of our experiences. Kierkegaard, therefore, and his existentialist successors were perfectly correct in pointing to the positive aspects of anxiety. Quite frequently it is the source of progress and fuller self realisation. Neither in psychiatry nor in everyday life can it, therefore, be the aim to eliminate anxiety; what has to be done is to educate man to take anxiety in his stride, to make use of it, and to overcome it. The eruption of anxiety in psychodrama will have the use that the therapist makes of it.

Yet another point often raised against psychodrama is that purely verbal therapies force the patient to intellectualise his primitive impulses by giving verbal expression to them, while in psychodrama, on the other hand, he is literally encouraged to translate these dangerous impulses into actions and thus to act at the most primitive, regressive level. Here again the observation is correct, but its negative evaluation erroneous. Apart from the fact that this critical argument does not take account of the more intensive catharsis of the psychodramatic act, it also ignores the close connection between motor behaviour and intellect.

Piaget, in his researches, has proved that for a child perception, action, and thinking, are a unity which branches out into its component parts only very gradually. Only after a number of years is the link between thought and bodily movement replaced by that between concept and word. But even in the word, in the most abstract sign, a residue of motor behaviour is preserved. Now, since early childhood experiences are of the greatest significance in psychotherapy, and since these experiences are bound up with movements rather than words, strictly verbal therapy must lead to a falsification of the material, at the same time condemning to uselessness the rich memory material that could have emerged through motorial associations.

It should also be considered in this connection that many patients—and many healthy persons, too—feel a discrepancy between their capacity to think and that to act. Reducing this discrepancy through a psychodramatic scene may formally be called a kind of regression; but Jung emphasized, with full justification, that there are useful regressions. Freud defined thinking as experimental action. But the models of fancy are very often blurred and incomplete. The engineer, therefore, constructs a tangible model, to check his ideas and to enlarge upon them. The psychodramatic scenes resemble such models. They do not only strengthen the capacity to act, they give fresh impulses to thinking as well. The psychodramatic re-translation of the abstractions into their factual original situations is in itself already a cultural task. The fear of strengthening action impulses, however, which psychotherapists seek to rationalise by pointing to dangerous regressions, corresponds to a dominant tendency in our society.

For no matter how one may judge the theory of feeling of James-Lange and the theory of empathy of Theodor Lipps, it remains beyond doubt that originally feelings and bodily movements form a unity. Now our society does not forbid the individual to have emotions, but it does demand that he renounce a direct translation of his feelings into movements. He may get angry, but he is punished severely if he follows his primary impulse and

makes a physical attack upon someone. Nor is fear prohibited—but it is regarded as shameful simply to run away. Even violent gesticulations in the course of a heated discussion are frowned upon in many countries. Both the angry and the fearful man may turn to the police; but even the best functioning police force does not satisfy the urge to translate emotions in bodily movements. Inevitably repressed motional impulses lead to tensions, which are removed to but a very small extent in sport, for movements in sport are too far removed from the primary emotion. The many psychosomatic illnesses, foremost among which are damage to the organs of blood circulation and digestion, seem to be a direct consequence of these repressed motional impulses. In primitive societies, where the separation between thought, emotion, and bodily movement, has not yet made great progress psychosomatic disturbances of the kind referred to are much less frequent.

Primitive man was bound to totems and taboos by his ignorance. Modern man, by the bewildering abundance of the most divergent informations, is bound to single theories—and it is quite impossible to decide whether spontaneity is to-day greater or smaller than it was in the days of more primitive cultures. The significance of spontaneity and the dangers inherent in "cultural conserves" have already been dealt with exhaustively by Moreno, and a passing reference to his work should suffice at this juncture. What is decisive in this connection is the statement that psychodrama demands the spontaneity of all concerned, thereby contradicting the psychotherapists' stereotyped attitude in particular and the preference for canned cultural values in general.

In the present state of affairs spontaneity and applied science appear to be irreconcilable opposites. To be truly creative means to unite opposites.

DYNAMIC PSYCHOTHERAPY IN THE SOVIET UNION

ISIDORE ZIFERSTEIN, M.D.
University of Southern California, Los Angeles

Looking back from my present vantage point at my discussions with Soviet psychiatrists, I realize that I approached them with two preconceptions.

I assumed, firstly, that Soviet psychiatry was monolithic; that is, that every Soviet psychiatrist subscribed uniformly to a certain theoretical structure and that all Soviet psychiatrists employed the same therapeutic techniques, based on this structure.

To be sure, the theoretical foundation upon which Soviet psychiatrists base their practice is different from ours for two important reasons. Traditionally, and historically, Russian psychiatry has had its roots firmly attached to physiology. The leading names in early Russian psychiatry were neurophysiologists, like Bechterev and Korsakov. Physiologists like Sechenov have had an enormous impact on Russian psychology and psychiatry. Over all looms the epoch-making work of Ivan Pavlov on the physiology of the higher nervous activity. Pavlov's researches enormously stimulated, but also overshadowed and inhibited, original thinking in the same way that our giant, Sigmund Freud, has affected psychiatric thought in the West.

The emphasis on neurophysiology is also in part the result of the materialist orientation of all Soviet thought. (I use the term materialist in its philosophical sense.) Their materialist orientation leads Soviet psychiatrists to concentrate their attention on looking for the material causes of psychological phenomena. In my discussion of actual case histories, I got the impression that the Soviet psychiatrist, when he sits with his patient, tries to visualize not only what is going on in the patient's psyche, but also the physiological processes going on in his central nervous system. I could imagine the Soviet psychiatrist tracing in his mind's eye the irradiation of waves of excitation and inhibition in the cerebral cortex and trying to localize the "inert sick points" of excessive excitation.

This leads to great emphasis being placed in psychiatric treatment on various physiological modalities, ranging from general hygienic measures, rest, regulation of diet, through a variety of pharmaceuticals, to experimental techniques like subcutaneous injections of oxygen, repeated small transfusions, injections of sulphur in oil, and prolonged fasting.

For the same reason, the diagnostic work-up of the psychiatric patient will include neurophysiological tests, such as tests to determine how quickly the patient forms new conditioned reflexes, and how stable they are; and word-association tests accompanied by electroencephalographic studies to determine whether there are abnormal brain-wave tracings in response to certain stimulus words, which are then considered as complex-indicators.

The second theoretical, philosophical base of Soviet psychiatry is Marxian sociology, which stresses that the social structure in which the individual is born and reared is crucial in determining the way in which his neurophysiological functioning develops; and the kind of conditioned reflexes that are produced in the individual through the operation of the first and second signal systems. This approach is closely related to the conviction of Soviet thinkers and scholars that they are pioneering a new social order that is more closely attuned to basic human needs than preceding social systems such as slavery, feudalism, and capitalism.

The Soviet psychiatrist is therefore keenly interested, when obtaining an anamnesis, to find out all he can about the patient's social relations, his attitude toward work, his vocational adjustment, and other environmental factors that may have contributed to the causation of his mental illness. The psychiatrist obtains this information not only from the patient, but also from relatives, friends, and co-workers.

This emphasis on sociological factors is reflected in the therapy. Stress is laid on efforts to change the noxious social influences that produced the illness. For this reason it is much more usual to hospitalize neurotic patients in the Soviet Union than in our country. The persons close to the patient, from whom anamnestic material was obtained, will also be utilized by the therapist to help restructure the patient's social and work relations along more healthy lines. Recommendations may include a change of residence, a change of place of work, and/or vocational retraining. Since the trade-unions and the factory managers are expected to cooperate with the psychiatrist, these recommendations are usually carried out.

