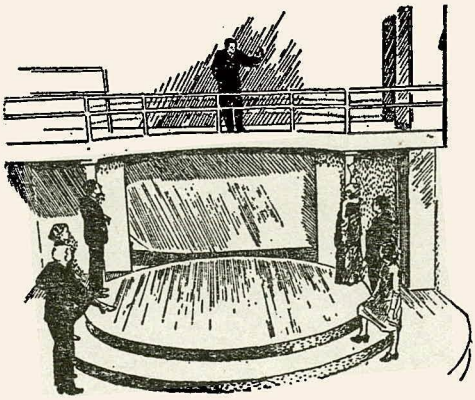
GROUP PSYCHOTHERAPY

A Quarterly



23rd Annual Meeting
Hotel Statler Hilton, Washington, D.C.
April 3-5, 1964

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY
AND PSYCHODRAMA

Vol. XVI, No. 3, September, 1963

GROUP PSYCHOTHERAPY

Volume XVI September, 1963 Number 3

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FOUNDED BY J. L. MORENO, 1947

GROUP PSYCHOTHERAPY

Volume XVI September, 1963 Number 3

Beacon House Inc.
Beacon, N.Y.

GROUP PSYCHOTHERAPY

Volume XVI | September, 1963 | Number 3

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: $12.00, including subscription to this journal.

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

THE ACTUAL TRENDS IN GROUP PSYCHOTHERAPY*

J. L. MORENO, M.D.
Beacon, New York

This is a democratic Congress in which all methods, major or minor, have been given a place in the sun. Its very organization is based on a process of democratic legality. Group psychotherapists have come to Milan from all over the world. Many of the scientific stars have taken a backseat in order to give the new generation a word. Although the most important forerunners have been doctors of medicine, group psychotherapy is not an exclusively medical discipline. Scientists from many disciplines have made contributions toward it, psychologists, sociologists, educators, ministers and others, and they have received a fair representation on the program of this Congress.

HISTORIC OVERVIEW

When group psychotherapy began forty years ago its period of scientific discoveries, it was important to point out its essential characteristics, to guard its independence and to develop its own concepts and terms. A great deal of the controversy in the early years of the group psychotherapy movement was caused by its attempt at emancipation, the determination and desire to establish a new field of research, and to delineate its boundaries. Our position has still not changed in essence, we are still fighting on two fronts. It is like a young nation trying to ward off enemies from without; applied to our case, it is the struggle to distinguish ourselves from psychoanalysis, existentialism, social psychology, among others. And also like a young nation, the movement is plagued by internal rivalries, the enemy from within.

EARLY VISION

The dawn of a new science is often hidden in the clouds of an inspired vision. It begins as poetry, as a prophecy. Group psychotherapy is not an exception from this rule. Here follow the illustrations of three of its forerunners, in their chronological order: Moreno, Burrow and Marsh.

Moreno envisioned the coming of a therapeutic world order, in contrast to the religious world order of the past and the political world order of the present. Here follow some significant quotations of his earliest vision:

* Abridged Presidential Address read at the Third International Congress of Group Psychotherapy, Milan, Italy, July 18, 1963.

(*a*) From "Einladung zu einer Begegnung" (Invitation to an Encounter), 1914. It initiates the concept of the encounter, interpersonal dialogue and role reversal.

> "A meeting of two: eye to eye, face to face.
> And when you are near I will tear your eyes out
> and place them instead of mine,
> and you will tear my eyes out
> and will place them instead of yours,
> then I will look at you with your eyes
> and you will look at me with mine."

(*b*) From "Rede über den Augenblick" (Speech About the Moment), 1922, page 22. "How can we be present in the Here and Now? A feeling must be related to the object of the feelings, a thought must be related to the object of the thoughts, a perception must be related to the object of the perceptions, a touch must be related to the object of touching. You are the object of my feelings, the object of my thoughts, the object of my perceptions, the object of my touch. This is an encounter in the Here and Now."

(*c*) From "Rede über die Begegnung" (Speech About the Encounter), 1923, page 24-25. The following words postulate the need for a therapeutic world order. "There are situations for one, there are situations for two, there are situations for more than two, there are situations for all existing beings. When a situation is so structured that its problems are attached to one, then they can be solved by this one to whom they are attached, but if a situation is so structured that the problems are not connected to one only but to two, then they can not be solved except through both the two of them who are involved. But if a situation is so structured that it involves numerous individuals, more than two, then the problems can not be solved except by all the ones who are involved, but when finally a situation is so structured that the problems involve *all* beings, then they can not be resolved but by *all* who are involved in them."

Thus the early Moreno tried to do through group psychotherapy what "religion without science" has failed to accomplish in the past and what "science without religion" has failed to accomplish in the present. He envisioned society as the patient. He anticipated that we have to go beyond psychiatry and develop "sociatry," the study of the pathology of human society as a whole.

Burrow, in a dark, philosophic language, gropes in a similar direction (The Group Method of Analysis, 1927). It appears to him "that in his

separativeness man has inadvertently fallen victim. . . . " "Man is not an individual, he is a societal organism." Burrow emphasizes "the inadequate basis of the private method of analysis. . . ." "The continuity of the group and the isolation of the individual are processes which are exclusive of one another."

Cody Marsh expresses it as follows: "The students who clustered about Pythagoras, Socrates, Zoroaster, were partly seekers for knowledge, but were also seekers for emotional help. They conducted the so-called peripatetic schools wherein the students walked about with the teacher as he talked. The physical effort involved in these walks, probably combined with the instructor's teachings, to make a form of group therapy as well as a form of education." (1935, *The Journal of Nervous and Mental Disease*, Vol. 82).

Philosophy of Group Psychotherapy

The first question which can be raised is: why group psychotherapy? Adjustment may make human relations sterile. Maladjustment may make them more spontaneous. A sane world may be stereotype, an insane world may be creative. The question: why group psychotherapy, falls into the same category as: is eating, sleeping and reproduction necessary? They are a matter of survival. Living in groups is also a matter of survival. There is no alternative, to live in groups or not to live in groups, we are existentially stuck. Group therapy is a process which goes on regardless of whether it is done by means of scientific methods or not. The answer is that ongoing, unorganized group psychotherapy can be improved by scientific methods.

The second question is: if the individual is only a fragment or a part of reality, what is real and more comprehensive? Our answer was that however real the individual is, the group is a greater reality and includes it. Mankind is a greater reality still than the groups and the universe at large includes all individuals, all groups and all possible mankind. In Moreno's philosophy the essence of the universe was its creativity-spontaneity. The development of physical and cultural conserves with the latter getting the upper hand more and more, led to the pathology of man, who became deficient as a spontaneous and creative agent. The objective of group psychotherapy became, therefore, to stimulate and train man's spontaneity and creativity, in the vehicles in which he naturally exists, that is, in groups.

With different connotations, Burrow asked the same question. His answer was: the individual is an illusion, the race—phylum—is the real reality. We have to analyze the group through phyloanalysis and return the

I into the phylum. Burrow's query was how to integrate individual man into the bioracial groups from which he has separated himself.

The neurosis of man has been visualized by the theoretical forerunners of group psychotherapy in various ways. It can be best expressed in terms of the fundamental process of alienation from reality. For Marx, for instance, who can be considered as a forerunner of theoretical group psychotherapy, the cause of the neurosis is the *economic* alienation of man, the fragmentation of man's productivity in the work process. For Burrow the cause of the neurosis is *biological* and *phyloanalytic* alienation of man, the separation of his I from the total phylum. According to Moreno the cause of neurosis is the *cosmic* alienation of man, his alienation from the essential meaning of the universe, its primary creative processes. It stands to reason that the philosophy envisioned by these early leaders would determine to a large extent the type of method which they sponsored and the kind of operations they considered significant. Marx found it indispensable to solve the economic alienation of man by a social revolution in which the working man becomes the top figure in the hierarchy of values. Burrow turned from verbal group therapy to the study of the distortions of the physiological condition of the individual produced by his separateness. He engaged, therefore, in physiological experiments and abandoned the group vehicle. Moreno saw a remedy in developing methods which would train and retrain the behavior of individuals and groups in terms of their spontaneity and creativity. He claimed that the economic and the biological neurosis of behavior are interlocked and related to the more primary neurosis of spontaneity and creativity.

Hypotheses and Theories

The next step was to go beyond philosophy. Psychotherapy is the treatment of the single individual, for instance, by psychoanalysis. Group psychotherapy is the treatment of a group of individuals, for instance, by psychodrama. What can science and scientific method do to move from an unorganized, existential group psychotherapy towards a scientifically oriented group psychotherapy. Following the model of clinical medicine we considered diagnostic procedures as the first step, not individual diagnosis, but group diagnosis, focusing upon the study of the free, spontaneous actions and interactions within groups.

Group diagnosis can be made on the basis of methods of observation, of interview and group tests. Widely used group tests are the role test and the sociometric test. The sociometric test proved particularly useful. This

sociometric test (the term is derived from *metrum* and *socius*, i.e., measurement of a person's relationship to his fellow-men) is based on the following principles: the individuals of the group are asked to select (or exclude) from its membership a number of associates on the basis of a clearly defined yardstick, such as, say: "With which of your comrades would you prefer to go into battle?"—or: "With which members of the group would you most like to work together in one room?"—or: "Which members of the group would you most like to have as co-patients?" The results are reproduced graphically in the form of a "sociogram": the individuals are indicated by circles (females) or triangles (males), and the interpersonal relationships by connecting lines in various colors, e.g., sympathy by a red line, antipathy by a black one, etc. The sociogram gives a reliable picture of the degree of cohesion of a particular group and of the psychological currents within it. It also shows the sympathetic and antipathetic currents flowing towards a particular individual. Some individuals emerge as favorites in one or other respect, while other structures (e.g., pairs, triangles, chains) show which individuals exhibit an affinity for one another.

The emergence of certain definite structures is not a haphazard phenomenon but is determined by the degree of maturity of a particular group. From this we deduced the so-called "sociogenetic law," which states that higher forms of group organization always proceed from simpler forms. In its ontogenetic development, the group organization is to a large extent a mirror of the form modifications which succeeding prehistoric communities of the species have undergone in the course of their development. An individual may enjoy a low sociometric status while exhibiting sociogenetically a higher stage of development. This explains why in school sociograms, for instance, a certain pupil often remains isolated because his social and emotional development is more advanced than that of other members of the group. The most popular individuals in a sociogram are frequently those belonging to the same sociogenetic grade. Even where the test is repeated and the possible choices extended, the sociometric structures—so far from changing on the lines of a mathematically calculable probability—in fact constantly yield similar results.

From this recognition developed the "sociodynamic law," which lays down that sociometrically isolated individuals, i.e., those who appear isolated, unnoticed, or little noticed in the sociogram tend to remain isolated and little noticed in the formal social structures also; moreover, the greater the number of social contacts, the more marked this isolation tends to be. Conversely, individuals who appear markedly "favored" in the sociogram tend to remain

favored, the more so in proportion to the number of their social contacts. This sociodynamic principle affects the group in exactly the same way, riding roughshod over all economic and cultural barriers and setting up new standards of "rich" and "poor," namely "emotionally rich," and "emotionally poor." These sociometric differences which evidently exist in our society, are of immense importance for psychotherapeutic situations. It has, for instance, been recognized that an individual's chances of success and satisfaction in the psychological, social, and economic spheres depend on his sociometric status. It has also been observed that sociometrically isolated individuals tend to be less successful when applying for jobs and seem to be more prone to industrial accidents than the "favored" ones and those who find it easier to work together with others.

Sociometric researches led to the discovery of two further laws, viz., the law of "social gravitation" and the law of the "interpersonal and emotional network." In the medical domain, the introduction of "perceptual sociometry" has proved particularly valuable. In this, the individual draws a sociogram of the individuals living with him in a group situation, i.e., their perceived relationships both with one another and towards himself. This sociogram is then compared with another sociogram based on objective selection. Disorders of social perception, as revealed by this comparison, are particularly characteristic of psychotic individuals, e.g., paranoid subjects and schizophrenics.

In the course of years several hypotheses have been formulated. (1) Groups have a matrix of interpersonal relations, a specific social structure which can be explored, defined and measured by means of well calculated group methods. (2) The social matrix is an interpersonal network. Disturbances within it can be observed, tested and recorded by means of sociograms, actograms and role diagrams. (3) Structural changes take place in groups according to several factors, age, race, sex, economics and culture. (4) Groups grow like "trees." They have a specific sociogenesis. One can study the evolution of groups from the unstructured level at birth to their horizontal and vertical ramifications in later years. (5) Groups develop cohesiveness and stability. The factor which holds groups together is called *tele* in contrast to transference which tends to dissociate them.

The analysis of the sociograms forms the basis of which the plan of treatment is then drawn up. The first problem is to establish whether a particular individual requires treatment or the entire group, also what changes in the group structures are desirable in order to promote normalisation of these structures, harmonisation of the entire group, and hence also

the restoration of the individual to emotional health. This is obtained by means of group psychotherapy and psychodrama.

Although the structure of such a science of the group is still in its infancy, significant steps have been made by sociometry, microsociology, group and action research, which justify great hopes for the future.

The Scientific Method and Group Psychotherapy

All group psychotherapists have come to agree that a *science of the therapeutic group* is basic to the establishment of scientific foundations of group psychotherapy.

But how is a science of the "therapeutic" group possible? It is often considered in conflict with the demands of pure basic science. The advent of group psychotherapy has had a revolutionary impact upon the orthodox, customary meaning of the scientific method which John Stuart Mill developed after the model of the physical sciences. Mill had come to the exasperating conclusion that the experimental method can not be applied to the social sciences, their subject matter being too complex; eo ipso, it could not be applied to a science of the group thus making group psychotherapy an anecdotal, second-class science. My argument was (see my book "Who Shall Survive?", 1934, and "Sociometry, Experimental Method and the Science of Society," 1951), contrary to the model postulated by physical science that group research, whether under laboratory or in situ conditions, *must* appear of *consequence* to the subject. The subjects must be motivated, they must expect to be helped, or potentially helped, by the process. If the subjects are cold themselves, uninvolved in the outcome of the research, it has no tangible validity. The very fact that the methods of group psychotherapy are so constructed that the patients are subjectively participating, involved in the process and expecting beneficial results from it, has given the patients the "status of research actors" and the experimental method in social science a new slant. Every group psychotherapy session, (analytic, discussional or psychodrama), is an experiment. Cold laboratory experiments carried out by academic social psychologists with subjects who are unmotivated and uninvolved from within their own depth, are of questionable value. In this context, indeed, we are in full accord with Mill.

How to set up a group psychotherapy experiment and a comparable control group which permits rational evaluation and measurement, became the earliest task of sociometry and of sociometric group therapy. All schools of group psychotherapy have explicitly or implicitly followed this thought,

and have tried whenever possible, to go beyond the anecdotal evaluation of the group process and set up experimental situations.

Group Methods

Group psychotherapists are in agreement with the principles of group psychotherapy elaborated above, but they differ widely as to the methods. Let us enumerate some of the most characteristic ones.

Methods of Group Psychotherapy

(a) *Socioanalytic group psychotherapy.* Here the elucidation of the group structure is the central problem. Sociometric methods are used. The individual is not seen in isolation but in interaction with the other members of the group. Individual, group and milieu analysis are part of a comprehensive socioanalysis. The indications for treatment rest upon scientific experiment and not upon the postulation of intuitive hypotheses. As the knowledge of group structure grows the therapeutic operations change with them. Socioanalytic group psychotherapy is behavior and action-centered. It uses adjuncts like psychodrama and behavior training in order to mobilize the deeper recesses of the group. The sociometrist and psychodramatist operate in the here and now and prepare the patients for the encounter of future situations.

(b) *The group analytic approach.* It leans heavily upon psychoanalytic concepts but recognizes that the group has a configuration of its own and refutes the idea that the group is the place to analyze transference neurosis. It emphasizes the difference between group analysis and psychoanalysis. It leans upon Moreno's sociometry and Lewin's field theory.

(c) *Psychoanalysis of groups.* A distinction is being made between group analysis and group "psycho" analysis. The group psychoanalyst must be first of all a psychoanalyst. It is the practice of psychoanalysis within a group, by means of free association, dream interpretation, and the analysis of transference neurosis. It is all like in individual analysis except for the group setting which is merely an "adjunct" to individual psychoanalysis. Without the individuals there are no groups. Every group patient has to undergo a preliminary individual psychoanalysis.

(d) *Group dynamics.* The members of the group suppress their identity as "private" individuals. They are engaged in symbolic interactions. The sessions are conducted in the present tense. Role playing may be engaged in, however, it has no therapeutic involvement, it is nominal and symbolic.

Group dynamics is especially used for training aims in groups, for instance, in industry. Just as group psychoanalysis underplays the group, group dynamics operates as if the individual does not exist.

(e) *Eclectic group psychotherapy.* It combines many methods, socio-analysis, group analysis, psychodrama, hypnosis, drug therapy, autogenic training, etc., and has made numerous original contributions.

