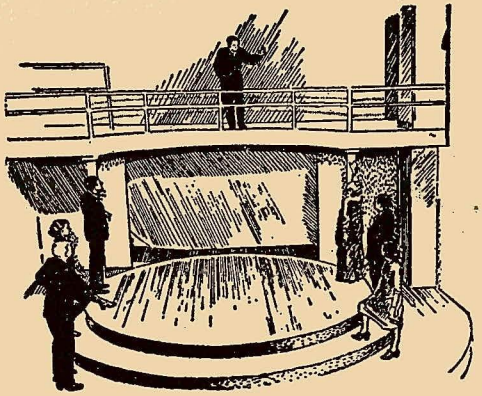
GROUP PSYCHOTHERAPY

A Quarterly



25th Annual Meeting
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AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY
AND PSYCHODRAMA

Vol. XVIII, No. 1-2, March-June, 1965

GROUP PSYCHOTHERAPY

Volume XVIII March-June, 1965 Number 1-2

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Volume XVIII March-June, 1965 Number 1-2

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AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY
AND PSYCHODRAMA
25th ANNIVERSARY

CITATION

PITIRIM A. SOROKIN, PH.D.

Professor Emeritus, Harvard University
President, American Sociological Association

February 5, 1965

Dear Dr. Moreno:

I joyfully join a legion of scholars in congratulating you and the American Society of Group Psychotherapy and Psychodrama, founded by you, with its anniversary. I take this occasion to express my highest respect and admiration for your extraordinary creative achievements beneficial to all of us and to a multitude of human beings helped by your methods of therapy.

My state of health does not allow me to write a longer essay on your and Zerka Moreno's contributions to sociometry, group psychotherapy, psychodrama, sociodrama, sociology and psychology.

With my admiration, respect, high regards and best wishes to both of you and your Society.

CITATION

AUSTIN MACCORMICK, PH.D.

Professor Emeritus in Criminology, University of California at Berkeley
Formerly New York City's Commissioner of Corrections
Exec. Director of the Osborne Association, Inc., New York City

April 14, 1965

Dear Friend:

I have been far too slow in writing to thank you for the copy of your pioneer book, and telling you what a pleasure it was to see you at the dinner last month and to share reminiscences with you. I erred in not giving you full credit for being "the father of group psychotherapy in prisons." It has come a long way since 1932, and is now our most useful tool in going beyond the mere imparting of skills to the real task of helping offenders resolve deep-seated problems.

THE GROUP PSYCHOTHERAPY MOVEMENT SINCE 1932, A LOOK BACKWARDS AND FORWARD*

F. LOVELL BIXBY, PH.D.

Consultant on Probation, State of New Jersey, Trenton

Apparently I owe the honor of being a speaker to my longevity and I'm glad that I have inherited that trait. I'm not really going to talk to you about the development of group psychotherapy and psychodrama, because I don't know anything about it. I'm here in the guise of an historian since you might say I made my living by crime ever since I was a young boy and the only thing that I could think of to say was something that I perhaps knew myself and have lived through. In a way, I had something for dinner tonight that probably no one else in this room had; I had a large slice of humble pie which I had to eat. And one of the reasons I agreed to come here this stormy night was so that I could say it publicly, because I was at that historic meeting in Philadelphia in 1932 and I was enormously skeptical. I was young then and I had no hesitations because I knew so much more then, than I do now. I had no hesitation saying this man Moreno is either the greatest thing since Barnum or the greatest thing since Freud, but I thought it was Barnum. I'm not sure whether I said that out loud or not, but J. L. knows that I thought it, because we've met each other since.

Many young people in the correctional world like the late Holsopple and myself resisted that new thing, group psychotherapy. And when I got this invitation to come here tonight I began to think back and say "why did we resist it so? Why were we so unwilling to listen?"