One result of the Soviet psychiatrist's sociological approach to the cause and cure of mental illness is the great emphasis that is placed on work therapy. In the Soviet Union, work is considered a basic element in normal, healthy living. It is therefore considered a basic element in the treatment of the mentally ill. Work-therapy is not occupational therapy as we know it in our country, although they do have occupational therapy in the Soviet Union as part of their recreational program. Many of the mental

hospitals and psychiatric out-patient clinics or "dispensars" have on their grounds fully equipped factories where patients produce marketable articles, under the supervision of professional foremen. The patients receive regular wages for their work. The Soviet psychiatrists pointed out to me that work-therapy helps to maintain the patient's contact with reality and prevents a regression into "hospitalism." It also helps the patient maintain his self-esteem and serves as a transition to normal living outside the hospital, and to work under ordinary conditions in outside industry. Work therapy, further, is used for vocational retraining, where this is indicated. Many patients leave the hospital qualified for better jobs, with higher pay than when they entered. This fact has helped in removing the stigma and fear of the mental hospital that used to prevail in the general population.

The second preconception with which I approached my Soviet colleagues was the belief that there was little or no dynamically-oriented psychotherapy in the Soviet Union. I had received this impression from reading various reports on Soviet psychiatry, such as Joseph Wortis' book, "Soviet Psychiatry," and Bruno Lustig's "New Research in Soviet Psychiatry" (1957), as well as from direct reading of the Russian psychiatric literature.

Actually, Russian psychiatry is not monolithic. Russian psychiatrists employ a wide variety of psycho-therapeutic techniques. And, I discovered, to my great surprise, that there is a large and growing trend toward dynamically oriented psychotherapy.

To be sure, there are psychotherapists whose main emphasis is on re-educating and redirecting the patient. These therapists attempt to demonstrate to the patient the lack of rational foundation for his symptoms, his attitudes and his relations with people; and to teach him to adopt a more rational way of life. This technique is often accompanied by general discussions with the patient, on his level of understanding, of the principles of psychopathology, of the way in which neurotic symptoms are formed, and of the neurophysiological principles of inhibition and excitation.

There are other psychotherapists who employ various techniques for distracting the patient from his preoccupation with his symptoms through setting up for him a busy schedule of activities and by stimulating new interests. This technique is used particularly in obsessive compulsive patients. The rationale is based on the Pavlovian concept that the illness is due to an inert point of excessive stimulation in the cerebral cortex. The attempt is therefore made to set up other points of excitation in the cortex, through a variety of external stimuli, thus inducing a state of inhibition in

the original "sick point." Closely related to this viewpoint is the use of suggestion in the waking or hypnotic state, sometimes with the aid of narcohypnosis. The rationale is that these suggestions stimulate new points of excitation in the cortex, and thus bring about an inductive inhibition in the inertly excited "sick point."

K. I. Platonov of Kharkov advocates the use of combined psychotherapy which he calls "explanatory-persuasive-suggestive." In a series of interviews, a study is made of the causal factors in the illness: an "investigation of the concrete predisposing and provoking causes, a study of the factors traumatizing the mind and the nature of their influence (their repetitiveness, duration in the preceding life of the patient) and, finally, an analysis of the physiological mechanisms underlying the given neurosis."[1] These are explained to the patient and persuasion is used to get the patient to relinquish his pathological reactions. In some cases, verbal suggestion in a drowsy state or during suggested sleep may be added. "Depending on the case, it is sometimes necessary to resort to more complicated measures (change of environment, living conditions, occupation, etc.)." The applicability of any or all of these approaches is determined for each case in an individualized way.

I discovered, however, that there is a large and growing number of psychotherapists in the Soviet Union whose basic approach is that neurotic illness is caused by intrapsychic conflicts, and who employ a dynamic, uncovering type of psychotherapy as the treatment of choice in the neuroses. This group includes some of the leading psychiatrists in the Soviet Union, like Professor V. N. Myasishchev, director of the Bechterev Research Institute in Leningrad, and Professor M. S. Lebedinskii, of the Academy of Medical Sciences in Moscow. A leading member of this group, Professor E. K. Yakovlyeva, of the Bechterev Institute in Leningrad, writes as follows:[2]

> "The pathophysiological mechanism of psychasthenia and obsessive-compulsive states is elucidated by the works of I. P. Pavlov and his school. However, the clinical investigation of these states, as of other neuropsychiatric illnesses, requires a knowledge not only of their pathophysiological basis, but also of the specific characteristics of the personality, its conscious relations and other aspects of the psyche, an accounting of which opens up the pos-

[1] K. Platonov: "The Word as a Physiological and Therapeutic Factor" (Foreign Languages Publishing House, Moscow—1959) p. 224.

[2] Yakovlyeva, E. K.: Pathogenesis and Therapy of Obsessive-Compulsive Neurosis and Psychasthenia, (in Russian) Leningrad, 1958, pp. 135 and 136.

sibility of understanding the pathogenesis of the illness and working out a rational system of treatment.

"The basic method in treating these illnesses is psychotherapy, combined with somatotherapy. Experience shows that the most effective method of psychotherapy is deep or rational psychotherapy, a system which, in contradistinction to other authors (Dubois, Freud, and others), stems from an investigation of the real life history of the patient and his experiences, and has the aim of restructuring the interpersonal relations and helping the individual toward a constructive resolution of his life-problems."

I was able to find the strong current of dynamic psychotherapy that now exists in the Soviet Union because I am primarily interested in dynamic psychotherapy, and because I speak Russian. I had many conversations with Russian psychotherapists in the course of which we argued about the similarities and differences in our theoretical orientations and in our clinical techniques. They were particularly critical of psychoanalysis. They maintained that psychoanalytic theory is too one-sided in that it does not pay sufficient attention to the physiological and social factors in the patient's illness. And they objected to the passivity of the psychoanalytic technique.

The Soviet psychotherapist plays an active role in guiding the direction of the interview. Interviews may last anywhere from thirty minutes to two hours and may, in certain cases, be carried on daily for many months. Soviet psychiatrists emphasize that they never employ dynamic psychotherapy as the sole method of treatment. They supplement it with both physiological and environmental measures.

In our theoretical discussions, the Soviet psychiatrists disagreed with my use of such terms as: "the unconscious," "repression," and "resistance." They felt that talking about "the unconscious" was not scientifically justified since it made too sharp a division between what is conscious and what is unconscious. They stated that there was no experimental proof of the repression of painful experiences. And they maintained that while patients may forget or may be reluctant to confide in the therapist, it was not desirable to say that they were resisting. They also decried what they considered the tendency of psychoanalysts to overemphasize the role of sexuality in the causation of neurotic illness.

I soon found that I learned more by exchanging actual case material with these Soviet psychotherapists than by engaging in lengthy theoretical controversies. I obtained from them fifteen detailed case histories, and these communicate the flavor of Soviet dynamic psychotherapy much better

than can any description of their techniques. A translation of one of these case histories[3] is presented herewith.

Case History

Patient C., a 24-year-old woman engineer, has been suffering for two years with a "phobia" of a bad odor emanating from her own person. Because of this fear she stopped work, stopped associating with people, and even going out of the house, since she smelled everywhere an unpleasant odor which she ascribed to herself. During the years of illness she developed a habit of sniffing the air. Her sense of smell as a result became extraordinarily acute.

The patient didn't state the causes of her illness. She only noted that she first sensed the bad odor in a kino theatre, but at that time she did not yet attribute it to herself. On the following day, in the auditorium of the Institute, among her fellow-students, she again smelled the odor, decided it emanated from herself, and immediately left. Since then, she began to observe herself intensely, stopped attending lectures, appeared at the Institute only for examinations. Graduating with difficulty, she began to work, but soon had to quit because of the odor which followed her. No treatment helped, and because of suspicion of emotional illness, the patient was sent to Leningrad, to the Bechterev Institute.

She was born into the family of a white-collar worker. Healthy child. No infections. No pathological heredity. Until the age of 8, she was the only child; mother's entire attention was concentrated on her. She studied at school and in a musical technicum. She had great success everywhere. The family considered her capable, gifted. On graduation from school she entered an Industrial Institute. During the siege of Leningrad, she was evacuated with her mother and younger brother to Omsk. She experienced many difficulties, including malnutrition. There were many tragic experiences—she lost her brother, who died of dysentery, and her father and younger sister who had remained in occupied territory.