(f) *Group oriented psychodrama.* It adheres mainly to five principles: warming up, spontaneity, acting out, group cohesiveness and group catharsis. The term spontaneity was forty years ago an expression of reflexive behavior. After many ups and downs it has become a respectable catalyzing agent even among the most orthodox psychoanalysts. The value given to acting out has gone through equally dramatic transformations and it is now generally agreed that "therapeutic acting out" is possible in a supervised setting. Minor forms of acting out take place in the course of all types of group sessions. The protest against considering acting out as a therapeutic device was maintained as long as it was assumed that acting out increases the resistance to therapy. But how can we resolve resistances in the sense of the orthodox psychoanalyst unless the forms of resistance are brought to the surface so that they can be observed, treated and validated by scientific methods? Freud has pointed out that the task of psychoanalysis is the resolving of resistances. But how can we dissolve them unless we put the patients into operation so that they expose the conflicts underlying these resistances, unless we encourage them to act them out in order to dissolve and to control them?

(g) *Multiple group psychotherapy.* Early psychodrama used in addition to the chief therapist, a team of co-therapists, auxiliary egos. In recent years the use of two therapists, two males, or one male and a female, or two females, has become frequent. In group psychodrama multiple psychotherapists help to structure a miniature society. In group therapy they may duplicate the pair of parents in the natural family. They facilitate communication although they often mobilize new conflicts between the therapists.

(h) *Family group psychotherapy.* Group psychotherapy is family-centered. The group is already given in its natural constellation, in contrast to the synthetic group formation of the clinic. The family is the patient, not the single individuals within it. The sociograms of homes and families and their exploration by means of observation, psychodrama and role playing

opens a new vista for the mental hygiene of family life. The center of therapeutic attention is the actually existing family, and not a group to be constructed. In intimate ensembles like the family the study of co-conscious and co-unconscious states offers productive clues.

(i) *Marriage therapy.* Marital partners are treated jointly with all the individuals pertinent to their problems. Psychodrama is the method of choice but also interpersonal therapy is of advantage; confrontation techniques are often useful.

(j) *Bi-focal psychodrama and bi-focal group psychotherapy.* Groups of parents and children are treated separately, one a mirror of the other. Groups of mental patients and their families are treated side by side in separate sessions.

(k) *Didactic group psychotherapy.* Group therapy through lectures or through textbooks.

(l) *Therapeutic Community.* It is an offspring of group psychotherapy. In its modern, scientific form it was rediscovered by Moreno in 1931; in a therapeutic community all individuals are involved in a process of reciprocal participation, not only as patients but as members of that particular society.

Recent outstanding developments were reported in Scotland, Dingleton Hospital; in USA, Fort Logan Mental Health Center, Denver, Colorado; in Lubec, Czechoslovakia; in Milan, Italy; and in Paris, France.

(m) *The total, all-inclusive therapeutic community.* The therapeutic community is carried to its extreme, similar to the Ghetto of Prostitutes in Vienna (1913) and the sociometrized communities in the depression period in the USA in 1933. Refugees, mental patients or drug addicts (Synanon) live together in common houses or communities, engaged in mutual, therapeutic interaction. Life is entirely open; therapy is all-inclusive: housing, living quarters, menage, clinic, and sex are parts of a single package. The patients help each other; professional therapists are excluded, discipline, restraint and punishment are self-imposed.

(n) *Treatment at a distance.* The case of a young girl who suffered from a violent, acting-out disorder was reported. It became apparent that the psychotherapist should be eliminated as a contact person, and a young girl was employed to live in the patient's home to help her. The hired girl became the substitute, the "double," who came to the psychotherapist at regular intervals with the parents of the patient, so that the patient could be treated "in absentia." The double portrayed the way the patient acted, and was guided by the therapist in how to interact with her charge in life situations. It was a kind of bifocal psychodrama in which the treatment at a

distance was linked to an actual person, an auxiliary ego, and was carried out in two places, in the home and in the clinic.

(o) *Telephone therapy.* The telephone, an intensive part of our technological culture, is becoming increasingly also a therapeutic instrument. In a telephone circuit, patients and therapists communicate with each other. If the technologist could replace the "audio telephone" by a "video telephone" the patients and therapists could not only hear but also see each other in action. This might make telephonic psychotherapy a better adjunct to the real process.

(p) *Group hypnosis.* Group hypnosis is frequently used as an adjunct to group psychotherapy.

(q) *Hypnodrama.* The warming-up process in a psychodrama can be supplemented by hypnotic trance.

(r) *Drug induced group psychotherapy and psychodrama.* The effect of LSD-25 is greatly facilitated by treating the patients in groups. Psychodrama has been used to structure the vague feelings and hallucinations of the patients.

(s) *Television psychodrama.* Psychodramatic treatment of alcoholic groups has been effectively supplemented by mass media of communication, such as television.

(t) *Therapeutic motion pictures.* Motion pictures are used as adjuncts to group psychotherapy and psychodrama sessions. They are effective in stimulating the warming up of the patients. A number of motion pictures have been produced which feature psychodramatic techniques like the double technique or role reversal. The film "David and Lisa" is a commercialized example of a therapeutic film.

(u) *Social psychiatry and sociatry.* Emphasis is moved from the individual and the group to the larger environment, ecological and epidemiological studies prevail.

(v) *Training methods.* Version A: the budding group psychotherapist and psychodramatist is trained within an ongoing group psychotherapy session with actual patients. This method of training is practiced increasingly by the majority of group psychotherapists. The training period required is a minimum of two years. Version B: the position of group psychoanalysis is that the budding group psychotherapist has to undergo as an indispensable part of his training a comprehensive individual psychoanalysis.

(w) *Mass psychiatry and the open public session.* This is a forerunner of mass psychiatry. Psychodramatic sessions are directed for large audiences. They often take the form of a sociodrama. The audiences amount to

anywhere between twenty to several hundred. The sessions portray common problems and are characterized by intensive audience participation. The treatment of large numbers is in contrast to the small groups of seven to ten in clinical settings. They have become a part of the therapeutic culture in New York City and other metropolitan centers in the USA. One can visualize the combination of these large public sessions combined with the medium of television so as to reach and treat millions of individuals simultaneously. It will represent a kind of mass prophylaxis fulfilling the first sentence in the author's "Who Shall Survive?" (1934), "a truly therapeutic procedure cannot have less an objective than the whole of mankind."

Highlights of the Plenary Sessions of the Congress

(A) The Presidential Address pointed out the reasons for the large attendance from countries all over the globe in the successful modification of group methods adapted to new cultural settings—and the growing integration of the various methods towards a common goal.

(B) The address of Professor Hans Hoff, University of Vienna, on Psychosomatic Medicine and Group Psychotherapy, pointed out the value of the group methods for psychosomatic ailments.

(C) The discussion of the various forms of psychodrama—classic psychodrama, USA; analytic psychodrama, France; and symbolic psychodrama, Austria and Germany.

(D) Debate of the relation of Freud to group psychotherapy led by Professor Ramon Sarro, Barcelona University, Barcelona, Spain. Outcome: Freud's work has had an indirect impact upon group psychotherapy, but group psychotherapy has been able to create its own concepts, terms and methods without however disregarding its debt to the long history of philosophy and psychiatry reaching back to Hypocrates, Aristotle and Socrates.

(E) The Volume of Proceedings of the Third International Congress of Group Psychotherapy is being prepared with over two hundred contributions.[3]

Synthesis and Future Objectives

We must face realistically all the fronts in the group psychotherapy movement, scientific, clinical, cultural, political, its growth as well as its spread. The movement has become easily the most popular and influential among the psychotherapies of our time. But in the rapid spread there is

[3] For pre-publication orders write to International Council of Group Psychotherapy, P.O. Box 311, Beacon, N.Y.

danger that the movement may go out of hand. The many trends and subforms, although a sign of productivity and progress, threaten to break it up from within into fragments.

All senior group psychotherapists who have worked, often continents apart, remember that we have gone through: (1) *a period of discovery,* between 1910-1945 in which concepts, principles and methods were discovered and re-discovered. This period of discovery seems to have substantially come to an end since the Second World War. Then followed (2) *a period of controversy and growth* during which the First International Committee of Group Psychotherapy was born, 1951, and two international Congresses took place, one in Toronto, 1954, and one in Zurich, 1957. It was a difficult time between 1945 and 1957, but the movement has survived its greatest challenge, the rivalries from within. I believe that with the new International Council and the current International Congress, a new period has been launched; (3) *a period of integration.* It is our hope that within the next period, group psychotherapy and its associated disciplines prove themselves to be the greatest development in psychotherapy in our century, symbolizing the Third Psychiatric Revolution.

1. Our first task is to maintain, if at all possible, the *unity* and *continuity* of the movement.

2. Next in importance is to maintain the *identity* of the movement. The movement has a common name, generally accepted as group therapy and group psychotherapy. A common name is indispensable, just like Darwinism, psychoanalysis, Cybernetics, in the scientific field. We should encourage various scientific innovations in the field, e.g., group psychotherapy, sociometry, group analysis, family therapy, psychodrama, etc., but we should maintain a common overall name by which we are known.

3. Another matter of supreme importance for a scientific movement is the quality of the methods used, the soundness of its theory, and their validation. They should be repeatedly examined and continued progress should be made in this area. The foremost desideratum of a scientific-therapeutic theory is that it works and that it is valid.

4. Methods of group therapy have to be modified in accord with the cultural trends in various countries. The standards of teaching and training cannot be rigid, they must change. Only through a world society can uniform systems of teaching and training be formulated.

5. Because of the world spread of the movement, a world society is indispensable. The task assigned to us by the Zurich Congress has been the writing of a *Constitution* of the World Society.

6. Besides the Constitution for a World Society, we need to maintain the ethical standards and the dignity of our profession, and to protect us against abuse and moral deprivation. It is imperative that we formulate and practice in accord with an ethical code, the ethical code of the group psychotherapists. Following the example of the founder of medicine, Hypocrates, who gave us the Hypocratic Oath, we have tried to formulate a Group Oath which could express the ethical principles upon which our group practices are based.

7. The next task is the establishment of research and training centers in many places, so as to give the scientific genius of the group therapeutic movement opportunity for contributions which enhance the progress of our science.

8. Group psychotherapy requires the virtue of tolerance for the ideas of others, their egos and their methods, and as much as humanly possible, we must abandon self interest in the name of the common cause.

9. We have begun to consider the formation of an International Group Psychotherapy Research Foundation which will provide means for research, scholarships and the development of training centers.

10. Group psychotherapy must start in your own home, in your own family, in your own workshop, and it must start, therefore, in our own World Society of the future. The idea is bigger than any one of us. We must work hard to develop it as well as spread it.

11. There are many among us who visualize the group movement not only as an edifice limited to the exchange of ideas but as a practical world organization with roots in every country and structured according to regions, each region having their regional representatives in the world body.

12. As I look around at this assembly, we must be proud that delegates from over fifty countries have come to Milan. It is like a challenge that the next Congress be still richer in scientific ideas and contributions than this one and that it be attended by delegates from still more countries. Group psychotherapy in its many varieties is needed everywhere and so let us carry it to the farthest corners of the earth, and let us make true the prophecy that a therapeutic world order will result from the anguishes and sufferings of mankind.

Last not least, I feel moved, in the name of the entire assembly and the Directors of the International Council of Group Psychotherapy, to express our profound gratitude towards our gracious hosts, the President of the Italian Republic, Mr. Antonio Segni, the President of the Government

of the Province of Milan, Avvocato Adrio Casati, the representatives of the two universities, Rector Professor Franceso Mario Vito of the Catholic University, and Rector Professor Caio Mario Cattabeni of the University of Milan, the Mayor of Milan, for their hospitality here in Italy as well as for their assistance in making this Congress such a vital success.

GROUP PSYCHOTHERAPY WITH PSYCHIATRIC OUT-PATIENTS

JEROME D. FRANK, M.D.

Psychotherapeutic resources for psychiatric out-patients are overtaxed and inefficient. These are two sides of the same coin, since if the treatment methods were more expeditious and efficient, we would be better able to handle the volume of patients who request help. The overloading of most out-patient facilities, evidenced by long waiting lists, is generally recognized; their inefficiency may be less known. The inadequacy of current psychotherapeutic methods appears in the large number of patients referred to psychotherapy who drop out before receiving an appreciable amount of treatment and in the low improvement rate for those who remain in treatment. In clinics who reported data on this, thirty to sixty-five per-cent of patients drop out of treatment prematurely. The improvement rate is equally discouraging. An analysis of the treatment results at the Phipps Clinic found that although forty-two per-cent of the out-patients treated are rated as improved at the time of termination of contact, only seventeen per-cent are discharged with the rating "maximum benefit, improved." This is consistent with reports from other clinics.[1]

The use of group therapeutic methods would appear to be a promising way of meeting the challenge posed by long waiting lists, high patient turnover and low improvement rates. The purpose of this article is to review certain aspects of experience with group therapy at the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, in order to point up some of the problems involved and some possible solutions.

The Psychiatric Out-Patient Department accepts for diagnosis and treatment all patients over 14 who earn less than approximately $5,000 a year for a married couple. Sixty per-cent of the patients are between the ages of 20 and 40. The remaining forty per-cent are equally divided between those under 20 and those over 40. They are equally distributed as to sex. About seventy per-cent are white and thirty per-cent colored. Seventy per-cent earn less than $3,000 a year. About forty-five per-cent have had less than an eighth-grade education; forty-five per-cent have gone through high school; the remaining ten per-cent have been to college. Thus we deal primarily with urban lower-class and lower middle-class adults of grammar or high school educational level.

[1] Rosenthal, D. and Frank, J. D., The Fate of Psychiatric Clinic Outpatients Assigned to Psychotherapy, *Journal of Nervous and Mental Disease*, 127: 330-343, 1958.

There are about 5,600 treatment contacts a year, mostly for individual psychotherapy. Over the past five years the percentage of individual treatment visits has ranged between fifty and sixty per-cent. The next most common form of treatment is group therapy, with percentages ranging from fifteen to thirty-four per-cent. The number of groups of out-patients running concurrently in the Clinic usually ranges between five and seven. Since many of the Clinic patients are employed, we have found it necessary to conduct several evening groups.

When a patient comes to the Out-Patient Clinic, after being registered he is examined by a senior medical student under the supervision of a psychiatrist. On the basis of this examination, certain patients are referred to group psychotherapy. No satisfactory criteria for referral to group therapy have been developed, since these await better specification of the kinds of patient who are most apt to benefit from this kind of treatment.[2] As most of the visiting psychiatrists use only individual psychotherapy in their private practice, they tend to refer patients to this as the treatment of choice, swinging periodically to group therapy when the waiting list for individual treatment has become hopelessly clogged up. Referrals include all types of neurotic patients and some in the ambulatory psychotic spectrum as well as character disorders. In general, patients are referred for group treatment who seem not to be acutely ill, or who for one reason or another seem to the examiner not to need individual therapy.

Most of the group therapy is conducted by psychiatric residents under supervision. Each resident is permitted to select for his group those patients with whom he thinks he can work best. This results in certain patients being repeatedly passed over, a difficulty which is handled informally by the willingness of a senior staff member to invite patients who have been repeatedly passed over to join his group. Usually the judgment of the residents proves to have been vindicated, in that such patients do not come, or, if they do, drop out promptly.

Senior residents conduct groups and each has assigned to him a junior resident as an observer. In this way all residents have a chance to familiarize themselves with a therapy group before conducting one. All residents are asked to observe a group, but none are required to conduct one since we have found that some individuals cannot successfully manage this type of treatment.

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[2] Freedman, M. B. and Sweet, B. S., Some Specific Features of Group Psychotherapy and their Implications for Selection of Patients, *International Journal of Group Psychotherapy*, 4: 355-368, 1954.

In addition to undergoing a learning experience himself, the observer helps the group leader by keeping notes of the meeting on which to base later discussion and by being in a position to point out to him aspects of individual psychodynamics and of group relationships which the leader, because of his preoccupation with conducting the group, may have failed to notice.[3] To this end, observers and leaders are requested to spend some time discussing the group meeting immediately after it. This also gives the leader an opportunity to ventilate any pent-up emotions which may have accumulated during the meeting itself. Since the observer, ideally, should offer emotional support to the leader, we allow leaders to pick their own observers, in an effort to assure that the pair will be congenial. Each resident-observer pair reviews their group session with a senior staff member once a week.

Observation of therapy groups has proved to be an excellent device for teaching the pathology of interpersonal relationships, since the simultaneous presence of many patients multiplies opportunities for significant interactions and the unconstrained atmosphere encourages patients to express themselves freely. To enlarge the observational experience of the residents, one senior staff member conducts a group which they can observe and discuss with him.

Since the main emphasis of the Phipps Clinic training program has been on intensive individual psychotherapy with in-patients, it has been difficult to maintain the interest of the resident staff in group therapy with out-patients, and it has taken several years for this program to become firmly established. The predominant type of group therapy offered is perhaps best termed "interview group therapy."[4,5] Groups consisting of up to seven adults meet once a week for an hour and a half. They have no formal agenda. The leader attempts to promote free discussion with honest expression of feelings. This type of activity enhances patients' self-respect, evokes the attitudes and behaviors related to their illnesses, and helps them to achieve a better understanding of themselves and more successful social relationships.[6]

The group leader has a personal interview with each patient before

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[3] Nash, H. T. and Stone, A. R., Collaboration of Therapist and Observer in Guiding Group Psychotherapy, *Group Psychotherapy*, 4: 85-92, 1951.