However, she handled these difficulties, and continued her studies at the Institute and at the age of 22, while still in Omsk, she married a soldier. Her husband left for the front on the day after the marriage. She took his departure very hard; she cried a great deal when informed of his being wounded. On his discharge from the hospital, the husband unexpectedly announced he would not return to her. This news shook the patient.

---

[3] —Ibid, p. 94 ff.

Objectively: The patient is somewhat asthenic, pale. No pathological findings in the internal organs and nervous system. Consciousness clear. Intellect good. Conduct completely adequate. Emotional reactions lively, but mood somewhat depressed because of her condition which she finds hard to bear. The idea of the odor emanating from her is persistent, not yielding to correction at first; but her critical attitude toward it is preserved, although at times she experiences doubts and ambivalence toward the pathological idea.

In the hospital she kept herself isolated; avoided association with patients. She is rather tense, and constantly sniffs the air.

In view of the peculiarity of the patient's symptom, Professor I. K. Zyuzin proposed a series of experiments, to investigate the acuteness of her sense of smell. It turned out to be amazingly acute, e.g., patient distinguished odor of spirits of camphor in a dilution of 1 to 50 thousand, and with some uncertainty, dilution of 1 to 100 thousand. With closed eyes, she could distinguish to whom a pair of gloves belonged, after having smelled the hands of various people, a feat that no one else could duplicate.

Worthy of attention also is the sharply slowed up smell adaptation of patient and the easy establishment of previously perceived odors under the influence of the stimulation of other sensory organs. Such a change in perception in the patient in connection with pathogenic conditions is interesting. If we conjecture that according to anamnestic data, the patient's olfactory functions had in the past not been unusual and if we associate to this the fact that since her illness she tensely sniffs the air, then we can evaluate the dependence of our functions upon our attitude toward them, and upon the mobilization of alerted attention (dependence on cortical influences).

For the understanding of the pathogenesis of the given illness, the first anamnestic information communicated by the patient was, naturally insufficient. However, in psychotherapeutic conversations with the patient, directing her attention, we succeeded in obtaining essential additional information which clarified the genesis of the symptom. A detailed study of the conditions of her upbringing showed that despite their apparent normality, there really obtained a series of unfavorable influences which had considerable significance in the formation of the patient's relation to herself and to the surrounding reality. It became clear, that, after the birth of her younger sister, the patient who until then had been the idol of the family, was quickly pushed into the background. The patient's mother who

was very unstable and emotional, displaced all of her attention to her second daughter from the moment of her birth. She openly began to value the younger daughter higher than the older, frequently telling everyone that the younger was better, smarter, and prettier, and even, according to the patient, frequently calling the patient, in the presence of others, a dope. The younger sister, as she grew up, gradually adopted the same attitude toward the patient.

It appears that this entire childhood period about which the patient at the beginning had given no information, was full, for her, of unpleasant, degrading experiences because of mother's attitude toward her. At the beginning, the mother, praising her and being ecstatic over her, developed in her a striving for distinction, toward a heightened self-evaluation; later, mother began sharply to emphasize her shortcomings, and this made the little girl reserved and withdrawn. Patient recalls that early in life she was a happy, attractive little girl who loved noisy games, dances; later, she became serious. Deciding, in accordance with mother's evaluation, that she was ugly, and therefore would never marry, the patient became completely absorbed in studies. She became an outstanding student in the university and this, according to the patient, completely compensated her, so that she considered herself, in spite of the series of hardships, sufficiently healthy.

A serious psychic trauma, which served as the source of her breakdown was produced by her marriage. She married at age 22, while in the evacuation, a man whom she knew very little, but who, at the beginning, demonstrated a great persistence in courting her. At first the patient didn't want to marry him because he was beneath her culturally, and her mother did not like him; but, feeling a powerful sexual attraction to him, she registered a marriage with him against her mother's wishes.

The first night of the marriage was, according to the patient's admission, a source of difficult, unpleasant experiences. Finding herself in the same room with her mother, she was very embarrassed by her presence; and so, in spite of her great sexual excitement, she was very reserved with her husband, avoiding his endearments, and his attempts to approach her. The husband, irritated by her attitude, and not understanding the reasons, made many coarse remarks to her, and turning toward the wall, fell asleep. This deeply offended the patient. On the following day, he left for the army. The patient changed markedly from that night on. Again there appeared her feeling of low self esteem, which had previously been compensated by her successes at the institute. She felt herself pitiful, insignificant, "worse than the others." It oppressed her that her mother had witnessed her

degradation. It was painful to hear her mother's recriminations about her thoughtless marriage. But along with these experiences of degradation, there increased steadily her awakened sexual attraction to her husband. During the two months after his departure, she was in a constant state of excitement—she waited for his letters, often went to the post office, cried a great deal. It became clear that it was precisely during this period that there appeared her sensation that she was producing an odor.

How did this symptom develop?

In order to determine this, it was necessary to clarify all of the preceding life situations, the patient's reactions to them, as well as to know the peculiarities of her personality. In conversations with the patient, there gradually emerged a series of facts which she had not previously communicated because, in her opinion, they had no relation to the illness. However, these facts helped us to achieve a deeper insight into the genesis of the symptom. The patient perceived the odor for the first time in the kino theatre where it was stuffy, crowded, and where the air was, indeed, saturated with all kinds of odors. There, the patient related, she sat next to a certain young man, a neighbor in their apartment who began to declare his love for her, and she too, at the moment, felt a powerful attraction, which she was afraid to acknowledge, even to herself. On the following day, while she was sitting at table among her fellow-students, the thought occurred to her that she can still be attractive to young men. At this point, she again became sexually excited, but then immediately there appeared the fear that she might give herself away. At this time, she suddenly smelled an odor, exactly the same as in the kino theatre, which she now attributed to herself, and feeling deeply ashamed, she left. We can conjecture that, at this moment, there developed in her a conditional connection between sexual excitement and the odor. On the following day she began to seat herself at a distance from everybody, to avoid association with her fellow-students because as soon as young men came near her, she experienced a certain agitation in her stomach, and she began to perceive that very same odor. Because of her fear of this odor, which, it seemed to her, now emanated from her, she finally stopped attending the institute, and later left her work.

In the conversations with the patient, it was established that the events in the kino theatre showed her the possibility for satisfying her sexual drive; the patient saw that she could be pleasing to a young man; but these events at the same time called forth a need to suppress her sexual feeling. In accordance with the moral standards that she set for herself,

she considered it impossible to establish a liaison with another man while she was married. The development of this viewpoint, as was shown by a study of her concrete life-story, was furthered by the authority of her father, who always severely criticized "moral looseness," and who even broke off his friendship with his best friend when he found out that the latter had left his family. As the patient later explained, her awakened sexual feelings were extremely unpleasant to her; she felt a revulsion against herself for having such an "animal instinct."

Further questioning clarified still another series of circumstances which explained why the patient developed specifically a phobia of odors. Alongside of what has already been presented, the patient communicated the following information about herself: Not long before her marriage, there lived with her family for two weeks, a cousin, a very slovenly man, who importunately pressed her with his love. His overtures seemed to her "an animal excitement"; his bad odor was unpleasant to her, and elicited feelings of revulsion in her. In addition, her previous landlady had suffered from flatus, but continued to go out in society. In the patient's words she was very embarrassed by the conduct of this woman. It seemed to her that with such a defect it was impossible to be among people.

All these conditions reinforced the pathological temporal connection, and strengthened her notion about the impossibility of being among people because of the unpleasant odor she gave forth. But her absenting herself from society, especially of men, because of her fear that her odor would expose her sexual excitement, "like an animal's," naturally did not resolve the contradictions which had arisen. On the contrary, these contradictions kept becoming deeper since, being a passionate woman, she had a great urge for male company, and she therefore had to make ever greater efforts to struggle against these strivings.