[4] Slavson, S. R., *The Practice of Group Therapy*, New York: International Universities Press, 1947.

[5] Powdermaker, F. and Frank, J. D., *Group Psychotherapy: Studies in Methodology of Research and Therapy*, Cambridge: Harvard University Press, 1953.

[6] Frank, J. D., Some Aspects of Cohesiveness and Conflict in Psychiatric Out-Patient Groups, *Bulletin of the Johns Hopkins Hospital*, 101: 224-231, 1957.

placing him in the group. This permits the patient to meet him and gives him the opportunity to acquaint the patient with the ground rules of the group, to try to deal with anticipatory misgivings, and, if possible, to discern one or two interpersonal problems related to the patient's illness which may serve as foci for group discussions.

Individual interviews are ordinarily discouraged during the course of therapy. Occasionally a resident carries a patient in both group and individual therapy or a patient is in individual therapy with one resident and in group therapy with another. These variations work out successfully. The groups are semi-open in that there is usually a slow turnover, with perhaps two or three new patients being brought in every few months. Residents are advised to admit more than one new patient at a time so as to avoid too much focus on the newcomer, which is often very stressful for him. Quite a few patients drop out within the first ten sessions, often having derived some benefit. Others seem prepared to remain in group therapy indefinitely and get passed on from one resident to the next. The great bulk of patients, however, seem to derive maximum benefit from group therapy within eight months to a year.

Among the limitations of the group therapy program are the lack of a satisfactory way of screening patients for group therapy and the high attrition rate both from the waiting list and from the groups themselves. As an exploration of one way of meeting these problems we ran an experiment in which patients were first placed in "diagnostic" groups of 11 to 15 members.[7] It was hoped that through such groups characteristic behavior patterns of patients could be reliably identified by direct observation, and that those patients who attended all the meetings of a diagnostic group would be more apt to remain in group treatment later. For such a screening method to be useful, the diagnostic groups themselves should not drive patients out of treatment; that is, we assumed that placing all patients accepted for psychotherapy in such groups would not cause them to drop out any more frequently than if they were directly placed in a treatment group after a full initial work-up.

We found it was possible reliably to classify patients with respect dominance and dependence on the basis of observing them in from four to six group meetings. The observer and the doctor of three diagnostic

[7] Stone, A. R., Parloff, M. B. and Frank, J. D., The Use of "Diagnostic" Groups in a Group Therapy Program, *International Journal of Group Psychotherapy*, 4: 274-284, 1954.

groups independently rated patients on this dimension and their ratings correlated from .77 to .95.

It was also found that the drop-out rate from these diagnostic groups was not significantly greater than from the smaller therapy groups. Of the sixty patients placed in diagnostic groups, thirty-five per-cent dropped out before the end of the sixth meeting, whereas of seventy-seven patients who were placed in treatment groups after receiving thorough diagnostic study, thirty per-cent dropped out within the first four meetings. On the other hand, patients proved to be no more likely to stay in therapy groups after being in a diagnostic group than if they had not had this experience. Foulkes and Parkin have described the organization of an out-patient clinic using intake groups and preparatory groups before patients are placed in therapy groups and report good results.[8]

The real test of any therapeutic program is, of course, its effectiveness. In conjunction with a large-scale study of responses of patients to different types of psychotherapy, we had an opportunity to compare results of group therapy one and one-half hours once a week and individual therapy once a week over a six-months period for roughly equivalent patients.[9] The experimental design called for the patients to be assigned randomly to group therapy or individual therapy, each type of therapy being conducted by three psychiatric residents; that is, each psychiatric resident had a therapy group and an equivalent number of patients in individual treatment. The patients were evaluated with respect to discomfort and social ineffectiveness by means of specially designed rating scales at the start of treatment, again after six months, and at regular intervals thereafter. The effectiveness of treatment was judged in two ways: first, by the proportion of patients who remained in treatment more than four sessions and, secondly, by the improvement in discomfort and social ineffectiveness.

The attrition rate in this study was about fifty per-cent. Although this is within the thirty-five to sixty per-cent attrition from individual therapy reported by other clinics, it was higher than the thirty-five per-cent drop-out rate which is more characteristic of our Clinic groups. Several possible reasons for this elevation were found, which are not relevant to this discussion.

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[8] Foulkes, S. H. and Parkin, A., Out-Patient Psychotherapy: A Contribution Toward a New Approach, *The International Journal of Social Psychiatry*, 3: 44-48, 1957.

[9] Nash, E. H., Frank, J. D., Gliedman, L. H., Imber, S. D. and Stone, A. R., Some Factors Related to Patients' Remaining in Group Psychotherapy, *International Journal of Group Psychotherapy*, 7: 264-274, 1957.

It is of some interest that patients who dropped out of group therapy, in contrast to those who left individual therapy, were scored as more socially ineffective initially than those who remained. No qualitative differences in kinds of ineffectiveness between those who dropped out of the two kinds of therapy could be discerned. Those who rejected both types of treatment tended to be more irresponsible, withdrawn, and impulsive than those who accepted them.

Most of the patients who rejected group therapy after a brief exposure indicated that the group experience intensified their symptoms, primarily through hearing about the illnesses of other patients. Patients who stayed in treatment reported, on the other hand, a diminution of their sense of isolation through the group or a gain in self-confidence through the realization that others were sicker than they were.

All but one of the drop-outs from group treatment occurred in the groups of two therapists and were equally divided between them. The therapist who lost only one patient from his research group had previously organized a group from the waiting list from which he had no losses. The other two therapists each previously had inherited leadership of groups they had observed and had supplemented them with patients of their own choice. Nether lost any patients from these earlier groups. This suggests that the high attrition rate in their experimental groups may have been related to the fact that, in contrast to the doctor who held his patients, they had never before organized a group *de novo*.

More of the patients who dropped out than of those who remained in group treatment complained of a feeling of remoteness from the doctor. They reported that he was an enigma, that they did not know him, and that he was not doing anything for them. In an earlier study we found that groups in which the doctor did not offer active support were especially stressful for patients who feared lest shameful impulses or characteristics would be brought to light, and those who feared that they might be stimulated to the point of losing control by the remarks of others or who tended to pick up symptoms from others.[10]

The findings of this study with respect to dropping out of treatment are consistent with generally held views. They suggest that group therapy is more stressful than individual therapy for many patients, especially those who "catch" symptoms from others or need strong support from the doctor. Some such patients may derive sufficient support from the feeling of group

[10] Powdermaker, F. and Frank, J. D. *Op. cit.*

belongingness, however, to outweigh their feeling of diminished support from the leader. From the standpoint of the therapist, the two who were conducting a "new" group for the first time were probably more uneasy than the one who had had this experience before, and therefore may have been less able to offer patients the support they sought. Thus these findings suggest that to hold patients in group therapy, the therapist should foster their feeling of group belongingness and should clearly convey his interest in their welfare. It has been our general experience that with increasing experience of the therapist, the drop-out rate of his group patients decreases.

Although in this experiment many more patients left group therapy than individual therapy prematurely, there was no difference in improvement rates for those who remained in treatment.[11] For both types of treatment, about seventy per-cent were rated as improved in discomfort, and about eighty per-cent as less socially ineffective after six months, and the size of drop in the average scores on both scales was the same regardless of the type of treatment. The average improvement was maintained over a five-year follow-up.[12] For patients who were able to accept group therapy under the rather adverse conditions of the experiment, it was apparently as helpful, on the whole, as individual treatment. This is consistent with other evidence that factors related to patients' remaining in treatment need not be the same as those related to improvement.[13]

Although, as these figures indicate, interview group therapy helps many out-patients, we believe that additional patients, who are not particularly well suited to insight therapy, might benefit more from other group approaches, and are making some explorations along these lines. For several years we have conducted a small occupation therapy program for out-patients. Occupational therapy offers a means for reawakening dormant interests and stirring up latent initiative. It has, therefore, proved useful for older patients or chronically psychotic ones whose interests have become

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[11] Imber, S. D., Frank, J. D., Nash, E. H., Stone, A. R. and Gliedman, L. H., Improvement and Amount of Therapeutic Contact: An Alternative to the Use of No-treatment Controls in Psychotherapy, *Journal of Consulting Psychology*, 21: 309-315, 1957. Thorley, A. S. and Craske, N., Comparison and Estimate of Group and Individual Methods of Treatment, *British Medical Journal*, 1: 97-100, 1950.

[12] Stone, A. R., Frank, J. D., Nash, E. H., and Imber, S. D., An Intensive Five-Year Follow-Up Study of Treated Psychiatric Outpatients, *Journal of Nervous and Mental Disease*, 133: 410-422, 1961.

[13] Frank, J. D., Gliedman, L. H., Imber, S. D., Nash, E. H., and Stone, A. R., Why Patients Leave Psychotherapy, *A.M.A. Archives of Neurology and Psychiatry*, 77: 283-299, 1957.

constricted. In this program, group forces are implicit—that is, there are no group activities as such but the same patients meet regularly and work together.

Depending on the interests of particular members of the resident or senior staffs, different types of groups have been tried. A therapeutic social club for out-patients existed for several years, the primary purpose of which was to alleviate loneliness by providing an atmosphere for experiencing mutually beneficial social interactions. It proved mainly useful in assisting the transition of in-patients from the hospital to the community, and therefore was terminated when this function was assumed by the day hospital program.[14]

For some months a group of chronically psychiatrically disabled patients was conducted in cooperation with the Maryland Vocational Rehabilitation Service, and the results have been reported elsewhere.[15]

A resident with a special interest in directive methods conducted a group run along the lines of Recovery Incorporated[16] for several months in an effort to provide a therapeutic experience for patients who because of lack of verbal facility or for other reasons had difficulties in unstructured groups. Although actively supported by the senior staff, the resident gradually lost interest in this approach, probably because it ran counter to the general therapeutic philosophy of the clinic.

As this is written, an out-patient adolescent unit is being formed which will include all therapy groups of adolescents and will continue to stress group approaches, as well as involvement of parents in the treatment program. Groups of married couples are being started, and a program of family therapy is under consideration.

This survey of group therapy activities in the Psychiatric Out-Patient Department of a teaching hospital leads to several tentative conclusions. In psychiatric teaching institutions intensive individual psychotherapy is regarded as the method of choice. All major teaching activities in connection with therapy are directed toward it, and the residents receive their chief supervision in this type of work. Group therapy, therefore, goes against a

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[14] Webb, W. L., Experience with a Day Hospital Unit at the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, *Maryland State Medical Journal*, 10: 131-133, 1961.

[15] Wheat, W. D., Slaughter, R., and Frank, J. D., Rehabilitation of Chronically Ill Psychiatric Outpatients, *Rehabilitation Literature*, 21: 158-160, 1960.

[16] Low, A., *Mental Health through Will-Training*, Boston: Christopher Publishing House, 1950.

local cultural trend. Only after one or two generations of residents have been through a group therapy training program does it seem to develop sufficient roots to be able to continue on its own momentum.

Administratively the biggest problems are how to select patients for groups, and how to modify group therapy techniques to meet the needs of different types of patients. In this connection the use of large intake or orientation groups as a means for determining subsequent therapeutic assignment warrants further exploration.

From an educational standpoint, group therapy affords a very effective way of demonstrating disturbances in social behavior of psychiatric patients in relation to their inner conflicts.

From the standpoint of therapy, the results of interview group therapy seem as good as those of individual treatment for those who accept it, but the attrition rate is higher. Interview-type therapy, however, whether group or individual, seems poorly suited to the requirements of many clinic patients. Most of the clinic population are lower- or lower middle-class and have only limited education. Such patients are unused to verbalizing their feelings and attitudes, and often cannot see the value of a therapy which emphasizes such verbalization.[17] Group methods permit exploration of other means of modifying the attitudes of these patients in a helpful direction. Out-patient clinics with their rather large patient populations afford excellent testing grounds for experimentation with variations in group therapeutic methods, and this should be encouraged.

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[17] Robinson, H. A., Redlich, F. C. and Myers, J. K., Social Structure and Psychiatric Treatment, *American Journal of Orthopsychiatry*, 24: 307-316, 1954.

THE RELATIONSHIP OF GROUP PSYCHOTHERAPY TO INSTITUTIONAL ADJUSTMENT

ROBERT L. WOLK, PH.D.[1]

New York City Criminal Court Psychiatric Clinic[2]

Group psychotherapy is part of the therapeutic program at many correctional institutions. The group process is thought of as an adjunct and aid to the readjustment of the individual when he is returned to the community after his period of imprisonment. Here, the major emphasis of correctional institutional group psychotherapy usually is that of post-institutional adjustment.

Group psychotherapy also plays an important role in the adjustment of the inmate to the institution while he is still incarcerated. Many inmates require assistance in resolution of their immediate personal problems before they can approach problems that involve deep insight and understandings of their dynamic personality structure. In many instances, immediate problems, as well as more basic problems of personality, may lead the inmate into various forms of anti-institutional behavior.

Frequently, institutional adjustment is hindered by abreactions and distortions of the personality structure. These reactions may become intensified by the authoritative, sterile, frustrating experience of institutional life. Personality factors that led to the maladjustment in the community may be similar or contributory factors that lead to poor institutional adjustment.

This paper's purpose is to demonstrate the value of a group psychotherapy program in relation to institutional adjustment.

One of the criteria for adjustment is considered the "disciplinary or infraction report." Serious infractions of the institutional rules can be reported to the Adjustment Committee[3] by any member of the institutional staff. This Committee then determines the punishment. The nature of disciplinary reports can be illustrated by examples ranging from the use of profane language to the extremes of attempting to escape or inciting a riot. We can assume that an inmate who receives many disciplinary reports has been violating the rules

[1] Study performed while the author was a staff psychologist at Bordentown Reformatory, Bordentown, New Jersey.

[2] Appreciation is acknowledged to Dr. Emanuel F. Hammer for his editorial suggestions.

[3] Usually comprised of the principal keeper, correctional officer on a rotating basis, and a psychologist.

of the institution frequently and as such has not been able to adjust adequately to the regime of institutional living.

Although as many factors as possible were controlled in this study, there were variables that could not be limited or measured. Selection for group psychotherapy was roughly based upon the recommendation of the Psychologist and the Classification Committee. As such, many men were referred for group psychotherapy because of poor institutional adjustment, while others were referred because it was felt the group process would act as a deterrent to potential or future anti-institutional behavior.

The institution itself is a modern one, housing men between the ages of 17 and 30. Staff included a psychiatrist and several psychologists and psychiatric social workers.

The modal intelligence classification for the institution population was dull normal. The distribution of both the group-therapy men and men not exposed to group psychotherapy was also dull normal.

One calendar year from July 1 to June 30 was selected as the period for evaluation of the group psychotherapy program in relation to institutional adjustment. During this time 101 men were attending group psychotherapy sessions and a total of 560 sessions were held. The groups and sessions were distributed as follows: Two therapists led all the groups. One therapist led five groups and the other led three groups. Seven of the groups were the usual orthodox type with eight or nine men in each section. The eighth group was a sociodrama group which contained 13 men. Each group met twice a week for one and one-half hours each session. At the beginning of the measured year the mean number of months for men in group psychotherapy was 6.45. During the course of the year, the other five hundred and eighteen men in the prison population were not exposed to the group process. Groups were randomly constructed as to therapist or method of treatment in order to eliminate selective influences or factors playing a role in the results.

Results

A total of 1271 disciplinary reports were issued during the year. The reports were distributed heterogeneously throughout the population by tiers. Men exposed to group psychotherapy were also evenly distributed throughout the institution.

Of the total number of disciplinary reports given by the institutional staff, 87 were given to inmates in group psychotherapy, while 1184 reports were given to men not in the group psychotherapy program. Thus, members

of the groups averaged .86 infraction reports each for the year, whereas men not in group therapy averaged 2.29 each, a statistically significant figure at the .01 level of confidence.

TABLE 1
AVERAGE NUMBER OF CHARGES PER YEAR

	TIERS	G.T. Men	Non-G.T. Men
WING	1	0.067	0.28
A	2	0.61	1.34
	3	0.80	1.17
WING	1	2.25	3.44
B	2	1.33	2.60
	3	2.00	0.99
WING	1	0.25	2.41
D	2	1.33	2.72
	3	1.71	2.49
WING	1	1.75	3.24
E	2	0.75	2.94
	3	0.70	3.25
	Average charge per man for year	0.86**	2.29**

** Significant at the 0.01 level of confidence.

DISCUSSION

The results of this study demonstrate that men actively engaged in group psychotherapy tend to make a better institutional adjustment than those individuals who are not engaged in treatment. The results were consistent for each area of the institution, regardless of the ratio of group psychotherapy men to non-group-psychotherapy men.

An interesting note is that many of the officers were aware which inmates were in psychotherapy. The sociology of prison is such that the man who is in psychotherapy may be viewed in a biased fashion by some of the prison personnel and may tend to receive infractions more readily than other inmates. Such unenlightened staff members tend to work against the psychotherapeutic program.

Twelve men who were in the group psychotherapy program obtained ten or more charges each prior to their entrance into treatment. These men were included in the study although, at the time of evaluation, they were in treatment for a little more than a year. Six of these men received two or less reports for the measured year, four of them received three or four reports,

and two received six disciplinary reports. None of them received more than six infractions during the measured year they were in treatment.

Infractions were tabulated to determine if there were increases in the number of infractions specific to the days of the week. No significant differences were ascertained.

Forty-two of the men in the group psychotherapy program were responsible for all 87 charges. Hence, 45 men in group psychotherapy (more than half) did not receive any infraction reports during the test period.

Insights gained in the group process have to be tested. All too frequently, these new conceptualizations cannot be tried until the inmate has been released. Upon release, the parolee has other problems to face, as well as immediate situational frustrations, such as prejudice and rejection by his family, friends, and often employers. Adjustment to a foreign environment, an environment that the parolee has not faced in some cases for as long as five years, can be most difficult. It is hypothesized that the group process, which helps the inmate both in facing his immediate problems while under correctional supervision and to experience some acting out in therapy prior to his return to the community, can assist the inmate to attempt to use these new found strengths while still in the institution.

Based upon the findings in this study, we can then assume that group psychotherapy in a correctional institution serves not only to help the individual adjust post-institutionally, but also assists in the institutional adjustment itself. This is particularly important because frequently the penalty for a serious infraction of prison rules involves loss of "good time," which requires the inmate to remain in prison for a longer period of time. If the group psychotherapy process helps an individual make a better adjustment and consequently he does not lose his good time, he then is returned to the community in less time and effects a considerable saving both in human life as well as in cost to the community. Good institutional adjustment also reflects parole possibilities which again serves the same effect.

Summary

This study demonstrates the value of group psychotherapy in effecting institutional adjustment in a correctional institution. Individuals who have spent a year in group psychotherapy have a significantly fewer number of infraction reports, which are assumed as one indice of adjustment to the institution. It is then hypothesized that group psychotherapy plays an important role both prior and subsequent to the inmate's return to the community.

THE ACTION SOCIOGRAM

BARBARA SEABOURNE, M.A.

St. Louis Training Institute of Group Psychotherapy and Psychodrama

The purpose of this paper is to demonstrate the use of a technique, called the Action Sociogram, which brings together in a more vitalized way two approaches to group treatment; the psychodramatic approach as a form of treatment and the sociometric approach as a means of obtaining and analyzing data on group relationships. Dr. J. L. Moreno, who developed both approaches has consistently urged more intense use of these two methods and this paper is considered a practical extension of the concepts and techniques which he has so impressively provided. The technique presented here will show how the Sociogram, which is well known as a paper and pencil drawing, representative of group relationships, can be brought directly and actively into the Psychodrama session as a diagnostic, therapeutic, and warm-up technique.

The Psychodrama session itself, in which the spontaneous activity portrays the "living" of the material shown on the paper and pencil sociometric drawing, is a natural arena for the "drawing" of a human, action Sociogram. By the use of the whole Psychodrama arena, including floor, stage and other levels, height and distance can be portrayed. Social distances can be represented, not only in "far" or "near" dimensions, but also in "high" or "low" dimensions. By position, posture and facial expression, the relationships usually represented on paper Sociograms by lines and arrows can be dramatically portrayed by the actual persons involved or their role representation. In this manner, it is possible to "draw" a human, action Sociogram in the Psychodrama session which is similar to that usually drawn on paper.

Such a technique has the added advantages of yielding increased information based on spontaneous reactions throughout the "drawing" procedure, of being amenable to therapeutic manipulations such as role reversals, doubling and other techniques, and can be used as a warm up to other therapeutic work in the session. In addition, this technique may be used in research to explore more closely group processes. During the development of and experimentation with the Psychodramatic or Action Sociogram at the St. Louis State Hospital, it has proven a useful technique in gaining information and diagnostic cues in many patient groups, both in protagonist-centered sessions and sessions focusing on the group as a whole. It is also useful in staff communication groups and psychodrama training groups.

At present, the development of the Action Sociogram has included successful experimentation in working with (1) an individual's perception of his Family Sociogram; (2) an individual member's perception of the group relationships to himself, or the Group Sociogram in regard to a single protagonist; and (3) the Individual's or Group Sociogram in regard to the relationships with the therapist.

This paper will present via example and discussion these uses of the Action Sociogram.

I. A Sociogram of the Family

Three uses of the action family sociogram will be shown. These are: (*a*) as a means of obtaining social history and other information on the family members and their relationships to each other and to the patient as the patient sees them. This may be primarily information for the therapist; (*b*) as a means of giving the group information about a member and an opportunity to "know" more clearly his perceptions and to react to them and to share information about themselves with him; and (*c*) as a device to explore various problem areas, conscious and unconscious, in a manner amenable to gradation, depending upon the patient. That is, as a device which can be used with as much or as little interpretation as the Director sees fit.

Example A: The Informational Family Sociogram

A new patient has joined an ongoing group. The director decides to gather information about of this patient as rapidly as possible, since the older members are working vigorously on family relationships. The older members know of each others' family and often refer to each others' families in the sessions as well as having tele (social empathy) for each other on the basis of this information. The new member may be excluded from much of the interaction unless information is gathered quickly for the other members. In addition, the therapist wishes to know how to cast roles for this patient; he must "warm up" his auxiliaries to the new patient by providing them with information to be used when the new member emerges as protagonist. He will need to know how best to use the new patient in auxiliary roles or as protagonist. He needs to get hypotheses about underlying factors which will be revealed in the information. He will need to provide a structure within which the new patient can operate without undue pressure in his first session as protagonist.

A psychodramatic sociogram will be a likely choice here since it is

personalized but "task oriented" for the new member. It involves many persons from the group and much movement so that feelings of being "on the spot" are minimized. In addition, the protagonist does the arranging, which means he can set his own pace—in this sense he has control of the material emerging. The strong non-verbal element of this method often provides not only a clearer portrayal of the roles but protects the new patient in his initial session from premature verbal interpretations by members who have been in therapy a longer time. In other words, he is, by his arrangement, doing his own interpreting and is thus protected.

The Director suggests "that we get to know something about the new member, X, by finding out who is in his family and what they are like." He asks X to choose someone to be himself. X asks his auxiliary ego to place himself somewhere in the room in some posture that shows his feelings. Auxiliary ego, X, puts himself, slumped in a chair, on the stage. X now chooses his mother from the group and puts her on stage standing by his auxiliary ego's chair, hand on his shoulder. X is asked to describe her facial expression. (DIR.: If her feelings showed on her face what would her expression and her posture be?)

Now X chooses his father from the group. He scratches his head, does not know exactly where his father would be. A double is assigned, who helps him express his ambivalence and confusion about what his father is really like. He finally says, "Oh, we'll put my sister in first and then my father would be standing close to her." He chooses and places his sister on the far side of the room.

DIR.: "What is her position and posture?"
PT.: "Well, she was sick a lot—she would be sick, I guess." (His auxiliary ego sister is put on the mattress looking sick and helpless and groaning. The auxiliary ego father is placed in a chair, comforting her).
DIR.: "Put Father's chair where it would be." (Patient places chair beside mattress where the back is toward the stage; that is, back toward the patient.)
PT.: "That is all in my family."
DIR.: "Look at it closely, are there any changes or corrections you would make? You can use any way you wish to show their relationships and feelings."
PT.: "No . . . it is this way."

Now, depending on the patient and the group pace, the director may cut the scene or press for more material. This patient seems to be willing to go farther if he is given help in finding a direction to move toward.

The group is involved and warmed up to X and his family. The director decides to continue.

DIR.: "As you look at this picture of your family, what stands out to you?"

PT.: "Well (laughs) they are all slumped but my mother." (Director instructs Mother to stand very erect.)

PT.: "Yes, she stands very straight. She is a big woman." (Director puts Mother on chair—same posture, same position, same expression, but now on the chair towering over X: "Like that?")

PT.: "Yes, that is more like it. I guess she would have her hand on my head." (Mother does so.)

DIR.: "Lightly, heavily, or how?"

PT.: "Well, pretty heavy, I guess—kind of like she is holding my head so I can't turn it." (Mother grips his head hard, now using both hands so that he cannot turn it.)

PT.: "Yes . . . that's more like it . . . the way I feel."

DIR.: "Anything else about your Mother here you would revise to show her more clearly?"

PT.: "Well, I guess she would be looking a little harder at me . . . not real hard . . . not that hard . . . just sort of frowning." (Mother does so.)

DIR.: "Look at the others as well as your mother . . . are there any corrections?"

PT.: "No, that is just the way it is."

DIR.: "Is there anyone, maybe someone who lived there or not, any person who is important to you who is not in this scene but who in your feelings should be?"

PT.: "No . . . expect I had a brother, but he died before I was born."

DIR.: "Who and where would he be?" (Patient chooses as an auxiliary ego brother a very handsome, verbal male who tends to dominate most sessions and places him dead on the floor on the other side of X himself. His expression is one of anger.)

DIR.: "Who is he angry at?"

PT.: "I don't know . . . maybe me (laughs). I've got his place."

DIR.: "Is this like your mother's frown or is that different?"

PT.: "Now that he is in there, I guess she would be looking at him."

DIR.: "How?"

PT.: "Very longingly . . . very sad, he is dead. I don't know why I think that . . . he was hardly ever mentioned." (laughs) (Director instructs Mother to keep looking longingly at dead son, then frowning down on X, then looking longingly at dead son.)

PT.: "Yes, yes . . . that is it. That's the way I feel."
DIR.: "Any other changes?"
PT.: "No." X now looks at the scene silently for a moment.

The director here can move in many ways, such as into a soliloquy, place X in his own role or in other roles or move back to the group reaction and closure.

Because time is running out, the director here cuts the scene and the group discusses it, each comparing it with their own families. The group is very empathic to X now. The director asks the auxiliaries for their reactions to their roles. The girl who played the sister says she was tense in that role. This is discussed . . . she says she felt guilty getting all of the father's attention. "He should have been sitting on his wife's bed, not his daughter's." Another patient asks her if her mother was jealous of her. She denies this. One female patient thought that part was as it should be—her father favored the boys and she was hurt because he didn't like girls. The discussion continues in this vein of comparative feelings until time to close.

This example, while illustrating the technique of using the informational family sociogram, clearly shows how useful such a session can be in revealing dynamics of the patient as well as his perception of the family members and their relationships. The persons chosen for the roles (such as the handsome, verbal and dominant member to be the dead brother) not only are projective information from the patient for later use in therapy, but also indicates to the therapist potential auxiliary egos in further work with the patient in the future. In addition, the reactions to the roles by those chosen stimulate involvement and material in others to be explored or interpreted in this or later sessions. (The reactions of the girl who was uncomfortable in this session getting the attention from the father may indicate that a later session with her should be set up in such a way as to explore the "triangle" of her own family situation which she probably perceived.)

In this session, the group warmed up to X and his family sociogram very quickly. In some sessions, factors may be operating which lessen the involvement of the group as a whole or which decrease empathy for the patient. One such session occurred when the family presented was so large that all the patient members of the group were in role. For instance, some had their backs to others, and could not see the picture from the protagonist's viewpoint. In this case, the director had the patient role reverse with each member in the "cast" so that each, one at a time, had a chance to come down to the floor and see the "picture" in total. This succeeded in greatly

increasing empathy and stimulating comparisons in later discussion. One patient, who while in role "felt nothing," was startled to see the total picture and explaimed, "My God! They are as far apart as my family!"

The role reversal with each of the sociogram figures by the protagonist has many advantages. The protagonist may show more ease or discomfort in the role enactment of some family members, which should be noted for further exploration in later sessions. In the informational session, as well as in interpretative sessions, the director may wish to put the patient in other roles to test for role reversal ability. He may put the patient in his own role either to stimulate involvement or to test for emotional involvement. (If the patient seems more involved arranging and watching than he does in the role, this may indicate he will respond best to distance techniques.)

We have also found that newly formed groups move more quickly to personalized material and cohesion by having a brief action sociogram of each member's perception of his family.

Example B: The Use of The Sociogram in an Interpretative Session

In this example, for convenience, we will look at the material presented in the above example and show how this technique would be used to stimulate feelings and exploration of feelings, conscious and unconscious.

The sociogram has been staged, this time with the purpose of exploring "feelings about your family." X has completed his arrangement. The dead brother is beside X on the floor glaring at him. Mother is on a chair, gripping X's head so that he cannot turn it and alternately looking longingly at the dead son and frowning at X. Father, with his back to the others, is sitting on a chair leaning over the mattress where the sick sister lies helplessly. She is softly groaning.

We now put X in his own role, with a double. X does a soliloquy. Depending on the cues he gives, Mother and others react to further stimulate him.

During the soliloquy he says of his Mother, "She doesn't want me to see him (brother)." (Mother screams, "Don't see him!")

The Director calls for a role reversal

The patient is now his Mother. As Mother, X says to her son (auxiliary ego X), "He (dead son) was my favorite . . . don't go trying to imitate him." Later: "Look straight ahead. Don't get the wrong direction."

DIR.: "Mrs. X, where are the directions in this room now?"

PT. (as Mrs. X) replies: "There is a good way straight ahead. There is a wrong way (to brother) and there is a wrong way (to father)."

DIR.: "What about those wrong ones?" (Toward brother and father.)

PT. (as Mrs. X—with a double) brings out the wish to keep X from being like his father or his brother. The "direction" straight ahead becomes "Mother's" path . . .: "Yes, you should be like me."

Patient goes back to being self. Mother continues his lines, gripping his head, not letting him look at the men; insisting he be like her. Patient gets very involved, says: "Oh, I feel caught . . . he (brother) is lucky, he is dead." *Director Role Reverses Patient and Brother.*

As brother, X brings out anger and sorrow for X who is in his "place." "Look where it got me . . . I'm dead."

DIR.: "How did that happen?"

PT.: "She should have had a girl . . . I can't be like her."

DIR.: "What about X, he may not want to be like her, a woman like her, either?"

PT. (as brother): "She might smother him or something. He will sure be mixed up anyway."

The patient goes back to being himself, Mother pressuring him, brother warning him. X, interacting with his double, begins to explore the wish to "know father better"—to know how father "got away from her." *The Director Calls for a Role Reversal with Father.*

Patient as father isn't interested in looking at his son. "I have my daughter here and she needs me. He (X) has his mother." (Auxiliary in daughter role groans). Auxiliary as X calls to him: "I don't want her, I don't want to be like her. I need you."

Patient as father: "You don't act like it . . . you are always with her."

The Director changes X back to self and father repeats last statement to him.

X looks startled, starts, stops, and unsure whether to go to father or not. With his double, X verbalizes a fear that father will reject him, then Mother will reject him too and he will be all alone. He indicates fear of Mother's anger, but the Director begins to get increased clues that underlying this is fear that he will hurt his Mother if he goes to Father and some corresponding guilt. (Mother is instructed to get angry then weak everytime he looks toward

Father.) Although she is angry, she is now expressing more desperately, "Don't leave me!" Sister and Mother are placed in between X and Father, making them farther apart, Mother shoves X and says, "Don't be like him, be like me!" Sister pulls Father back and groans, "I'm so helpless . . ."

Because it is time to begin closure of the session, the Director interrupts the scene and asks X for his feelings. "I'm so mixed up and tense, I am all in knots!" Director polls the group for reactions. Group members have empathy for X's feelings. Some would be angry at Mother. One, patient Z, observes that the women in X's family are "destroying" the men.

DIR.: "Destroying?"
PT. Z: "They won't let them be men. They rule the men by being so weak. My father thought he was boss, but when my mother cried he didn't know what hit him."

Director briefly puts the women on chairs between X and Z (together) and their fathers. The women both are strong, but crying. He asks X and Z for comments: X: "Yes . . . I guess so." (Seems stunned.) Z is more verbal in his reactions. Because time is running out, the Director cuts the scene and has X and patient Z, with doubles, walk around and talk aloud about the session, after which brief closing comments are made and the session ends.

II. THE GROUP SOCIOGRAM

The following is an example of how to obtain a perceived sociogram representing a single protagonist's perception of the group in relationship to himself.

Protagonist Y has arisen from the group. He is concerned about how the members feel toward him. While a behind-the-back, role reversal or soliloquy might be useful here to obtain the patient's perception of the group's reaction to him, the Director chooses the action sociogram to increase group involvement and spontaneity in a graphic way. Y is asked to place himself somewhere in the room showing psychodramatically and nonverbally his feelings about his position. He may play his own role or an auxiliary ego may be assigned to play him. He now is asked to choose a group member and place him in terms of how close or distant he feels the other person's feelings are about him. He is told to use levels of height and distance, depending on what he wishes to express. He is asked to indicate by posture and facial expression this person's feelings about him. He may "show" by taking the position and expression himself or he may give verbal instructions to the other member how to appear. Other members are asked to follow Y's instructions without comment until the action picture

is complete. This is continued until he has arranged the complete group. While it may or may not be explored, the therapist will note the order in which the protagonist chooses others. Exploration of this depends on the Director's judgment about the patient, the group, and the goals.