In this case history, as in all the others, we are presenting schematically, those data about the development of the illness and the formation of the symptom which in reality became clear only gradually in the course of acquainting ourselves with the concrete life story of the patient.

At the beginning of the treatment with psychotherapy, she did not connect the symptoms of her illness with the circumstances enumerated above. However, gradually, in connection with the ever-greater uncovering of the sources of the development of the "sick-point," she began to clarify and to understand the connection between her symptom and her experiences. There became clear the conflict between her sexual excitation and the striving to suppress it in connection with her developing relationships.

As she became aware of this connection, her pathological state began gradually to be eliminated. The patient began to associate with other patients, began to go into the "Red Corner," and even to participate in the evening amateur theatricals of the patients. She also stopped sniffing the air. Gradually the symptoms faded and finally completely disappeared. The patient was discharged in good condition.

Further observations showed that she continued well, associated with people, got back to work, and significantly, her sense of smell which had become acute during her illness, became normal. Two years after the therapy, the patient remarried, gave birth normally, continues to work at her specialty and there is no trace of her previous illness.

In conclusion, we can say that the precipitating factor in the development of the illness was the unsuccessful marriage which turned out to be the source of a complicated inner conflict. In the development of the illness, there played a role, on the one hand, the patient's entire past life experience, the attitudes which she had towards herself, and toward the questions of friendship, love, marriage and morals; and on the other hand, the awakened powerful sexual drive. As a result of the developed conflict, there was established an emotional overstrain which weakened the nervous activity. On the basis of such a weakened "prepared" foundation, the patient at this period developed a phobic symptom, as a pathological conditioned reflex. The patient's lack of understanding of the essence of the conflict furthered the reinforcement of the developing symptom. Only the uncovering in the process of psychotherapy of the true causes of the illness, the elucidation, with the help of the doctor, of the connection of the phobic symptom with her complex experiences helped the patient to become aware of the sources of her conflict, and rationally to evaluate the situation that had developed. Psychotherapy which was structured along these lines brought about the cure of the neurosis.

To an American psychoanalyst, the most striking omission in this case history, as well as in the other fourteen case histories, is the total lack of any mention of either transference or resistance. From my discussions with Soviet psychotherapists, as well as from reading some of their theoretical papers on dynamic psychotherapy, I have concluded that an effort is made by the therapist at all times to carry on therapy in a state of positive transference. I would also conclude that the Soviet psychotherapist does not hesitate to give his patients transference gratification and to present himself to the patient as a strong, benign, parental figure.

This brings up the possibility that patients would develop an unanalysable dependency on the therapist. I discussed this danger with the author of this case-report. She stated that no such dependency developed in the patient described above, who has been followed up for five years, or in any of the other cases. Follow-up studies, which are carried out regularly and consistently in all cases, showed that the patients were able to carry on independently in outside life.

This raises some basic questions about the relationship between the goals and values of a society and the goals and techniques of psychotherapy. It may well be that techniques of psychotherapy that are effective in a collective society like the Soviet Union would not be applicable in our individualistic society, and vice versa.

It would be of special value in this connection to make a more thorough study of transference in Soviet dynamic psychotherapy, and I hope to make such a first-hand study in the near future.

On the basis of my preliminary observations of Soviet society and Soviet psychotherapy, I would propose the following tentative hypothesis: The Soviet psychotherapist does not hesitate to present himself to the patient as a parental figure because this is in keeping with the character of social relations in the Soviet Union. Soviet society is what I would call a collective parental society. From earliest childhood, the individual is taught that his well-being depends on the well-being of the group, and that he can best fulfill himself by contributing to the advancement of the group. During my stay in Russia, I observed numerous instances of adults taking a parental interest in each other. The tendency to look out for each other, to mind each other's business, seems to be part of the personality of the Russian people.

Perhaps then, the Soviet therapist is able to assume a parental attitude toward the patient, because he knows that, after the patient is discharged from treatment, he will have available many parental figures in his environment; the factory manager, the trade-union, his neighbors, the whole society.

In the last analysis, the aim of psychotherapy in any society is to enable the patient to function effectively within that society. Perhaps, too, the patient-therapist relationship is a reflection of a given society's ideal of what interpersonal relations between adults should be.

In our country, the psychoanalyst tries to set up an atmosphere which is modelled after what we consider the ideal interpersonal relationship between adults in our individualistic society, that is, as complete permissive-

ness and laissez-faire as is possible. We must, however, accept the possibility that in a different society, the therapist-patient relationship and the techniques of psychotherapy will be modelled after its ideal of interpersonal relationships.

A comparative study of these factors in American and Soviet psychotherapy may add to our understanding of these basic questions. It may also make a contribution to current discussions about what constitutes mental health. Finally, it could be a valuable exercise in learning to be objective in evaluating mores and professional techniques which may be different from those to which we are accustomed.

BIBLIOGRAPHY

Joseph Wortis, *Soviet Psychiatry,* The Williams & Wilkins Co., 1950.

M. S. Lebedinski, *Psychotherapy in the Soviet Union.* "Progress of Psychotherapy," Vol. V, 1960.

J. L. Moreno, *Psychiatric Encounter in Soviet Russia,* "Progress of Psychotherapy" Vol. V, 1960.

INTERPERSONAL THERAPY AND CO-UNCONSCIOUS STATES, A PROGRESS REPORT IN PSYCHODRAMATIC THEORY

J. L. MORENO, M.D.

Moreno Institute, Beacon, N. Y.

I. *Historical Note*

Group psychotherapy and psychodrama have had a similar historical fate. They have had to defend their birthright against the persistent efforts of the psychoanalytic movement to absorb them since I brought them from Vienna to the U.S.A. in 1925.

Group psychotherapy developed for a decade (1925-1935) within the framework of psychiatry and social science, with group structure (sociodynamics, sociometry and microsociology), and the role concept as cornerstones until by 1936 the psychoanalytic intervention[1] began. This intervention broke the method into two directions, the original direction, "socioanalytic" group psychotherapy and the second direction, "psychoanalytic" group psychotherapy. Since then socioanalysts and psychoanalysts have been up in arms against each other, a conflict which has not yet been resolved.

Psychodrama, with sociodrama and role playing as its subdivisions, remained fairly intact until about 1950. It was again the intervention of psychoanalysts which tried to bring about a schism. This time, however, the schism did not come from the U.S.A. but from France. The "classic" psychodrama was confronted by the "analytic" psychodrama.[2] The operations are about the same except for different views as to the value of interpretation.

II. *Co-Unconscious States and the Function of the "Interpsyche"*

The "return to Freud" is a nostalgic reaction of every new generation of psychoanalysts. Whenever a new method arises on the scene they have to make a decision either to accept the new orientation undiluted or to return it to their father, Freud, by adapting it to psychoanalytic theory, at least by giving him lip-service. The movement of such a to and fro between extreme anti-Freudism and extreme Freudism can be shown in

[1] Renouvier, Pierre, *The Group Psychotherapy Movement and J. L. Moreno, Its Pioneer and Founder,* Beacon House, Inc., New York, 1957.

[2] Anzieu, D., *Le Psychodrame Analytique Chez L'enfant,* Presses Universitaires, 1959.

behalf of every concept of group psychotherapy and psychodrama. The task how (1) to harmonize traumas of the remote past with the living moment, the structure of the here and now, the present constellation of events; (2) to relate the abreactions of the individual organism with the role structure in which it operates; (3) to harmonize ego psychology with role psychology; (4) to combine the dissociative character of transference with the integrative function of tele; (5) to reconcile psychodynamics with sociodynamics; (6) to confront intrapsychic phenomena with interpersonal relations; (7) to harmonize psychological phenomena with a monistic concept of the body, presents great difficulties. Sullivan's theory of interpersonal relations (1938)[3] has added "nothing new" to the classic psychoanalytic situation. That is the reason why he was so easily accepted. My own system of "two-ways" interpersonal relations (1937)[4] which preceded that of Sullivan was bypassed. Now it is generally considered as the core of interpersonal theory.

Recently it is the theory of the psychoanalytic unconscious which is in a serious crisis. We have no means of proof for the idea that the unconscious is an "entity" which underlies and dominates all psychic phenomena. We prefer to talk about unconscious "states." The distinction which Freud made between unconscious and preconscious has proven equally unproductive. The "origins" of unconscious states are probably closely allied to the origin of nocturnal dreams. Both can be comprehended as forms of "introverted creativity" (see my "Canon of Creativity" in *Who Shall Survive*). The individual unconscious (Freud) and the collective unconscious (Jung) have been found insufficient to cover the wide area of interpersonal relations. The individual unconscious is related to the psyche of a single individual. Jung's collective unconscious is universal but void of means of proof, inapplicable to any concrete collectivity facing the therapist. The advances of interpersonal therapy have made it imperative to define and study the phenomena "between" persons and between groups and with this to hypothecate the existence of co-conscious and co-unconscious states. The hypothesis of co-unconscious states has great methodical value; it enables us to study unconscious states within an experimental setting. (See my *Psychodrama*, Volume II).

The "first" encounter between two individuals who are destined to form an intimate ensemble is the starting point of co-conscious and co-

[3] Sullivan, Harry Stack, *Psychiatry*, Volume I, 1938.

[4] Moreno, J. L., Psychopathology of Interpersonal Relations, *Sociometry*, Vol. I, 1937.

unconscious states. These states gain in significance from encounter to encounter. They are experienced and produced *jointly* and can, therefore, be only jointly reproduced or re-enacted. A co-conscious or a co-unconscious state can not be the property of *one* individual only. It is always a *common* property and can not be reproduced but by a combined effort. If a re-enactment of such co-conscious or co-unconscious state is desired or necessary, that re-enactment has to take place with the help of all partners involved in the event. The logical method of such re-enactment "a deux" or "a plusieurs," is psychodrama. However great the perceptive ability of one partner of the ensemble might be, he can not produce that event alone because both partners have in common their co-conscious and co-unconscious states which are the matrix from which they draw their inspiration and knowledge. Co-conscious and co-unconscious states are phenomena which they have "co"-produced and which operate between partners who live in "intimate" ensembles and can not be substituted by other persons; they are irreplaceable. They are tied together through "encounters"; it is life itself which binds them together and it is the experiences of living which develops between them an "interpsyche," a structured stream of co-conscious and co-unconscious states. The encounters between individuals and the co-conscious or co-unconscious states developed between them are the source from which tele, transference and empathy spring. Their operation within every group setting has been stated by many observers and a consensus has been reached. *Transference dissociates, empathy perceives, tele integrates.*

My experiment with multiple couches (1921) raised the question: how can several individuals, each with a separate unconscious track, communicate on an unconscious level? In order to make such communications plausible we may assume the existence of co-conscious and co-unconscious states. They play an important role in the life of persons who live in intimate contact like father and son, husband and wife, mother and daughter, siblings and twins, lovers and close friends, but also in other intimate ensembles as in work teams, combat teams in war and revolutions, in concentration camps or charysmatic religious groups. Being thrown together by social destiny into situations which require rapid communication, co-action and cooperation, such persons must often act not only as individuals each separate from the other, but as an ensemble. Such persons, involved in immediate and often spontaneous and ill-prepared co-action, have to surmount numerous emotional difficulties by confronting each other. It is not an interaction between unequal partners like in the symbiosis between

mother and infant but between two *equal* partners who are sufficiently mature to challenge each other. It is an "encounter" between two individuals both of whom have developed a self of their own.

III. *Development of the Concept of Co-unconscious States*

The first time I suspected the existence of co-conscious and co-unconscious states was in my work with spontaneous actors (1921 and 1923). A cast of actors, day by day worked routinely together and had to gain an intuitive perception of how the various co-actors in a "new" fully unrehearsed situation might think, feel or act, so that they could act in conformance with them and produce together a significant scene. I postulated then that the co-players in impromptu productions have to develop a special kind of communication talent which I called "mediale Verständigung." "Sie haben eine Art Feingefühl für die gegenseitigen inneren Vorgänge, eine Gebärde genügt, und oft brauchen Sie einander nicht anzusehen."[5]

The concept of medial understanding was the forerunner of what I call today co-conscious and co-unconscious states. Such a technique of reciprocal comprehension and "interpersonal memory" seemed to make possible astonishing matrimonial psychodramas, husband and wife reaching back into their first encounter and reliving, often with astonishing detail, all their moments of love and suffering, their silent tragedies and their moments of great decision.[6]

We call any mental process co-unconscious if neither of the intimate partners remembers an episode which we are obliged to assume has taken place. Large parts of the inter-psyche are apparently normally co-unconscious.

We call a mental process *partly* co-unconscious if one member of the intimate ensemble is amnestic of the episode whereas the other member recalls it. Such amnesia can be explained in several ways, f.i. 1) partner A does not remember because of having been in the position of the actor when the scene took place; partner B remembers because of having been in the position of observer (act-hunger theory in psychodrama). 2) Partner A repressed the scene because it was unpleasant for her to remember. 3) The explanations 1) and 2) may supplement each other.

In the acting out of significant episodes for which both partners are amnestic, they usually begin at a point they both see clearly (co-conscious

[5] Moreno, J. L., *Das Stegreiftheater,* 1923, p. 57. Translated into English, *The Theater of Spontaneity,* 1945, p. 68.

[6] Moreno, J. L., *Das Stegreiftheater,* p. 75-78, *The Theater of Spontaneity,* 89-92.

states). They are guided by vivid "co-enactment pictures." "It was on September 17th, after supper, in the livingroom." Now comes a blank for both and they both begin to explore alternatives. "You were standing." "And you were sitting near the piano—you tore the picture of my mother to pieces." They begin to move around, to act out fragments and then dismiss them until they reach their common track.*

---

* Recently I read an article by A. R. Luria, "Memory and the Structure of Mental Processes" in *Problems of Psychology,* Numbers 1 & 2, 1960, published by Pergamon Press, 122 East 55 Street, New York City, in which he describes a man endowed with a phenomenal memory. Luria's report has no bearing upon interpersonal relations and "*interpersonal memory,*" as dealt with here. The report concerns the memory processes of a *single* individual; but the pictorial memnotechnique the subject used to memorize a text in a language unknown to him (Italian) is akin to the classic psychodramatic technique of acting out in a familiar frame of reference, concretization of life scenes, using the names of people one knows, objects, streets, forms of speech and space and time signals. As we know, our protagonists, by using the most intimate, private denominators of their life, feel exceedingly comfortable in the presentation of their strangest experiences. This man, Shereshevskii, by putting unknown words he has to remember into a vivid personalized network, a la psychodrama, is able to carry them along and to remember them at anytime in the future. Herewith follows one example given by Dr. Luria on page 85 of the abovementioned journal:

"The beginning of Dante's 'Divine Comedy' was given to Shereshevskii for memorizing. Slowly, isolating each word, he read through a series of lines. Let us confine ourselves to the first three lines:

Nel mezzo del cammin di nostra vita
Mi ritrovai per una selva oscura
Che la diritta vis era smarrita.

Here is the technique of memorizing employed by Shereshevskii, recorded directly at the time of the experiment (December 1937); the second reproduction being 15 years later.