With the completed drawing, several avenues of exploration are open and within a single session, various methods may be used, depending on what the Director wishes to explore. The following are some alternatives:

(1) There may be role reversals. Y may become patient Z and be asked to soliloquize about his feelings about Y. The Director may stimulate this by such questions as, "Why are you so far away from Y, Z?" "I notice you are glaring at Y, why is that, patient Z?" It may be well to have role reversals with each member of the group. We get, in this way, Y's perception of how each member sees him.

(2) Y may in his own role soliloquize, with or without a double.

(3) There may be a brief soliloquy by each member about their reactions to where Y has placed them in regard to himself. This may or may not be with a double.

(4) The sociogram may be cut and a behind-the-back scene done with Y who hears others discuss their reactions to where they were placed and how they saw themselves in relation to him.

(5) Y may be asked to re-arrange the group as he wishes it would be.

(6) Y could be asked now to place another Y (the part that represents his self-attitude) in the arrangement. It may be well to have a soliloquy with this.

(7) Each group member may correct his position if he feels Y has misrepresented his feelings.

(8) Some person who seems very involved in Y's sociogram of the group may be asked to re-arrange the group in terms of how he feels they react to Y. The Director may assign someone to do this. An extension of this approach would be to have every member re-arrange quickly the group in terms of how they think each person reacts to Y.

(9) The session may turn to fostering communication between one or two persons and Y and the sociogram may be dropped, using it as a warm up to other scenes. An example of this may be: In a role reversal or in a soliloquy Y and Z seem to be reacting most strongly to each other. Y wishes they could be closer. Y may soliloquize as Z and Z as Y. Y says, "I wanted to ask him to have coffee the other day with me. I was afraid to." A scene of this may be set up and the sociogram dropped.

(10) Y may say, "Z is a lot like my father," and the session may become centered around the perception of Z and father, with the group perceptions becoming secondary.

(11) Group tele may be stimulated by asking Y to assign names of family or significant figures in his past life to appropriate members in the roles and places he has assigned them or to soliloquize about each.

As can be seen the variety of material which can be elicited by this technique is vast. The use of the technique as described here is to stimulate and explore consciousness of reactions of group members to each other. What is done with this material, via the action sociogram or following it, will be determined by the therapist's clinical judgment.

III. Transference to the Director and Others in the Action Sociogram

The action sociogram can be used also to explore transference material. In the following example, the patient explores his perception of the therapist and the groups' relationships to the therapist.

During the warm up discussion, patient Z reveals anger "at the session." With the help of a double, he begins to focus this anger on the Director. "We can't tell when you are pleased or not. You are so calm about everything." "You may be thinking about other patients when we are spilling our guts!" A scene begins where Z plays the therapist, an auxiliary being Z. As the Director, Z ignores himself and focuses on patient X. Z, in the role of Director, has been instructed the use "asides" to express underlying feelings. In an aside, he says: "I like X . . . he works hard in here. He wants to get well." An auxiliary mirrors Z and is angry at the session, and the Director. Z as Director, in an aside says: "He is the last one in this group I want to work with today. I'll not even listen to him," and turns his attention to X.

At this point the Director chooses to do a sociogram on Z's perception of the Director's feeling toward the members. Z becomes himself and is told to arrange the group in terms of distance, height level, posture and facial expression in relationship to the therapist. With an auxiliary playing the therapist, Z arranges the group. He has the Director on a chair with his hands outstretched but a bored expression on his face. He places patient Y at the therapist's feet. Others are placed in varying distances around the Director. Some are reaching toward him, some are sideways and ambivalent toward him, some are slumped, some are shaking fists at him. He places himself: "I guess I'd be at his feet, dammit! . . . begging for some attention!"

He places himself with one hand stretched upward and open, and the other a fist toward the therapist. The auxiliary playing Z alternates between "begging" and shaking his fist at the therapist. The Director calls for a *role reversal*; as the Director, Z talks about his feelings about each patient. He is most negative with Z.

The Director, after putting Z back as himself, is at a choice point. This material has touched on feelings among all the group members and many are reacting to Z's perception of the therapist and themselves in relation to him. The Director may choose to have other patients soliloquize about their feelings now. Out of this might come the sociograms of one or more other patients or a series of brief sociograms showing how much each of the others see the relationships to the therapists. On the other hand, the therapist can interpret via action Z's responses and continue in a single protagonist-centered session. If he chooses to do this, he could ask Z who in his life these figures represent. Often this will point out to Z that he is responding to past experiences as well as present ones. He may immediately put Father or Mother as Director and siblings in the picture for other patients. Often, the Director may wish to do this without asking Z. In fact, he may wish to abruptly have them become the family and suddenly confront Z with the interpretation of his projections. He may have them continue to be both; that is, they may be themselves (as Z sees them) and the projected family figure either as a synthesis of the two or sudden switches back and forth between them. It is important, however, that whatever is done with the original sociographic material, everyone in the closure discussion has a chance to talk about their reactions to it. In a hospitalized group many will need doubles to help them express their feelings about this material.

Summary

The above examples and discussion are illustrative of the wide range of uses and varieties of material amenable to dramatization and exploration via the drawing of an action sociogram in the Psychodrama session utilizing human spontaneity rather than paper and pencil symbols. If the paper and pencil sociogram is obtained and compared with the action sociogram, even more possibilities are open to its usefulness, including that of research. Further development of this action sociogram will hopefully yield more information about its method, uses, limitations and research potential. At the present time the Psychodrama Unit of the St. Louis State Hospital under the direction of Dr. Louis H. Kohler, is engaged in experimentation and development of this technique.

THE DEMOCRATIC ESSENCE OF PSYCHODRAMA

ABEL K. FINK, ED.D.

State University College, Buffalo, N.Y.

As psychodrama moves onto the world scene, as it begins to be employed in many cultural settings and to be modified in terms of situational limitations,[1] it is time to take stock of the method's philosophical core in order to insure its integrity. As Margaret Mead has noted,[2] the only real safeguard we have that psychodrama will not be used toward undesirable ends is to show conclusively that the method is essentially democratic in character and that it has built-in "fail-safe" mechanisms which serve to protect it.

In this paper, we shall attempt to demonstrate that psychodrama is inherently democratic. Whether approached from the position of the protagonist, the group or the director, we shall attempt to show that psychodrama is not only democratic in character but that its organic production is violated when democratic procedures are abandoned. Moreover, we suggest that the success of a psychodramatic production can be evaluated in terms of the degree to which the democratic spirit achieves actualization.

Basic to democracy is respect for the worth and dignity of the individual Let us note the experience of the protagonist in the psychodramatic production.

For the protagonist the psychodrama provides an uplifting experience. It enables him to feel important, for he achieves the notice and interest of an entire audience while occupying the spotlight in center stage. It is an experience which is ego-building and self-enhancing, for it enables him to achieve self-expression in portraying the story of his life.

The director is the protagonist's supporter and source of encouragement, and at time, his defender. He is a person who cares, who is interested, who is listening; indeed, the director is one who is concentrating, as perhaps no person has ever done, on understanding the protagonist's unsaid words and his unexpressed feelings. All of the director's professional talent is mobilized to enable the protagonist to portray himself and his drama in the fullest possible manner. The protagonist trusts the director, and has faith that the director will do him no intentional harm. On the contrary, he is convinced

[1] Note J. L. Moreno's description of the way he had to modify his approach in psychodrama demonstrations in various countries of the world.

[2] Banquet address, "Group Psychotherapy in International Perspective," April 13, 1963, at 22nd Annual Meeting of the American Soc. of Group Psychotherapy and Psychodrama, in New York City.

that the director will devote his effort toward the protagonist's fullest achievement of health.

The auxiliaries are the protagonist's social world; they play the roles that the successful unfolding of his drama necessitate. They are his supporters and his confidants. He confides in them in the ultimate sense, for he allows them (thru role reversal and doubling) to "get inside"—to think his thoughts and feel his feelings. He allows them to "come inside" because he trusts them. They are his advocates, they plead his case when he is unable to do so himself. They portray his conflicts and give voice to his concerns. As doubles, they voice the unspoken and sometimes, even the unconscious. They are able to do this for they have entered his soul (so to speak) and discovered its contents.

In all of these ways, the protagonist is respected and cherished by the director and auxiliaries. His personality is put forward in all of its dignity and majesty. It is he who is the master of his drama—for it is he who provides the clues which guide the production. It is his right to veto scenes or change auxiliaries or, if he so desires, to select new scenes and suggest new characters—for the drama is the story of *his* life. It is his readiness which determines what can be tried and it is his instinct for defense as well as his human dignity which enable him to stop the action by crying, "Enough!".

The protagonist is a volunteer. He is on the stage and in the scene because he wants to be there. His rights in this cannot be violated. When they are, he immediately begins to block and resist and the organic and spontaneous movement of the drama is violated. This goes also for the protagonist's right to choose problems to reveal, to determine the psychological level at which the drama is to operate, the pace of the action's movement, etc.

All this suggests that it is the full respect accorded the protagonist which enables his psychodrama to be portrayed; and that the greater the general sensitivity to his needs, the more fully will his drama be realized.

Basic also to democracy, is respect for the worth and integrity of the group, as well as respect for its ability to be responsible for its fate. Let us now examine the group's role in the psychodrama.

The Group

Essentially, psychodrama is a group procedure. The individuals who come together are helped to become a functional group as part of the warm-up procedure. They are encouraged to participate so that a drama may be enacted—but they are also cautioned of the significant degree of personal involvement that usually characterizes all who participated. They

are in this way warned of the possible impact of what they are about to witness, so that they know what they are getting into before they take the plunge.[3] They are also informed that the drama will be paced to their own readiness to get involved and their own level of participation—for it will also be, in essence, their own psychodrama.

The psychodrama provides the group with an opportunity to work through problems of common concern to its members. What occurs on the stage grows out of the group's needs which emerge and are identified during the warm-up. Generally, these concerns of the group are brought to a focus by the designation of a protagonist, one of its members in whom the group has taken an interest and with whom it wants to work via the dramatic action on the stage. The protagonist's drama provides a vehicle through which the group can further its own self-understanding and growth. The director's task is to help the protagonist express himself through the drama, but at the same time, he must enable the group to achieve self-expression. It is essential, therefore, that the director remain ever responsive to the group's level of interest and involvement, for unless the group continues to care deeply about the drama and is willing to support the protagonist, the production will falter.

If the group is denied its inalienable right to select the subject or protagonist, tension and antagonism develop. If the group is uninterested in the person selected for the drama or if a problem is imposed upon the group, resistance develops and the action will be blocked. There can be no meaningful drama without an interested and involved audience.

In psychodrama, then, the audience group is not a collection of passive spectators. Rather, the group represents an intrinsic aspect of the production, the source from which the protagonist and the action emerge and are sustained. Generally also, the group serves as a source of auxiliary egos. Trained professional auxiliaries, if available, can play an important part; but frequently, the most successful are those who emerge voluntarily from the group as the action proceeds. When this happens (and the group should be encouraged to participate in this manner) the learnings and insights are multiplied. Such voluntary doubling or other spontaneous participation represents a most significant development. It indicates that the group is involved and wants to forward the drama's progress. It suggests too, the assumption of

[3] See discussion of the preparation of the audience as moral imperative in Fink, Abel K. "The Case for the 'Open' Psychodramatic Session: A Dialogue," *Group Psychotherapy* 13:94-100 (June, 1960) p. 95.

responsibility on the part of the group; an implicit acceptance that the drama is basically a function of the group itself, and that every member of the group plays a therapeutic role.

Its awareness of its own responsibility also provides the group with a self-defensive device. The group wants to forward the action, but it also want to defend its members, including the protagonist, from harm. The group should therefore, have the right to veto actions which it sees as dangerous. It should not hesitate to warn the director of harmful possibilities; to block action which it is not ready to witness and otherwise to guide the action into safer channels. The director is wise to heed the advice of his group in setting limits on the action. By so doing, he is assured of group-sustained dramatic action and group trust; for he generally finds that his own respect for the group is reflected in its respect for him.

It is in the group's ability to bring out its own concerns as well as to utilize its full resources of knowledge, understanding and control that the democratic nature of the psychodramatic method is again demonstrated.

For the director the psychodrama is an experience in which he facilitates the utilization of resources of the group as it attempts to grapple with its concerns. The director does not bring problems to the group, rather he helps the group deal with its own problems. He serves the group as democratic leader by facilitating the process by which the group locates, explores and then attempts to resolve problems of concern to itself.

The director serves as group helper, but no matter how skilled he may be, he needs assistance in order to most adequately serve the group. Indeed, the directorship should properly be conceived of as a shared function. There are many times when the action loses its focus and the next step is uncertain. It is then that the director turns to the group for suggestions. Experience indicates that the group is often aware of nuances of the drama to which the director is insensitive and its advice is often invaluable in facilitating the action. Advice may also be volunteered by members of the group during the course of the dramatic action. The director must remain constantly alert to such suggestions and utilize those which are pertinent in moving the action forward. The more perceptive the group, the more valuable are its suggestions.

It is not unknown for a member of the group to approach the stage and assume the role of director himself. Such voluntary directorship may be very useful, but must be controlled to assure that it represents the needs of the drama and not those of a new protagonist.

Shared leadership, as expressed through sharing the role of director indicates a high level of group involvement; moreover, it suggests that the group is moving to the point at which it can produce its own dramas. It is an indication that the group is developing its skill—the democratic skill—of mobilizing its own resources in order to solve its own problems of living. Such a development would indeed indicate the way in which democracy can be learned through the proper practice of psychodrama.

The Danger of Violation

Accepting then, that psychodrama is in truth basically democratic in spirit, is it not possible that aspects of the method may be employed out of context for totalitarian ends? Unfortunately, this could happen. Specific techniques are essentially neutral and can be employed in the service of many purposes; but perhaps here too there is hope. If those who have contact with psychodrama can be made aware of its best practice, perhaps the liberating quality of the experience will hold in check the temptation to employ its techniques piecemeal.

A very real danger does exist, however, in that sometimes what goes under the name of psychodrama lacks the basic democratic spirit and in truth is really a violation of the method. We see this in the case of the director who is really a protagonist and who, under the guise of helping a group to resolve a problem, is in truth attempting to force the group to be concerned with his own problem. We see this too when the director, instead of allowing insights to grow organically out of the drama and out of the group's sharing of its common experience, attempts to force the group to accept his own perceptions of what has occured. We see malpractice also, when persons are forced onto the stage unwillingly, or are asked to pursue matters which they are unready to reveal. The only real safeguard in the long-run seems to be a concentration on a fuller understanding of the method and a more total commitment to democracy on the part of all concerned. As these are emphasized, protagonists will be encouraged to demand that their human rights be respected and groups will be more ready to stand fast in their determination not to tolerate attempts at manipulation.

Again, as Margaret Mead has suggested, the unscrupulous may select aspects of psychodrama piecemeal to be employed for their own ends, but when they do this, they are not really violating the integrity of the method, for the techniques they attempt to use are devoid of the democratic spirit and therefore are actually unrelated to the essence of psychodrama.

THE USE OF PSYCHODRAMA TO STRENGTHEN SELF CONCEPTS OF STUDENT NURSES

LEAH GOLD FEIN, PH.D.

Norwalk Hospital School of Nursing

THE PROBLEM

In 1954 group dynamic sessions were initiated by the writer with student nurses, sophomores at the Norwalk Hospital School of Nursing, at the request of Mrs. Virgina Gerry, Pediatric Supervisor. Mrs. Gerry had been concerned for many years with the difficulties student nurses displayed in relating to the children on pediatrics, the parents of the children, as well as to nurse's aids. She noted that the students were either too strict, dogmatic, controlling or too permissive and overindulgent to the children and their parents. Toward the nurse's aids the students behaved either in a superior, snobbish, authoritarian, dogmatic manner, furtively expressing disdain for the inferior education of the aids or they related as peers, fooling about and joking in the presence of the children or the students relating in a subservient, dependent manner to the aids. Furthermore, the students generally griped and complained about everything and everyone.

The behaviors described by Mrs. Gerry suggested to Dr. Fein that these students were uncertain and anxious about their roles, status and responsibilities on the ward. These anxieties and uncertainties led them into defensive behaviors that resulted in ineffectual function on the ward. Realizing that psychological variables in the nursing personalities play a major role in the well being of the patients and their striving for health, a group dynamic program was initiated to help the students come to the realization that their reactions and behaviors have a vital impact on the welfare of the patients.

PROCEDURES

One hour weekly, for a period of six weeks, the girls met with Dr. Fein and Mrs. Gerry in an informal setting. The purpose of the sessions was to help the students clarify for themselves their own identities and roles, face and accept many unacceptable feelings experienced and learn how to handle these feelings constructively for their own best development and for the welfare of the patients under their care. The girls were first oriented to the ubiquitous nature of unconscious motivations and to the universality of defense mechanisms in human behavior. Distinctions were made and exemplified between

constructive, destructive and ineffectual though seemingly neutral mechanisms of defense. To direct the attention of the students within themeselves, each student was invited to introduce herself to the group by considering and answering the question: "Who am I?". This startling question served to soften the girls for self-exposure in the group, which was essential, if the sessions were to elicit personal and interpersonal problems for examination and solution, in a brief six week course.