"I knew a woman called *Nel'skaya*—a ballerina. I placed her in a corridor (nel); alongside her I placed a violinist, he's playing a violin (*mezzo*). . . ; then there's some Delhi cigarettes (*del*); next to that I put a fireplace (*cammin*); (*di*). . . . there's a hand pointing to the door . . . someone says "get out" (*nos*) . . . a man peeps in through the door . . . gets his nose caught; (*tra*) he steps over the threshold; there's a child lying there . . . that's *vita;* (*mi*) I put a Jew on the scene, he says 'We're nothing to do with this'; (*ritro*)—a retort, a small transparent tube; (*vai*) . . . a Jewess runs along shouting 'ai, vai' . . . she runs along and when she gets to the corner of Lubyanskii Street there's father (*per*) riding in a cab; there's a copper on the corner, standing as straight as the figure 1 (*una*); next to him I put a dais and Sel'va is dancing on it (*selva*); so as not to confuse her with Silva I visualize the stage cracking beneath her and producing the sound of letter "e"; there's a shaft (*os*) sticking out of the stage and its pointing towards a hen (*cura*). (*Che*)—that's perhaps

The minimum requirement for a quasi-scientific proof that an event has taken place is that there be at least two individuals who have shared in the experience of that event, who can re-enact that event without communicating with each other in advance, that is, without rehearsal. If, for instance, husband A and wife B re-enact a certain scene X in which they have been participant actors as well as participant observers, they may be able to reconstruct that event with a fair degree of competence. We would assume, of course, that in such an experiment they would warm up each other to that recall, they would act it out and not only talk about it. After they have consciously enacted together an episode which they both remember, they may drift into episodes which they have both partially or entirely forgotten. In the course of such experimentation we have found a number of discrepancies. It is rare that the two partners perceive and re-enact that episode the same way, but there are some pure cases. (Category of pure but separate identity.) In a large number of cases each of the partners re-enacts their recall as well as certain aspects of the event of which the other partner is oblivious. We may say, therefore, that there is a portion a, with which partner A identifies himself; then there is a portion, b, with which individual B identifies himself, neither of them being able to recall the portion of the other (Category of mixed identity). Then there is a third category of relationship, a certain shared episode is not recalled by either of the two partners; in the course of the warm-up and re-enactment they stumble over some fragments and come to an agreement. This happens often to crucial parts of a common experience. (Category of common identity.) Summing up, there are certain episodes which are important to A, certain episodes which are important to B, and there are some important to both.

Our argument is, therefore, if A by himself could not re-enact the entire episode and B could not do so by himself, but if A and B could do it jointly, that it is plausible to postulate co-unconscious states. One may, of course, argue in favor of a different hypothesis, a science of signs (semiosis): A and B, being intimately related, may have developed in the course of the years a number of signs and symbols which they mutually recognize as meaningful, locus of physical objects, space signals, signs of avoidance, time conditions, sudden turns of the head, facial

a Chinaman—Che-chen; next to him I put a woman, a Parisian (*la*), who becomes Die in German (*di*); (*ritta*)—that's my assistant Margarita, etc., etc."

This note does not do justice to Dr. Luria's article by any means, it refers only to one aspect of it. The report deserves to be read in its entirety.

expressions, sounds and words, or sentences. But these motoric expressions and local signs also may have become a part of their co-unconscious constellations. The two hypotheses can be easily combined and tested. A great deal of research is still necessary to make the hypothesis of co-unconscious states plausible, but it has the advantage that we can work in the open with intimate ensembles of various sizes, change our hypotheses and establish an empirical basis for hypothetical construction.

IV. *Co-Unconscious States in Social and Cultural Contexts, A Forensic Psychodrama*

It has been conceived that co-unconscious states are the result of direct interpersonal experience between intimate ensembles of individuals. But they may be also the result of shared experiences on a social and cultural level. The personal contact of the intimate ensembles is then replaced by *indirect, transpersonal* or *symbolic* contact. The familial interpsyche is replaced then by a "cultural interpsyche." The sociodrama of a global group of participants becomes feasible as, for instance, in the case of the recent Eichmann Trial* in which common experiences shared by people from all walks of life were brought to enactment.

V. *General Discussion and Summary*

I have observed in the re-enactments of intimate and collective ensembles a number of rules. The memory of shared experiences differs in the partners. 1) Two or more individuals may supplement each other or be in conflict because one exceeds in visual perception of their common experiences, the other in accoustic or color perception, due to differences in their sensory apparatus. 2) Two or more individuals may supplement one another or be in discord with each other because their psychomotoric senses differ. One exceeds in sensitivity for locomotion clues; for instance, walking downstairs during the re-enactment he remembers that in the actual scene the stairs were curved and not straight. His partner, who was entirely blank for this locomotion clue, now that she sees herself taking part in that episode, is able to add to it her own reconstruction; at the bottom of the stairs she bows her head and kneels down in prayer. 3) In the enactment of their future, using the technique of future projection of how they expect to die, they expect that they are going to die together, but he sees the coming death in an explosion, she sees them being victims of an epidemic

* This was contained in Group Psychotherapy, Vol. XIV, No. 1-2, 1961.

scourge. Being in agreement or discord as to their "future" is often a clue for a harmonious or maladjusted relationship.

The relationship of co-conscious to co-unconscious states operates in various levels of intensity and depth. In some partners the co-conscious states of common experiences may be relatively high. Partners may have a near-photographic memory for certain events, for instance, for the first encounter, due to an extreme case of clairvoyance for each other. Or it may result from a long life of gradual acceptance, adaptation and integration, so that what they remember they both remember well, and what they hide from each other may have greatly decreased. Then there are partners who, although sharing experiences, have lived practically separate lives. Their range of co-conscious states may be weak and in small numbers. Their range of co-unconscious states may dominate their relationship.

One of the crucial problems in the area of interpersonal and intergroup relations is a physiological one, at least as far as our present knowledge goes. Each individual partner has his own brain which registers all *his* impressions, including the impressions he assumes his partner to have. What is true about partner A is equally true about partner B, C, D, etc. Each depends upon his own brain. This may be an adequate system for the single individual, but what is missing is an organ of *synchronization* of the physiological conditions of all the individual brains, brain A, brain B, brain C, brain D, etc., and of their epi-phenomenal counterparts, the brain C, brain D, etc., and of their epi-phenomenal counterparts, the psyches of these individuals. What is missing is a "co-brain," a "mankind brain." The fact that nature has not provided us with a *co-brain system,* a kind of unifying cerebral physiology of mankind, is probably the reason why sociometrists, sociologists, cyberneticists, anthropologists, religionists, etc., are trying to invent a substitute for such a brain. The sociogram, the sociomatrix, the automatic calculator, etc., are illustrations of such efforts. The experiments in extra-sensory perception, the training in tele perception and in spontaneity, might eventually in the process of evolution produce that co-brain, centuries or milennia from now. It will look then as if nature has provided us all along with such a synchronization organ. It will be a part of our world system, as well integrated into it as the cerebral cortex in the individual organism.

GROUP OATH*

This is the group oath to therapeutic science and its disciples.

Just as we trust the physician in individual treatment, we should trust each other. Whatever happens in the course of a session of group therapy and psychodrama, we should not keep anything secret. We should divulge freely whatever we think, perceive or feel for each other; we should act out the fears and hopes we have in common and purge ourselves of them.

But like the physician who is bound by the Hyppocratic oath, we are bound as participants in this group, not to reveal to outsiders the confidences of other patients.

Like the physician, each of us is entrusted to protect the welfare of every other patient in the group.

---

* Group psychotherapists and psychodramatists frequently feel the need to convey to the members of their groups, in the beginning or in the course of the sessions, what responsibility is involved for them during the process of treatment. The suggested group oath is not to be taken as a ritual, word for word, or as a dogma, but tries to convey the spirit of such an oath which may be expressed or silent, or tacitly accepted by all.

JLM

BOOK REVIEWS

GRUPPEN PSYCHOTHERAPIE UND PSYCHODRAMA, Einleitung in die Theorie und Praxis, by J. L. Moreno, M.D., George Thieme Verlag, Stuttgart, 1959, DM 48.00.

This book by J. L. Moreno represents the first authoritative and comprehensive textbook of group psychotherapy (in Moreno's interactional view of this concept) and of psychodrama in German. Its title does not convey that the book contains also a well rounded outline on 'Sociometry and the Pathology of the Group' (Chapter II, pp. 19-52). Following an introductory section on the History of his *triadic* system, sociometry-group psychotherapy-psychodrama, Moreno expounds the theoretical bases and the various modalities, categories, applications, etc., of group psychotherapy. The balance of the book is largely devoted to psychodrama, its origins, development, manifold applications, containing protocols of the psychodramatic treatment of matrimonial conflicts, of neuroses and psychoses (Chapters IV-VIII). The final chapter entitled 'The Group Psychotherpeutic Movement, A Global Survey' conveys his view of the future of this movement with the implications for the future of mankind in a hoped-for or postulated 'therapeutic world order', in contradistinction to the capitalist and to the communist world orders.

This book is a new creation in that it goes far beyond being a mere restatement of either his prior German writings between 1914 and 1923 and his subsequent American publications. Rather, it is a new concentrate of Moreno's thinking, a fresh enterprise attempting to win the minds of the readers in the German-speaking countries.

A translation of this new book into English is being prepared for publication by the Free Press (Division of McGraw Hill) and another into French is under the auspices of the Presses Universitaires de France; both are eagerly awaited and ought to bring the reader up to date on Moreno's latest thoughtways.

JOSEPH I. MEIRS, M.D.
New York City

"THE DIVIDED SELF, A STUDY OF SANITY AND MADNESS," by R. D. Laing Chicago Quadrangle Books, 1960, $5.00.

This erudite and exciting book introduces a fresh approach to the mind of the mentally ill. Dr. Laing desires to break through the barriers

set up by former classifications and systems and to explore the world of the psychotic. While not differing radically from the thinking of many mid-20th century therapists, he outlines his theories against a rich background of literary, historical and personal reference.

This volume is of particular interest to the group therapist because it deals principally with those people whose insecurity arises from their uncertainty as to whether or not they actually exist. As Dr. Laing points out, if these individuals recognize any part of themselves, it is the mind and it must be the goal of the therapist to help bring mind and body into union. These are the people who, I believe, can derive more help from a group experience than from individual therapy. By this I mean not the intermingling of patients as in a mental hospital, but the active leader-directed, goal-directed experience of group psychotherapy or psychodrama.

The book begins with an explanation of the author's motivation to write down his approach to the mentally ill. He feels that the tendency of psychiatry was to diagnose mental illness on the basis of the degree of difference between the psychiatrist and his patient. If the patient was different enough to be incomprehensible he would probably be diagnosed psychotic. Dr. Laing's experiences led him to feel that what these patients were saying to him did make sense and that they were comprehensible to a person who took the trouble to understand them. At first this caused him alarm and, eventually, understanding. The difference, he discovered, lay in the basic premise with which the patient began, namely, that he did not exist as an individual. Whatever being there was might belong to another person, or be spread out among a number of people, which led the patient to behave in widely divergent ways.

Dr. Laing makes his point with humility but with convincing persuasion. His book should be high on the 'must read" list.

MARGARET R. AMER, MSSW
Chatham, New York

August, 1961

"THE SOCIOMETRY READER," Edited by J. L. Moreno, The Free Press, Glencoe, Illinois, 773 pages, $9.50.

From Dr. Moreno's bold philosophical discourse on the *Social & Organic Unity of Mankind* to Jeri Nehnevajsa's brilliant paper *Sociometry: Decades of Growth,* we are afforded an intensive exploration of the various avenues that sociometry has opened up, and indeed, penetrated. An ap-

pendix that deals with global developments from 1950–1960 in sociometry, Dr. Moreno's review of *The Sociometric System,* and an Index, round out the 773 page volume THE SOCIOMETRY READER.

The book is divided into four basic sections: Part I-Foundations, Part II-Methods, Part III-Major Areas of Exploration, Part IV-History.

Part I is appropriately Dr. Moreno's "coup" with an assist from Helen Jennings. In presenting "Foundations," the founder presents his basic theoretical position and frame of reference. Here is an excellent source for the reader who would like to "tune in" on Moreno at his best. One cannot possibly convey, in a review of these writings, the remarkable insights and findings that Moreno presents as he discusses the Social Atom, the Theory of Interpersonal Relations, Tele, and other key concepts that are the cornerstones of sociometry. To whet the potential reader's appetite, one notes the vastness of the author's scope. Take for example, a few sentences from *Theory of Interpersonal Relations.* In considering psychogeography, perhaps the sociometric action version of human ecology, Moreno concludes magnificently and with great vision: "Is there any relationship between the attraction-repulsion patterns linking two houses and the physical distance between them? Is it possible that an excess of nearness retards healthy group formation just as much as an excess of distance? Which type of architectural organizations of a community stimulate group formation and which discourage it? What is the relationship of esthetic factors, such as the unattractiveness of the houses and street patterns in city slums and ghettos, to the development of social contacts and sociometric group formation? *The architect of the future will be a student of sociometry;* the site of cities, industrial plants, and resort places will be chosen so as to meet the needs of the populations living and working in them." It is this kind of expansive, cosmic concern that reveals the genius of the author, and his philosopher. Sociometry, as it permeates from this matrix, is a fulfillment and a merging in a sense, of both of these attributes.

Part II confronts us with an impressive array of research methods, and attempts to submit sociometric concepts to measurement. Joan Criswell, in introducing this section, notes that there is vigorous development in this direction. It would be unfair to single out any one paper in this section as well as in Part III without doing disservice to other contributors. This reviewer's personal interests in role-playing and measurement of role-playing capacities would necessitate further discussion of the paper, *Role Playing Skill & Sociometric Peer Status,* by Mouton, Bell and Blake. The interests of readers in other aspects of methods and measurement will be well satisfied by other papers in this section.

Part III covers a broad spectrum with consideration given to studies of leadership, problems of adolescents, community relations, formal and informal social systems, distance and friendship, decision-making, teacher judgments, morale, emotional interaction, all subjected to careful sociometric scrutiny and interpretation. The attempt to develop more refined methods and tools to help us to understand the nature of men in relation to their environment, is most noteworthy. One is struck by the degree of responsibility and seriousness of purpose in these studies. Further, the reviewer feels that we are past the point of talking about "pioneer works" and "crude instruments." Sociometry, the book loudly proclaims, is a full-fledged science, and one might even argue, the only social scientific approach that has the potential to keep pace with man in action, man intent in his pursuit of self-destruction, and alienation, and, at the same time, in pursuit of life and commitment and engagement.

Part IV affords a most scholarly summary of the province of sociometry, its past, present, and great potential for the future. Nehnevajsa raises controversial propositions concerning Moreno as well as sociometry and then deals with these with warmth and understanding.

A concise resumé of the intent and purpose of sociometry appears in Nehnevajsa's section on *Sociometric Theory: Its Meaning.* The challenge for future researchers and theorists, therapists and teachers to move toward more effective coordination is set forth in the section *Sociometric Vistas.* There are 22 sections to Part IV, each of them, as indicated by the two above-mentioned sections, a brilliant abstract of vital areas that concern sociometry and social scientists. The final section *Ask A Question,* asserts that small group research holds an important key to our understanding of societies and cultures, as well as to individual behavior.

It is difficult to conclude this review without urging the reader to secure the book, partly to excuse the reviewer for leaving out so much that should be read and learned. As in every encounter with Moreno, and his vigorous disciples, one can learn not only about society and group processes, and so forth, but one is ultimately confronted with learning about and seeing one's self as part of the vast network of sociogenetic processes that Dr. Moreno has unfolded before us.

EUGENE ELIASOPH
Director of Social Service
Berkshire Farm for Boys
Canaan, New York.

August 3, 1961

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND AND PSYCHODRAMA

Election Results

The ballots on the increase of dues show the votes of the majority of the members to agree to the increase of dues as stated thereon. Therefore, Members will pay $12.00 per annum, Associate Members $6.00 and Fellows $20.00.