Interpersonal conflict situations presented by the students were clearly defined in terms of the participants and situational conflict and were treated after some discussion, through the use of sociodrama. Intrapersonal conflicts were also clearly defined (a difficult process for the girls) and were then treated by use of psychodrama.

During the eight years that this program has been in effect, girls reported that the question "Who am I" made them take a good look within themselves for the first time. Many students admitted they did not like to identify themselves for they did not like the image they saw.

Results

Common problems that emerged from these sessions include:

1. Low status feeling with defensive maneuvers in relation to teachers, supervisors, head nurses and nurse aids "who seem so sure of themselves" and "who move in with their ministrations to patients without regard for the student in charge of the patient."

2. Low status feelings in relation to college peers "who look down on us as though we crawled out of a hole."

3. Resentments toward the nursing school administration because of limits on number of consecutive days off and the school indifference to National holidays. They complained "why can't we get days off during holiday time like other college students get"; "why can't we have long weekends like regular college students," "we're just slaves, they use us for their own needs."

4. Widespread resentment was expressed toward fellow students who "are teacher's pets," "who are grinds," or "loafers" or "who spoil it for the rest of us."

5. Widespread resentment was expressed toward staff and administration for dating limits, dismissal policies, punishment policies, e.g., "they don't understand that we are grown-ups and should be free to decide when and where and with whom to go out"; "you never know when you'll be thrown out, there

is no definite standard around here"; "they are inconsistent, sometimes they give severe punishments and sometimes they just laugh and tell you to be a good girl."

6. Disdain was expressed for the types of social events "planned for them."

7. Anger was widespread against the administration for the limits set against marriage during training. This policy has encouraged several secret marriages among the girls, creating the problem of maintaining secrecy about this event until graduation day.

8. General dissatisfaction was expressed with the setting due to the limits of meeting eligible young men for dating.

The effect of these sessions on student behavior was evaluated by the pediatric staff before, during and after the course and in student evaluations by other faculty. The general concensus of staff revealed that the students rapidly improved in relationships with patients, parents of patients and with co-workers, i.e., aids, peers, superiors.

Our results with the use of group dynamic sessions, psychodrama and sociodrama support the findings of Dr. Calvert Stein who used these techniques successfully with student nurses in Springfield, Mass. (Stein, *Group Psychotherapy*, 14, 1-2, 1961).

Our group dynamic program continues along with research into the drop-out problem, the development of non-academic supplemental selection procedures and the institution of inservice training of staff in research, communications and evaluation skills.

THE LIVE PRESENTATION OF DRAMATIC SCENES AS A STIMULUS TO PATIENT INTERACTION IN GROUP PSYCHOTHERAPY

R. L. GUNN, L. NAVRAN, D. SULLIVAN AND LEONARD JERDEN

Sepulvida V. A. Hospital, Sepulvida, Cal.

The value of dramatics as a therapeutic agent has been the subject of increasing exploration. Over the past fifteen years, Moreno (2, 3) and others have established psychodrama and/or role-playing as a valuable technique in itself as well as in therapy groups. More recently, Brigante and Kinne (1) have experimented with the use of films as a stimulus for a newly formed therapy group. They reported that the outcome depended on how the use of the films was structured, the attitude of the patients toward such a procedure, and the development of a suitable relationship between the patients and the group therapists.

The present study was concerned with the effects of *live* dramatic presentations of scenes portraying interpersonal problems on group therapy processes. An important difference between the use of films and the dramatic scenes used in this study is that the scenes offer no solution and so provoke more possibilities for discussion. It was hypothesized, therefore, that witnessing such scenes might well act as a stimulus for patients to discuss their own problems and work toward gaining insight.

Specifically, the study was designed to provide answers to the following questions:

a. What is the effect on group therapy processes of presenting emotionally charged dramatic material?
b. Would the reaction of chronic patients differ from those on the acute and intensive treatment service?
c. Would male patients react differently from female patients?
d. Would the impact of the scenes be greater if followed immediately by the therapy group meeting or after a time interval elapsed?

PROCEDURE

The subjects used in this study were psychiatric patients who were undergoing group treatment on the acute and intensive treatment (AIT) wards, as well as continued treatment (CT) wards of the Sepulveda VA Hospital. Four open, *on-going* therapy groups, each of which had been in existence for at least 3 months, were selected: a male and a female group

from the AIT service and two male groups from the CT service. The groups were composed of patients whose diagnoses included character disorders and functional psychoses which ranged in severity from substantial remission to openly delusional states.

Four scenes, somewhat modified to serve as abstracts of the larger plays' core conflicts, were taken from the plays listed below. They were chosen to provide a variety of inter- and intrapersonal problems as stimuli to the subjects:

1. *Death of a Salesman*—Two brothers reflect on the course of their lives and express hostility toward their father to their mother.
2. *A Hatful of Rain*— A wife alternates between pleading with and upbraiding her alcoholic husband. She accuses him of infidelity and he walks out.
3. *The Glass Menagerie*— A dominating mother criticizes her son's eating habits and nightly movie-going. The son, his writing ambitions frustrated, tells her off, but is made guilty by her martyred reproach.
4. *Tea and Sympathy*— A stern father is threatened by the homosexual possibilities in his son's association with a male instructor, and forces him to withdraw from the female lead role in a school play.

Recordings of *humorous* dialogues were also obtained from the hospital's music therapist and used as control material.

Patients who were members of the drama club served as our players. They were rehearsed and directed by one of the junior authors, a man with considerable professional experience, who also selected and adapted the scenes described above.

The dramatic scenes and the neutral recordings were presented to each of the four therapy groups during a four week period. The order of presentation to each group was as follows:

1. Neutral recording.
2. Dramatic scene followed by neutral recording.
3. Dramatic scene.
4. Neutral recording followed by a dramatic scene.

Each therapy group began at a different place in the order and then

rotated through the four conditions. Two of the groups met immediately after seeing the presentations, one met four hours later, and the fourth met two days later.

The cooperating group therapists were briefed on the objectives of the study, and were instructed not to initiate discussion about any of the dramatic material. Instead, they were to leave it to their group members to discuss the scenes, if they chose to do so.

A recording was made of each group meeting during the week prior to the initiation of the study. This was done in order to provide a base line from which to compare the interaction of the groups after the presentations. All the group meetings held during the four week experimental period were recorded. After all play scenes were presented, recorded individual interviews were held with each patient in the therapy groups and with those who acted in the scenes. A standard set of questions were used to explore the extent and accuracy of recall of the scenes, as well as their attitudinal and emotional reactions.

The execution of the experimental design was handicapped by both anticipated and unforeseen difficulties. An example of the former was the movement of patients in and out of the therapy groups. Since all of the groups of this hospital were open groups, no attempt was made to hold patients who were ready for discharge from the hospital just for the sake of the study. As a result, some of the groups admitted new members and these newcomers, as well as those who left the group, did not participate in the whole design. Moreover, the newcomers operated to lessen the cohesiveness of their groups during the process of their assimilation.

The main unforseen difficulty was the irregularity of attendance by some patients. There was no effort made to compel attendance, and some chronic patients "forgot" the meeting times. This absenteeism operated to disrupt the continuity of the design for both the absentees and their groups.

Results

An analysis of the group meetings taped prior to the experimental period yielded these judgments:

> Group I, the women's group on the AIT service, was at a most superficial level. The patients talked about the therapist, staffing problems on their wards and minor personal problems of one kind or another. There was little or no talk about themselves let alone any indication of approaching insight into the more serious problems which faced them.

Group II, one of the two continued treatment service groups, included patients who were considered to be close to discharge from the hospital and some who were clearly delusional in their thinking. In addition there were patients classified as character disorders. Although the problems discussed had more personal relevance than was the case for Group I, it was felt that they were peripheral rather than central to the illnesses of the patients. The easy interaction of the patients was noteworthy, considering the range of severity of illness.

Group III was a male group on the acute and intensive treatment ward. The therapist in this group was very active and didactic in discussing such problems as ambivalence, prestige, and self-destruction. His technique left very little time for the patients in his group to bring up, or discuss anything.

Group IV was the other group from the continued treatment service. As was the case with Group II, the patients in this group appeared to be much sicker than the patients from the acute and intensive treatment wards. Although delusional material brought out by one of the patients spot-lighted the session, various aspects of the personality dynamics of other members were dealt with. Although the therapist attempted to create an interplay of ideas relative to the members' personality problems, we felt that the approach was made on an intellectual level rather than being aimed at the development of emotional insight by the patients.

Our judgment of the effects produced by the dramatic scenes were based on a close review of the recorded group meetings and consultations with the participating group therapists:

Group I (met immediately after the scenes). Group I, on the whole, tended to continue its pattern of small talk. Some mention was made of the conflicts brought out by the scenes, and there was a brief discussion of one particular character. However, these discussions did not lead them to associations to their own personalities or life situations. Instead the scenes were briefly touched upon and then the group drifted into a more casual discussion of other things.

Group II (met two days after exposure to the scenes). The members of group II also failed to associate the scenes to their own problems. Their choice of subjects and style of interaction hardly differed from that observed during the session held prior to the experimental period.

Group III (met four hours after seeing the scenes). No indication of an association of the dramatic material to their own problems, either directly or indirectly, came out of the therapy sessions of Group III. The conflict between mother and son in the scene from Glass Menagerie was the only topic discussed by this group that

was related to the plays. However, this was little more than a casual discussion with no attempt made to analyze the problem, or the characters.

Group IV (met immediately after the scenes). Group discussions held by this group were generally dominated by one or two patients. Discussions were mostly exercises in bizarre or delusional thinking. Association of the dramatical material to the patient's problems directly, or as a stimulant to discussing their problems was not clearly indicated.

Summarizing the results above, there was no basis for concluding that there was any difference in the group verbal behavior after seeing the dramatic material. It mattered little whether the group met shortly after the scene or several days later. Although the chronic patients tended to produce more bizarre kinds of thinking than the patients on the acute and intensive service, there was no indication that the stimulus situation had much to do with their verbalizations. Similarly there was no suggestion of a male—female variation in the effect of the dramatic scenes on group therapy behavior.

Interviews with Individual Patients

The negative findings yielded by the group meetings were in sharp contrast to the statements made by the patients when interviewed individually.

Many of the patients in each group testified that they had been reached emotionally by the scenes they had witnessed. However, they did not discuss their reactions or verbalize their feelings in the group for a variety of reasons.

Group I: "I didn't talk in the group because

(a) I wasn't asked to do so."
(b) It didn't dawn on me to do so."
(c) There wasn't enough time. I'm shy."
(d) The material was too painful and private."

As might be suspected from the above, the motivation to use the group for dealing with their problems was extremely low. Five of the eight women expressed open reluctance to talk of personal problems, saying such things as:

(a) "I feel the cause of my problems is physical."
(b) "I can't put into words what I want to say."
(c) "After all, problems are normal in marriage."
(d) "Personal things should stay personal. Who would benefit? It could be embarrassing. You might get in deeper. I want to leave the hospital."

(e) "I would talk about things if they were brought up, but small things only. I reserve private things for the doctor."

Group II. In this group of chronic patients, one patient attempted (unsuccessfully) to talk out his reaction to one scene outside the group to a fellow group member. Two patients took the position that they were waiting for the therapist to bring up what the plays were all about—to find out what he wanted to know. A third stated that "each one of us was waiting for someone else to bring it up." Two others felt that the members were afraid of bringing up "deep" subjects because they weren't sure how the group would receive them. In short, this group needed and wanted active direction from their therapist; when it failed to materialize, their reactions to the scenes remained dormant.

Group III. In addition to lack of direction from the therapist, several other reasons for not opening up in the group meetings were offered:

(a) "It was inappropriate to talk in the group. I had already worked this out in individual therapy."
(b) "I didn't feel the problem was shared by other members of the group."
(c) "The group was on too abstract a level and not on a feeling level."

Group IV. The justifications offered by these patients smacked strongly of sheer negativism. Thus:

(a) "I don't know why, I was relatively new to the group."
(b) "I saw the scenes and that was that." (No connection was made with the group meetings).
(c) "I didn't feel too much like talking."

Two patients cited reasons already given by other group members. One was waiting for someone else to break the ice, and the other felt that the members were afraid to bring up important things for fear of how they would be received.

Interviews with the Patients Who Acted the Scenes

All six of the players (3 men and 3 women) were unanimous in their positive reaction to their experience.[1]

For some, the value lay in the catharsis for strong feelings permitted

[1] In this connection, the reader is referred to Moreno's analysis of the differences between the dramatic actor of the rehearsed drama form and the spontaneity player. He also discovered the "catharsis of the actor" vs. the "catharsis of the spectator" as described by Aristotle. It is the catharsis of action and of the actor which is a central pivot of psychodrama and its derived methods of action training. (Editor's note.)

by their roles. All of them shared the feeling that their performances were vital to the execution of the experiment. Since the director was a professional and they were essentially raw amateurs, they gained a feeling of real accomplishment when they felt they had satisfied him. Because he rehearsed them intensively, they did an outstanding job, and the ample praise they received from the staff and their fellow-patients gave external support to their feelings of doing something worthwhile.

Three of the players stated that their scenes had given them new insights into their own interpersonal relationships, because the scenes' action paralleled their own family experiences. For example, the patient who played the son in the *Glass Menagerie* scene reported that it had helped him to understand better why he had been in chronic conflict with his own mother, because he now could see his *mother's* point of view more clearly!

These reports by the patients were confirmed by reports from other staff members. The hospital's medical photographer informed the writers during the four week experimental period that the patient-actor assigned to work in his department had changed remarkably in his job performance. Where he had been sullen, slow, and doing a poor job before the experiment, he now was active, willing, and doing more work of much better quality than he'd ever done before. It had been a most astonishing transformation. The patient was able to take a part time job in the community a short time later, and subsequently made a successful adjustment when he was discharged from the hospital.

Discussion

Insofar as the original hypotheses were concerned, our findings were completely negative with respect to the scenes' impact on the functioning of the participating groups.

These results suggest that the negative findings could be attributed to:

1. The patients' deep resistance to going beyond the superficial level of socialization.
2. Our instructions to the therapists which kept them inert with reference to the scenes.
3. The entry of some patients into the groups after the experiment started.
4. The use of control material which may have encouraged silence in reaction to the scenes.

The writers feel that the experiment bears repetition with these changes in the design:

(a) The backgrounds of the experimental therapy groups' members should be reviewed and scenes should be selected which parallel the life experience or central conflicts of one or more of the patients.
(b) The therapists should have the freedom to be active in initiating and supporting the discussion of reactions to the scenes in the group meetings. This is especially the case in groups with psychotic members.
(c) The groups should, if possible, remain closed for the duration of the experiment.

It is generally accepted that group members need to work through their concern about the confidentiality of what is said in the meetings and be clear about the purpose of the meetings. In part, the negative results obtained are a reflection of the poor orientation of the patients to group therapy as a therapeutic medium. With an active therapist, the use of scenes might well help a collection of individuals who have not achieved these understandings work them out.

The effect (on the players) of playing the scenes suggests two possible courses of action in the therapeutic use of dramatics in the hospital setting. If scenes are used as advocated, the hospital's drama club would immediately become a therapeutic activity of far greater significance than is the case when it is merely a club which puts on occasional shows for hospital-wide audiences. An even more exciting prospect is having the scenes acted (or read aloud) by the group members themselves in their therapy group meetings. This would allow the therapist to give the patients he felt to be ready the chance to experience the role of the "significant others" in conflicts similar to their real life situations, as well as doing roles similar to their own way of behaving in real life. The catharsis and/or possible abreaction which might result could have great meaning for the patients and could be dealt with immediately in the group meetings.

In any event, it is clear that our negative results are far from the last word, and that further research needs to be done to answer the questions at issue.

Summary

Four on-going therapy groups were exposed to live dramatic scenes from current plays which dealt with interpersonal conflicts in family life. The design took into account differences in sex, degree of illness, and the time interval between the presentation of the scenes and the occurrence

of the group meetings. The hypothesis that the scenes might deepen the level of interaction in the group was not supported. There were no significant differences between male and female groups, acute and chronic patient groups, and groups meeting right after the scene presentations and those meeting at a later time. The scenes did have an emotional impact on individual patients, but they did not express their feelings in the group meetings for a variety of reasons. All six actors and actresses were affected positively by their experience. Further research is felt to be warranted, and its course is outlined.

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GROUP PSYCHOTHERAPY AND PSYCHODRAMA IN A COLLEGE CLASSROOM

JAMES FACOS

Vermont College, Montpelier, Vermont

The primary purpose of the instructor in any college should be basically to teach the material of his specific course in a way meaningful to the student. Many textbooks have been written, and courses given, to aid the instructor in accomplishing this main objective. However, it is my personal opinion, now founded on four years of advance college training of many subjects, that the techniques learned in group psychotherapy training[1] are of an invaluable assistance to an instructor; for the techniques lead not only to conveying the material at hand in a dynamic way to a majority of the students but, also, to having many of the students relate the subject matter meaningfully, with insight and wisdom, to their own lives—to the betterment of their own personal and interpersonal relationships, without the disadvantage of an overly intensified introspection or unnecessarily preoccupied self-concentration.