Next Annual Meeting

The meeting will take place April 6, 7 and 8, 1962, at the Hotel Sheraton-Atlantic, and at the Moreno Institute, New York City. Send outline of papers to: American Society of Group Psychotherapy and Psychodrama, 236 W. 78 Street, New York 24, N.Y.

Local Chapters

The Southwest Chapter of the Society has been actively engaged in meetings and conferences in St. Louis. Persons in this area are requested to contact Leon Fine, Psychodrama Dept., St. Louis State Hospital, 5400 Arsenal Street, St. Louis, Mo.

Miss Hannah B. Weiner is President of the New York Chapter. The next annual meeting of the chapter will take place on Nov. 17, 18 and 19, 1961 at the HOTEL HENRY HUDSON. For participation on the program, contact Hannah B. Weiner, Moreno Institute, 236 W. 78 Street, N.Y. City 24, N.Y.

Membership Applicants

Persons interested in joining the national organization may obtain membership blanks and information on the Society by writing to the Secretary: Miss Mary M. Angas, Linden Gate, Old Beach Road, Apt. 2, Newport, R.I.

ACADEMY OF PSYCHODRAMA AND GROUP PSYCHOTHERAPY

Next Annual Meeting

The forthcoming annual meeting of the Academy will take place in Toronto, Canada, at the Royal York Hotel, May 6, 1962. Chairman of the Academy is: Dr. Calvert Stein, 38 Chestnut Street, Springfield, Mass., and contributions to the program are now being invited.

The program is meant to present a "Capsule of Life", showing the application of psychodrama and group psychotherapy from the pre-natal level up to the preparation for and acceptance of death.

Academy Training Sessions, Beacon, N.Y. and New York City

The agenda for training sessions throughout the year now runs as follows:

November 23–December 6, 1961. February 17–March 2, 1962.
December 23, 1961–January 7, 1962. March 17–30, 1962.
January 20–February 4, 1962. April 14–27, 1962.
May 12–26, 1962

For registration and information, write: P.O. Box 311, Beacon, N.Y.

Industrial Training Session, New York City

A three-day workshop for *Problems of Human Relations in Industry* is scheduled for October 17, 18 and 19. For registration and information write: Moreno Institute, 236 W. 78 Street, New York 24, N.Y.

World Academy of Psychodrama and Group Psychotherapy

A World Academy of Psychodrama and Group Psychotherapy embracing all national Academies, the American, French, Spanish, etc., is being organized with headquarters in Paris and New York. For further information write to: 236 W. 78 Street, New York 24, N.Y., or to: Mrs. Anne Ancelin Schutzenberger, l'Institut Pedagogique National, 29, rue d'Ulm, Paris 5e, France.

Recognized Training Centers

There are at present four recognized training centers for group psychotherapy and psychodrama—The Academy in Beacon, N.Y., The Moreno Institute in New York City, St. Elizabeth Hospital's Psychodrama Department, Washington, D.C., and the St. Louis State Hospital Psychodrama Department.

The newly formed French Academy of Psychodrama and Group Psychotherapy in Paris is now being considered for similar recognition.

AMERICAN BOARD OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Applicants for Diploma

Applicants who wish to obtain a Diploma in Group Psychotherapy and/or Psychodrama may write to the Secretary of the Board, Mrs. Zerka T. Moreno, 236 W. 78 Street, New York 24, N.Y.

Applicants may be members of *any* of the existing societies of group psychotherapy or psychodrama. Evidence of qualification, training and experience must be submitted. For further details readers are directed to *Group Psychotherapy,* Vol. XIV, No. 1–2, March-June, 1961, p. 105, as well as the statement on minimum professional standards from p. 97-104 in that same issue of this journal.

At present there are a number of persons who may be considered for a diploma under the "grandfather clause." Their records are being carefully scrutinized. The grandfather clause is applicable to all pioneers in the broadest sense of the word.

1. Their contributions and experience may be, among others, in the field of research, methodology, testing, diagnosis, counseling or therapy.

2. Their professional status may vary widely. Considering that group and action methods are indebted to many behavioral, social and mental sciences, their status may be that of a psychiatrist, psychologist, sociologist, anthropologist, psychiatric social worker, social worker, nurse, educator, minister and/or allied fields.

3. The pioneering contribution may be in the field of creative thinking and writing, in the field of administration and organization of new ideas, in the origination of new journals and monographs in these fields which paved the way for the wide communication and distribution of pertinent ideas and methods.

4. Persons who have been proposed under the grandfather clause are, therefore, not only creative writers and thinkers but hospital administrators and organizers of societies and training institutes as well as scientists dedicated to basic research and laboratory work.

MORENO INSTITUTE FOUNDERS FUND

The following have sent in contributions to the Fund since the publication of the listing in the last issue:

Dr. Abraham Knepler
Dr. Benjamin Kotkov
Dr. Herta Riese
Dr. Alexander Bassin
Dr. Peter Angelos
Dr. Arthur Kramish
Dr. Lucy Schnurer
Mr. Jerry Fields
Dr. Dorothy W. Baruch
Mr. Don Murphy

On Sunday, October 15th the unveiling of the plaque will take place in the presence of Dr. J. L. Moreno, Life Fellow of the American Psychiatric Association. All 154 sponsors of the Fund are herewith invited to participate in the ceremony.

ANNOUNCEMENTS

The Eichmann Trial

In response to the event of the psychodrama presentation of the Eichmann trial in Chicago on May 7, 1961, a large number of responses have been received. From Israel four responses of distinction came, one from Prime Minister David Ben Gurion, the second from Gideon Hausner, Prosecuting Attorney, the third from Dr. Henrik Infield, Hebrew University, Jerusalem, the fourth from Dr. Hans Kreitler, College of Tel Aviv.

New Publications Abroad

Dr. D. Widlöcher, of the Children's Service at the Salpetriere in Paris is coming out with a new book on psychodrama entitled *Le Psychodrame de l'Enfant,* to be published by the Presses Universitaires de France in the autumn of 1961. The same publishing house will release the French translation of J. L. Moreno's German book by Thieme Verlag early in 1962.

Editorial Paidos in Buenos Aires is publishing a Spanish Translation of Moreno's *Who Shall Survive?* Editorial Horme of the same city will release a Spanish translation of Moreno's *Psychodrama, Volumes I and II.*

Dr. and Mrs. J. L. Moreno Honored

Le Groupe Francais d'Etudes de Sociometrie, Dynamique des Groupes et Psychodrame held a reception in honor of Dr. and Mrs. J. L. Moreno at the Hotel Lutetia in Paris on September 5, 1961.

REGISTRATION BLANK FOR ACADEMY OF PSYCHODRAMA AND GROUP PSYCHOTHERAPY

AGENDA FOR 1961-62

At the New York City Center:
Industrial Training Sesions, October 17, 18 and 19, 1961
Methods of Psychodrama and Group Psychotherapy, March 23, 24 and 25, 1962

Fee: $25.00 per day; $75.00 for entire Workshop

At the Beacon, N. Y. Center:

November 23–December 6, 1961
December 23–January 7, 1962
January 20–February 4, 1962
February 17–March 2, 1962
March 17–30, 1962
April 14–27, 1962
May 12–26, 1962

Fee: $25.00 per day; $75.00 for three day period; $90.00 for four day period $140.00 for one week period; $260.00 for two week period.

Mail Registration blank below with registration fee of $5.00 to:

THE ACADEMY OF PSYCHODRAMA AND GROUP PSYCHOTHERAPY

259 Wolcott Avenue, Beacon, N. Y.

Or to

MORENO INSTITUTE, 236 W. 78 Street,
New York 24, N. Y.

Gentlemen:

I am herewith enclosing my check for $5.00 as enrollment for:

From ..... to .....
Name .....
Address .....
Professional Connection .....

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. Elizabeths 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)