A secondary gain in the instructor's having had experience and training in group psychotherapy and psychodramatics is the insight it gives him in being able to "spot" emotional trouble cases; to help, if possible; to know when he cannot help; and to report his observations to the college, or to any other professional, counselor at hand—hopefully at a stage early enough to be of benefit to the student.

The techniques used in my classrooms are: (1) *directed discussions,* as class discussions, guided almost imperceptibly by the instructor along lines of discovery of, say, literature; (2) *psychodrama,* the acting out of specific situations in the original literature, to confront the students with a broader scope of insights by having them see as many sides of a situation as possible within classroom limits—and, when possible, to have the students relate the situation of a time-long-ago matter to their personal lives now; and (3) *leader observations*—the result of the class discussions and psychodramatics—which enable the instructor to bring vitally alive to the students the material studied, by applying necessary points in the work covered to their

[1] For such training, I am deeply indebted to Dr. Calvert Stein, Consultant in N.P. at Springfield Hospital and Faculty Graduate School, Springfield College, Springfield, Mass.

present lives, and, of course, to note the actions and reactions, positively or negatively, of the students to various areas of the material handled.

The main emphasis is on class discussion, guided by the teacher as a leader-director. Here the aim differs from group psychotherapy as a whole. In group psychotherapy, it is the aim of the director to bring to surface the latent or repressed attitudes, insights or emotions that have caused, or contribute to, a patient's neurosis; to see the patient in action and to guide the patient to self-discovery by ventilation first, through possible disassociation to valid self-identification. The evident premise is that one is dealing with patients *per se*.

In the classroom, on the other hand, one also has a group of individuals, but this group is of young, developing students. Consequently, the instructor's aim is to convey the material at hand to his students in a vibrant, meaningful way, with no visible *accent* on direct personal or interpersonal problems—unless it be a class in Human Behaviour.

It is here, within the confines and atmosphere of a classroom, that a measure of disassociation can most easily and advantageously be used. For example, the students who do not consciously identify with, or project into, *Romeo and Juliet* can attack or defend the characters and situations on a safe, intellectualised level of objective criticism. And so far, all is well and good.

But the instructor feels that *Romeo and Juliet* is much nearer now than the students would have it. The play to them is still of long-ago-and-far-away. He then guides them, by almost indifferent or off-handed questionings, into the interpersonal relationships and problems of incommunicability between teenagers and parents that form one of the central cores of conflict in the play.

By this method, he has set the play onto the stages of *their* lives and conflicts, has brought it alive to them on their own *emotional,* or personal, basis. In short, he has now led them to think of *Romeo and Juliet* not so much in intellectualised, disassociational terms, but in personalised, emotional terms, with identifications that spark the play with the life of here and now—their own lives.

The play, as well as further discussions of the play, takes on a meaningful depth. It becomes a mirror—wherein the students can see what they may have thought in their own personal conflicts and nature, as it is brought to a universal level. Any guilt or hostility that has been aroused in the students on this score becomes desensitised to a degree—according to their receptivity, wisdom and insight; and this is accomplished by seeing these emotions and

behaviour as universal, timeless qualities in most humans almost everywhere.

As a result, the instructor, by applying the first technique of group therapy in the classroom—that of directed discussion—can achieve a double effect: of bringing alive his material by guiding it unobstrusively into the students' personal lives, and of bringing to the receptive students insights into their own natures and the natures of those around them, the very insights which act as stars guiding to happiness.

The second approach—psychodrama—is easily attendant on the first, especially in literature courses. The instructor, aware of both his primary and secondary aims, can airily have any scene of any story, play, novel or poem—or a point in almost any essay—dramatised for effect.

The first dramatisation, book-read, if necessary, brings the work alive in terms of participants interacting—some even projecting and projecting well (without knowing it). After the scene, a discussion might well ensue—informal, yet guided, with all participating, even the shy ones, in an atmosphere conducive to a free exchange of ideas and an appreciation of each one's individuality and worth. Casually, the leader-instructor might personalise the discussion by asking, *in general*, What might the students do in like circumstances?

In *Romeo and Juliet*, for instance: "What would you do if you were Romeo? Or Juliet? Why couldn't you merely explain the situation and so avert the tragedy? Would you find it difficult to explain it to your own parents?"—And the sparks fly. The stage vanishes; Verona is here; then is now. And the play, the characters, the conflicts become alive in the students. Then the instructor—who might note some strong parental hositility here and there—may ask the emotionally involved students who indicate their identifications, "How would *you* handle it?" As a result, ventilation surfaces—ventilation *without either censor or comment*—and again the work takes on new meanings, and the students develop deeper insights. The instructor then simply turns to another point—while thoughts and emotions quiet into reflective awareness.

By using the material at hand, conflicts are ventilated, suppressions are acted out, and insights gained by the subtle use of role playing, role reversal, use of the double, and other well-known Moreno techniques in psychodrama. As a result, a double aim of the instructor may be achieved: to make an old work new, and to lead the students to wisdom.

As for the third factor in the use of group psychodrama in the classroom—the observations of the leader—the better and more varied his

training under a qualified group psychodramatist, the better job he can do. Obviously he must be astute enough not only to observe, but to observe accurately and to evaluate his observations validly. This is his main safety guide. He must—by observation of physical mannerisms, tonal inflections, variations of tone, actions and reactions, however minute—be aware who reacts to a specific part of the lecture or demonstration, and determine whether such response indicates normal, imposed or conditioned reflexes, or reflexes to too great a degree beyond the norm; ergo, indicative of an emotional trouble area.

If this be the case, he must almost instantly glide casually from that trouble area—even if only *one* person so reacts—to safer levels, as if it were all in a day's lecture (as it should be). In short, he must know by trained observation where the mark lies between insight and upset—where ventilation ends and disturbance sets in. He must note evasion, reluctance, rebellious defiance—and make the most of the non-verbal communication. He must, almost on the instant, decide whether to draw out a student or himself withdraw and, by some question or comment, reassure and reinstate that student's positive image of himself in class and elsewhere.

By this third technique, the teacher's guide, he must know when to ease from the subjective to the objective treatment of the material at hand, not to show overtly his own abilities and training unless specifically invited by the students, but to achieve the end for which he feels himself intended: to be a patient and kind teacher who is not afraid to demand as much of himself as he does of his pupils.

And if the teacher has background and training enough, not alone in his own specialised field but also in the field of group psychotherapy and psychodrama, his two-fold aim ceases to be ambivalent and becomes one: To turn out an informed and integrated a being as he can; and—using every blessed technique at his disposal, with the more, the better—so to be a true educator.

THE DIDACTIC VALUE OF ROLE-PLAYING FOR INSTITUTIONALIZED RETARDATES[1]

STANLEY J. BRYER AND ROBERT WAGNER
St. Louis State School and Hospital

Educational programs for slow learners should offer instruction which would motivate students to achieve maximum success in adapting to community life (McCaw, 1958; Wolk, 1958; Erickson, 1958; and Goldman, 1959). Such programs would emphasize the utilitarian value of academic subjects, thereby stimulating the student and increasing his resourcefulness. The necessity for social-experience curricula is reflected in the finding that the retarded exhibit more difficulty than do normal children in perceiving social situations (Hutt and Gibby, 1958). This is particularly crucial for institutional retardates because of the limitations which have been placed on their experiential growth. The cumulative effects of frustration in failing to meet social demands, and the meager environmental opportunities must result in damage to self-image, and therefore in a lowering of efficiency.

This study was designed to explore the relative effects of a program of academic training and an ancillary social-experience teaching procedure on student achievement among a group of institutionalized retardates. It is an examination of role-playing as teaching methodology with a curricular content of daily living skills. The choice of role-playing as the experimental pedagogic technique was given impetus by the finding of Tawadros (1956) that psychodramatic and spontaneity methods can be used to stimulate adolescents with an I.Q. range of 50 to react intelligently to social situations. Pilkey (1961) gave support to the empathic improvement of adolescent retardates as a result of their participation in psychodrama. Another description of spontaneous role-play technique as an aid to social perception of retardates has been offered by Sarbin (1957).

METHOD

Subjects

Subjects for the study consisted of 16 male, educable, mentally retarded students who were attending special evening classes in the St. Louis State School and Hospital. The Ss were equally divided into an experimental and a control group by means of matched pairings based on achievement test scores. Mean characteristics of the samples are shown in Table I. None

[1] Presented at the Twenty-Second Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, April 12, 1963, New York, N.Y.

of the Ss had defects of speech or hearing gross enough to prevent them from attending the regular academic classes provided for them.

TABLE I
SAMPLE CHARACTERISTICS

Group	N	Mean C.A. (Mos.)	Range	Mean I.Q.	Range
Experimental	8	262.50	192-372	61.3	48-90
Control	8	264.00	180-390	60.7	53-80

Procedure

The Elementary Battery of the Stanford Achievement Test (Form J) was employed to match the experimental and control Ss, and to measure possible differences between groups after a twelve week period. This instrument assays achievement level in reading, arithmatic, language, and spelling. Reading skill is measured by a subtest of paragraph meaning (PM), word meaning (WM), and a scale of average reading (AR_1), a mean score obtained from PM and WM. Other subtests are a spelling test (S), a language test (L), a test of arithmatic reasoning (AR_2), arithmatic computation (AC), and a scale of average arithmatic (AA), a mean score obtained from AR_2 and AC.

To maintain equivalent conditions for the groups all Ss were enrolled in the same school class. Each group attended separate weekly one and one-half hour review sessions which were coordinated with their regular course work. The control Ss were given work assignments and received individual assistance during their review period.

The experimental group was presented with a series of realistic situations to be role-played. A variety of operations which corresponded to the Ss academic course work were inherent in each of these situations. For example, in a drama concerned with the proper disposition of a payroll check, the protagonist had to perform the arithmatic, reading, and writing tasks related to devising a budget and filling out banking forms. Other productions were:

Applying for a job
Shopping
Completing an income tax form
Investigating how to get to a desired destination via public transportation
Eating in a restaurant
Using the telephone and phone directory

The role practice process followed the stages suggested by Hendry (1944):

1. Need sensitizing—making the student aware of his need for learning certain skills.
2. Warm-up of group to role-playing situations.
3. Effective observation of spontaneous drama by the audience.
4. Use of the follow-up discussion and evaluation period.
5. Repeating the dramatic episodes as a technique for supervised guiding of improvement in performance using methods such as role-play, role-reversal, doubling, mirroring, future projection, etc.

Results

Tables II and III respectively provide a comparison of pre- and post-experimental group grade score mean differences for each SAT test and

TABLE II
Initial Mean Differences Between Groups on Sat Scales

	Control Group		Experimental Group		
Scales	Mean	S.D.	Mean	S.D.	T ratio
PM	37.00	12.32	36.37	19.76	.06
WM	34.38	19.46	39.62	12.95	.56
AR_1	35.25	7.87	38.50	15.99	.17
S	36.50	5.83	37.87	3.35	.23
L	20.12	5.57	22.25	14.35	.28
AR_2	38.87	13.66	37.25	10.10	.37
AC	41.12	11.15	38.62	7.91	.60
AA	39.38	11.22	38.00	8.52	.34

TABLE III
Retest Mean Differences Between Groups on Sat Scales

	Control Group		Experimental Group		
Scales	Mean	S.D.	Mean	S.D.	t ratio
PM	38.12	12.11	43.87	18.85	1.13*
WM	36.75	5.19	41.25	17.40	.83
AR_1	37.50	7.72	42.56	15.97	1.01*
S	38.00	6.65	41.87	14.52	.55
L	17.63	8.70	30.13	21.27	14.20**
AR_2	39.37	10.28	41.25	16.38	.44
AC	42.38	2.20	43.62	9.68	.24
AA	40.25	10.90	42.50	10.36	.42

* Significant at the .20 level.
** Significant at the .005 level.

scale. A twelve-week interim elapsed between tests. Performance data from the first test served to match the Ss and construct the groups. As a result, application of the t test to the mean criterion scores shown in Table II yielded no statistical differences between the groups.

Data pertaining to the comparative effects of regular academic review and role-playing as review are summarized in Table III. Only the language test of the eight SAT measures analyzed discriminated between the groups to any significant degree. Means for this test were 17.63 for the control and 30.13 for the experimental groups, giving a highly significant t of 14.20 ($p < .005$). The language test deals with capitalization, punctuation, sentence sense, and usage. Increments in the experimental group means on the paragraph meaning test ($t = 1.13$, $p < .20$) and reading average ($t = 1.01$, $p < .20$) did not reach a conservative level of confirmation, but did offer possible trends which might be intensified as a result of extension of the role-playing program beyond three months duration.

With reference to these findings, it is of interest that the social-experience teaching procedure significantly elevated the language means since performance by both groups had been poorest on this test. The final language test scores were in balance with the other test levels of achievement. This evidence and the trend of higher achievement on the paragraph meaning test and the average reading scale indicate that the role-playing technique of academic review has its greatest impact on the verbal skills of retardates.

Summary

This study investigated the general hypothesis that the use of role-playing as a technique for academic review would provide retardates with greater means and motivation to understand the subject matter within a realistic context.

Sixteen institutionalized male retardates were administered the Elementary Battery of the Stanford Achievement Test. Ss assignment to the experimental or control group was based on matched pairings of test results. In weekly academic review sessions atended by each group, control Ss were provided with homework and individual assistance and the experimental Ss were presented with realistic role-play situations requiring equivalent academic performance.

Following twelve weeks of review, the SAT was readministered and mean differences between the groups were calculated for each SAT subtest. The resulting data showed significant achievement increases for the experimental group on the language test. While experimental group performance on

the other tests did not reach statistical significance over that of the controls, there was a trend toward increased verbal skills as a result of the role-playing experience.

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NEAR-SOCIOMETRIC[1] INVESTIGATIONS OF GROUP MEMBERSHIP SURVIVAL

ROLFE E. WHITE, B.A.

West Shore Branch, Cleveland Y.M.C.A.

AND

W. MARLIN BUTTS, ED.D.

Graduate School of Theology, Oberlin, Ohio

PURPOSE

This study is an attempt to show the relationship of those dynamic factors which control membership survival (new members, drop-outs, and attendance frequency) in five voluntary groups.

Description of the Groups Studied

The groups under study are Gra-Y Clubs. They are high status secondary groups with some natural and interest centered subgroups. The club members are boys from the fourth through the sixth grades—ages 9 through 12. Five clubs were studied; their initial enrollment varied from 15 to 47 boys. With the exception of one club, they are horizontal in socioeconomic status with the clubs varying from middle-middle to middle-upper class. The leadership for each club is furnished by a Y.M.C.A. Secretary who, in this case, is the author of this report. A total of 200 different boys were involved in this study.

METHOD

The following were selected as the variables that could be scientifically defined and studied in groups of this type:[2]

[1] In a sociometric test the choice and rejection decisions of the group members are capable of being put into operation so that the subjects are motivated to make genuine choices and decisions. In this context the present report represents a near-sociometric investigation. See Moreno's "Sociometry in Relation to Other Social Sciences," *Sociometry*, Vol. I, No. 1-2, 1937 (Editor's note).

[2] In this study proximity to the meeting place was uniform for all members because the meeting place was in a school gym and the meetings took place immediately after school, so that all candidates for membership were present in the school and enjoyed the same relative proximity (the ease of returning home after the meeting was not considered.) The size of the meeting places was the same for all groups.

Other factors which were studied, but not included in this report were: Size of the social atom, the leadership factor, the sociodynamic effect, and sociometric variations.

1. Group Growth:

$$\%G\frac{N-D}{E}\times 100$$

Where, G is the group growth

N is the new members (A new member was counted when he paid the accepted YMCA membership fee. He could only attend two meetings as a guest before joining.)

D is the drop-outs

E is the initial enrollment at the first session

2. Attendance Frequency:

$$\%\,Af\frac{A}{Pa}\times 100$$

Where, Af is the attendance frequency

A is the actual attendance

Pa is the possible attendance

3. Group Size:

The group size is expressed as the per cent of the deviation of the group from the maximum deviation possible between the largest and the smallest groups in this study. Thus, the smallest group represents the maximum deviation. The size includes the enrollment plus the new members at the time of sociometric investigation.

4. Group Tele Index:

The group tele index is the per cent deviation of the mutual choices from chance minus the per cent deviation of the unreciprocated choices from chance.

The computed chance equations were taken from Moreno and Jennings.(5)

The Sociometric Test

Earlier studies of these groups showed that limited choice and criteria sociograms did not reveal a clear picture of the individual social atom[3] or

[3] The definition for the social atom is "a pattern of attractions, repulsions and indifferences can be discerned on the threshold between individual and group. It is the smallest functional unit within the social group." Moreno, "Who Shall Survive," 1953, page 69.

of the group tele[4] index. Multi-criteria and unlimited choice, order, and quality sociograms shown in Table I were used. It was felt that the groups should be studied as an aggregate of social atoms of which the leader was a part. The test shown in Table I was developed to measure the nuclear shell of the social atom, distinguishing the outer and inner nucleus and social empathy.

TABLE I

SOCIOGRAM

Our Friends in Gra-Y

If it would be possible to allow anyone to join Gra-Y, list your friends in school who are not now in the club whom you would like to have join.

If you could have your choice of anyone in the group, what boys would you like to play with at the beginning free period of Gra-Y?

If we could have the elections all over again, what boys would you like to see as officers of the club?

If you were captain of a team about to play in a sport that required great athletic ability, what boys would you choose to be on your team?

It is a lot of fun to have close friends to play with in Gra-Y. Who are your *closest* friends that you enjoy being with the most who are in Gra-Y?

Who do you think enjoys playing and being with you the most in Gra-Y?

My name is ———————————— Age ——— Grade ————————

Other synonyms for the group tele index could be group consciousness, group awareness, and group cohesion. Criswell (3) introduced an equation for group coherence which was similar to the above. Thibault(7) used sociometry to measure one of the three variables defined by Back(1) which determines group cohesiveness, "namely, to those forces which derive from the attractiveness of group members." His studies measured cohesiveness in terms of the average resultant force toward remaining in a group which was determined by studying a member's preference for own-group to a relevant other-group. Moreno(5) defines tele as "The factor responsible for the increased trend toward mutualty of choice far surpassing chance possibility. . . ."(2) Attraction to the group is a function of the resultant forces acting on the member to belong to the group. The cohesiveness of a group is the result of all the forces acting on all members to remain in the group of which the tele index is only one of these forces.

[4] Tele is defined as "the simplest unit of feeling transmitted from one individual towards another." "It is responsible for the increased rate of interaction between members of a group, for the increased mutuality of choices surpassing chance possibility." See Moreno, "Who Shall Survive?" 1953, pages 311, 312 and 314.

In this study, the average number of different choices made by each individual was defined as the average nuclear size of the total social atom of the group members and was used in the chance equations as the number of choices per individual.[5]

RESULTS

Measurements were made of each group after each had convened for about 13 sessions. The data are recorded in Table II.

TABLE II
DATA

Group	Initial enrollment	Size	Growth	Attendance frequency	Group tele index
Goldwood	15	100%	66.6%	92.2%	76.5%
Wooster	27	69%	26.0%	88.0%	42.2%
Beach	27	55%	40.1%	94.0%	72.4%
Bates	32	48%	25.0%	86.0%	62.9%
Kensington	47	0%	14.9%	81.0%	58.0%

Growth, attendance, and tele were plotted against relative group size. It was evident that with the exception of one club, as the size increases, the attendance, the tele index, and the growth decreases. The one exception (Wooster) means that there is still a factor or group of factors which affected the membership survival of the one club, but were negligible in the other four.

The three factors: attendance frequency, group tele index, and relative group size were plotted on a multi-factorial graph. The area of each square produced by the factors for each club was graphed on log paper.

It is evident that in this study of these five groups, the three factors of attendance frequency, relative size, and group tele index are in balance with each other and have a definite effect on the group growth factor which establishes the thesis of this paper.

One possible error is the group tele index. It represents the tele of the group at the moment of the measurement and does not reflect the sociometric variations which will occur from session to session. The other factors represent all of the sessions to date of the measurement.

The total number of absences for all groups was 263. 77% of this number were absent more than once. Continuing the study of absences for

[5] There may be an element of error since Moreno and Jennings' equations of chance were developed for sociograms with limited choice while this study allows unlimited choice.

the subgroups in each club, it was evident that without exception one subgroup in each club suffered the greatest loss in attendance. The average number of subgroups in each club was three. The per cent of the absences for each was 16.7%, 27.7%, and 55.5% respectively. The absences for one subgroup in each group was greater than the totals of all the absences in the remaining subgroups.

Discussion

These results support the following theory of membership survival in groups of voluntary membership under the conditions described in this study:

The groups under study are large aggregates of social atoms composing from one to several subgroups all united in a fine system of balance. The nature of this system is determined by its initial size, and its initial group tele index. There are two ways that the balance of the system may be altered:

1. By increasing or decreasing the size of the group;
2. By increasing or decreasing the group tele index.

The Effects of Changing the Variables on the System

The system is said to be in balance when the group size and the group tele index remain constant over a period of time. Any fluctuation of one factor will change the environment of the group which may or may not threaten the group socioatomic survival. If the change is negative in valence, it will create a hostile environment which threatens socioatomic survival. If survival is threatened, the reaction of the group is to maintain equilibrium either by restoring the original altered factor, or by causing a corresponding change in the unaltered factor. If the change is positive in valence, it will create an environment which is favorable for group socioatomic survival, an environment which favors an increase in size or tele as long as equilibrium is maintained.

Causes of Changing the Group Size

The maximum size of a group relative to any monent in time is when the attendance frequency is 100%. Increase in size may be caused by growth (the assimilation of new members). Size may be decreased by two means, one is by decreasing the attendance, and the other is by drop-outs.

The accepted reasons why people join or remain in a group may be identified as two major sources of attraction: (*a*) the group itself is the object of the need; and (*b*) being in the group is the means for satisfying

the needs that lie outside the group. This study implies that the forces which draw a member to a group are socioatomic in nature. When the group is the object of the need, the individual social atom joins the group social atom to enhance his nuclear shell contacts within the group. But whether these contacts are tele (mutual) or infra-tele (unreciprocated) in nature has a definite effect on the group social atom and the group tele index. When being in the group is the means for satisfying the needs that lie outside the group, the individual social atom joins the group social atom to enhance his nuclear shell contacts outside the group.(2)

Causes of Changes in the Tele Index

Scheidlinger(6) listed the following concepts which when present enchance group cohesion:

1. The satisfaction of common individual needs for protection, security, and affection.
2. A predominance of positive affective interpersonal ties.
3. Shared ideals and interests.
4. An atmosphere of equality and justice.
5. Symbolic group ceremonials and activities.
6. Common enemies outside of the group.

Scheidlinger added the following elements which he says endanger group cohesion:

1. The uninhibited expression of drives (sexual or aggressive or both).
2. Undue egocentricity in individuals.
3. Extreme jealousy and competition.
4. Excessive negative transference reactions.
5. Too much frustration accruing from the demands of the leader or group code.

Thibault(7) showed that by creating experimental environments which would vary the cohesiveness of the group, the sociometric status would change correspondingly.

It is hypothesized from the preceding discussion that any variation of the group socioatomic system which is of negative valence will produce an environment which endangers cohesion. Thibault(7) explains his results in terms of the hostile feelings which are built up during his experimental sessions and which apparently get released through the catharsis afforded by the communication of aggression when the conditions favor this type of communication.

Moreno and Jennings(5) noted that the deviation of tele from chance

increased from the kindergarten through the adolescent periods of growth. This was significant in this study because the Wooster club which has the lowest tele also has the highest percentage of fourth graders.

The fact that there is a high number of repeating absences in low attending members and that subgroup survival is at the expense of another subgroup, indicates that the resultant forces of the communication, be it positive or negative, is geared towards group socioatomic survival, and more specifically toward subgroup socioatomic survival.

Moreno(4) has already hypothesized this phenomenon. He said that due to the consistency of socioatomic structure, and the measureability of an individual's emotional expansiveness, any change in the socioatomic membership causes an immediate reaction of social repair to re-establish the socioatomic equilibrium or *sociostasis*, as he called it.

SUMMARY

Those dynamic factors which control membership survival (new members, drop-outs, and attendance frequency) in the five voluntary groups in this study were found to be related to another factor defined as the group tele index. The relationships between these factors create an environment which effects group socioatomic survival, and more specifically, subgroup socioatomic survival.

The present study indicates that even though growth is a random phenomenon, the environment which promotes growth fluctuates with the balance of the size and tele of the socioatomic system so that in the long run, over a great number of meetings, growth is directly related to the existing environment which, in effect, it helped to create.

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AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Annual Meeting

The Twenty-Third Annual Meeting of the Society will be held at the Statler Hilton Hotel, Sixteenth Street at K and L Streets, N.W., Washington, D.C., on April 3, 4 and 5, 1964. On April 5, the morning meeting will be held in the Psychodrama Theater at St. Elizabeths Hospital, by invitation of its Superintendent, Dr. Dale C. Cameron. The meeting is also a commemoration of the 25th Anniversary of the Psychodrama Program at this hospital.

A number of papers have already been offered, but this is to ask all members to participate actively in the program, either as chairmen, speakers or directors of demonstration sessions. Your suggestions for program topics are most welcome. Please mail them to the Program Chairman, Zerka T. Moreno, P. O. Box 311, Beacon, N.Y.

New York Chapter Meeting

This chapter is holding its Annual Meeting at the Hotel Barbizon Plaza, Central Park South and Sixth Avenue, New York City, on November 15 and 16, 1963.

For details and program write to: Hannah B. Weiner, 1323 Avenue N., Brooklyn 30, N.Y.

Roster of Member's Activities

This section would like to include reports on professional activities of the members of the Society, including special lecture engagements, new publications, and any other news items of general interest involving professional efforts. Please send your news item in double spaced, typed form to: American Society of Group Psychotherapy and Psychodrama, P.O. Box 311, Beacon, N. Y.

The J. L. Moreno Award Fund

The Council of the Society voted during its last meeting on April 13, 1963, to set up a J. L. Moreno Award Fund. The Award is to be given in recognition of a member's outstanding services in the field of group psychotherapy and psychodrama.

The Council then voted the first two Awards, in the amount of $200.00 each, to Mr. James M. Enneis, M.A., Director of the Psychodrama Department at St. Elizabeths Hospital, Washington, D.C., and Mr. Leon Fine, M.A.,

Director of Psychodrama and Group Psychotherapy, St. Louis State Hospital, St. Louis, Missouri, for their services in the setting up of a Training Institute in their respective hospitals.

The Council will continue to observe the recognition of those whose services to the field, in whatever manner, are of outstanding nature. This Fund is an extension of the original recognition of the Society of authors whose publication was deemed of noteable value and who have been recognized in the past. Future recipients of the Award will be announced.

ANNOUNCEMENTS

Academy of Psychodrama and Group Psychotherapy, New York City

The New York Branch of the Academy is offering a Program of Training Seminars in the course of 1964, on the following weekends:

February 28-March 1	July 24-26
March 20-22	September 25-27
April 24-26	October 23-25
May 29-31	November 20-22
June 26-28	December 18-20

This program is open to mature professional workers, psychiatrists, group psychotherapists, psychologists, sociologists, educators, nurses, social workers, industrial personnel, pastoral counselors, and all persons working in the field of human relations.

A series of intensive practicum training sessions, intended to meet the numerous requests for training in the greater New York City area, as an extension of the program in Beacon, N.Y.

For further details and enrollment information, write to: Academy of Psychodrama and Group Psychotherapy, Moreno Institute, Inc., 236 West 78 Street, New York 24, N.Y.

Academy of Psychodrama and Group Psychotherapy, Beacon, N.Y.

The resident training periods for 1963-64 in Beacon will run as follows:

November 22-December 12, 1963	May 23-June 12, 1964
January 4-24, 1964	June 27-July 17, 1964
February 8-28, 1964	August 1-21, 1964
March 14-27, 1964	September 5-25, 1964
April 11-May 1, 1964	October 10-30, 1964

For further details and information, write to: Academy of Psychodrama and Group Psychotherapy, 259 Wolcott Avenue, Beacon, N.Y.

Annual Academy of Psychodrama and Group Psychotherapy, Los Angeles, Cal.

This once-a-year event will take place on Sunday, May 3, 1964, prior to the convention of the American Psychiatric Association in that city. The all-day meeting will include a luncheon meeting and dinner. Final details as to location will be announced. For information on participation on the program and for registration procedure, write to: Academy of Psychodrama and Group Psychotherapy, 259 Wolcott Avenue, Beacon, N.Y.

First International Congress of Psychodrama, Paris, August, 1964

The World Academy of Psychodrama announces its First International Congress, to take place in Paris, France, at the end of August, 1964. It is planned as an intensive training and communication forum for professional workers from all over the globe. The meetings will consist of training sessions in, among others, behavior training, sensitivity training, methods and techniques, as well as discussions by international panelists sharing their experiences with psychodrama in various cultural settings.

For further details and information, write to: J. L. Moreno, M.D., P.O. Box 311, Beacon, N.Y., USA.

Theater of Psychodrama

A Theater of Psychodrama has been built in the spring of 1963 on the grounds of the Psychiatric-Neurologic Clinic, University of Vienna, under the direction of Prof. Dr. H. Hoff. Plans are on the way to explore the potentialities of psychodramatic methods for the treatment of mental patients.

A Book on Sociometry in Hebrew

"Sociometry, Studying Group Relations, Introduction and Guide" by Hanan Bar-Netzer, published by Rubin Mass, Jerusalem, 1963, 186 pages, bound, price $3.50.

A Book on Sociometry in Italian

"Principi Di Sociometria" by J. L. Moreno, a translation of the English text of "Who Shall Survive?" published by Etas Kompass, Milano, Italy, 1963.

Volume of Proceedings, Group Psychotherapy, 1963

The Proceedings of the Third International Congress of Group Psychotherapy in Milan, Italy, are now being prepared. 150 to 200 contributors will present the actual trends of group psychotherapy in fifty countries. For preliminary orders write to P.O. Box 311, Beacon, New York.

International Group Psychotherapy

Volume II No. 1 of the Global Review will be published in conjunction with Group Psychotherapy, Volume XVI, No. 4.

Psychodrama Volume I

A third edition of Psychodrama Volume I by J. L. Moreno has just appeared, published by Beacon House, 500 pages with illustrations. Price, clothbound $12.00; paperbound $9.00.

IN MEMORIAM BERTHOLD STOKVIS

1906-1963

In September we received the sad news that our dear friend, Berthold Stokvis, had succumbed to a vicious disease. Up until May 1963 we enjoyed the vigor, superior judgment and the human friendliness and ever-ready co-operation of this good man, who had been our friend for the last twenty years.

At the age of twenty-six we find our friend Berthold Stokvis active as Psychiatrist and Neurologist after he had completed his medical studies. His thesis for Doctor of Medicine in 1937 indicated already the course of his creative work. The title of his thesis was "Contribution to the Knowledge of Psychology and the Psychotherapy of Patients suffering from Essential Hypertension, with the aid of Continuous, Automatic and Indirect Registration of the Blood Pressure."

A year later he was appointed Director of the Medical Psychology Laboratory of the Psychiatric University Clinic of Leyden and as a member of the Medical Faculty as Lecturer on Experimental Psychology.

Up to the outbreak of the Second World War Dr. Stokvis made a good name for himself as a scholar. Then came the great crisis in Europe but in 1943 we hear again of him. He came as a guest lecturer to us in Switzerland. In the following years he was invited to give lectures in Paris, Brussels, and Vienna. Notwithstanding the great misery of the war years, he had attained so much recognition that he received at the age of thirty-five in 1941 the Gold Medal of the Psychiatric University Clinic in Leyden in recognition of his scientific accomplishments.

In 1948 he was elected as Adjunct Professor for Patho-psychology at the State University of Leyden and as Administrator of the Clinic.

He became the Secretary of the Dutch Society for Psychology; Secretary of the Dutch Society of Rorschach Research; Corresponding Member of the Department of Mental Hygiene of the University of Basel (Switzerland); Secretary of the International Society of Pedagogics. Since 1952 he has been Editor of Acta Psychotherapeutica, Psychosomatica and Orthopaedagogica.

Among the additional honors we would like to mention the invitations he received as a Visiting Lecturer in the following countries: England, Switzerland, France, Austria, Germany, Spain, Belgium, Italy and USA. We were

always a witness to the strength of his personality, the profundity of his scientific knowledge, the modest manner in which he presented his ideas and the great friendliness which captivated his audience. From the great work which Berthold Stokvis has built up we cite here only his most important publications. Every publication mirrors the originality of Berthold Stokvis. Every publication is a document which makes him thus unforgettable.

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Last but not least, we come to the decisive contribution which Berthold Stokvis made as Secretary of the International Council of Group Psychotherapy. We have had the honor and pleasure to work in close contact with Dr. Stokvis. In 1957 we had him as a Lecturer in Experimental Groups at the International Congress of Psychiatry. When it came to elect the Directors of the International Council he was chosen as the Dutch representative. Because of his competence and popularity, he was chosen into the Executive Committee. As Secretary he directed all preparations for the International Congress in Milan. We met him shortly before he succumbed to his deadly disease; this was the last time and the occasion when the final preparations for the Congress were concluded. He who has done so much to make the

Third International Congress of Group Psychotherapy a success could not take part himself in the Congress. However, I had the profound satisfaction to hear from all sides in the last weeks of his life that his inexhaustible work has borne fruit.

We have many thanks to give to our great friend, now deceased. We mourn his departure and our deepest sympathy goes to his wife and children.

A. Friedemann
Biel-Bienne, Switzerland

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