And I think I know the reason, Dr. Moreno. It was a function of the times. I don't think we were unmitigatedly stupid. I think we were just at a certain period in the development of correction. We were in a power struggle, throughout this land. Austin McCormick knows, he lived through it. There was a very bitter struggle in those days going on in the correctional world, between the wardens, the practical men as they liked to think of themselves, and the few of us fugitives from the universities and the laboratories, and the clinics, who were breaking our way into the prisons and it was really a time of great strife and struggle. It was a very polemic era. We were the long hairs, we were threatening these people who had enjoyed a measure of success by keeping everything quiet, by practicing a uniform

* Keynote Address, given at the Twenty-fourth Annual Meeting, American Society of Group Psychotherapy and Psychodrama, New York City, March 20, 1965.

policy of keeping the individuality of the prisoners completely out of sight. I don't say it was not there but they kept it out of sight. And we came in with some idea of carrying out Thomas Mott Osborne's injunctions to turn these scrapheaps into repairshops and we were not welcome.

I well remember when I first went to the New Jersey State Prison as a summer replacement for the psychologist, I was sent over to see the warden who was ill and never recovered, but he had energy left to say to me: "I don't want any damn psychologists around here and you can go from the front door to your office, then you sit in your office until you're through and then you go out. You don't go wandering all over the prison." And shortly thereafter since I had to make recommendations about work assignments I thought it would be nice to get down to the shops and I was stopped by a large-size guard who said: "Where do you think you're going?" and I said: "To the shops," and he said: "You got a pass?" and I said: "I work here, I don't need a pass." And he said: "You need a pass," and I was turned back. And at that point I made a bad decision, I decided that either I was going to quit that day or stick around till I ran the damn place. So I stuck around till I ran it about twenty years later.

But that was the feeling of the times, and the watchword that we had, the thing that sort of symbolized us as opposed to these practical men, was our concern with the individual and individual treatment. But this man Moreno with his talk about group therapy back in 1932, we sort of equated with mass treatment and we wondered, what happens to the individual? And so we were blind and we were not receptive and I had to think of some reason for it, because I could not have been all stupid. So I thought of the following reason. We were fighting something, we were in a power struggle for control of the apparatus of correction and a power struggle is a good thing to generate heat but it doesn't help you much to cast light on the problem. And so it was for a long time.

Well, I got out of that thing and went on in the correctional business and the next time I had any remembrance of group therapy was when I was warden at the U.S. Reformatory at Chillicothe. I had set up a small unit for problem boys. I had a psychiatrist there; some of you know him, Dan Childs, who said that he would like to try some group therapy with these boys. Well, they were locked in securely, there was no key in the building even, so I said, "Go ahead, why not?" But at that time we were getting ready to go to war and my attention as warden was focused almost exclusively on our industries, where we were making goods for the army, navy, coastguard, and so on. But I must have had some kind of idea that this group business

was having some impression on the boys because later when I was borrowed by the State of California and we were setting up the program of the Adult Authority I suggested to Norman Fenton that it might be a good idea to introduce some group counseling. Well, actually, I did not know what I was talking about. What I really had in my mind was that all my life I have been striving to bring the custodial and the treatment group together. I never could see any possibility of getting anywhere as long as they were separated and so I said: "You know, we ought to get some of these people involved in talking with these people and maybe it would be better to do it in groups." And so he did. And, of course, it's been greatly successful. But even then I didn't really know what I was talking about. It was a way of involving personnel who I wanted to involve and I was thinking of that rather than the benefit it might be to the inmates.

So the first time I really ever got to see it and sense it and feel it was when I was in the army. And I was in the correction division in Washington and the Under-Secretary, Judge Patterson, said: "Well, there's something very unmilitary going on down at the disciplinary, at the Rehabilitation Center at Fort Knox and I'm getting all kinds of complaints about it. And you'd better go down and look into it. It's called 'group therapy'." And I thought: "Oh, my God, that again, I'll stop that." So I went down and I began to see what they really were talking about. And I think right here I should pause to make a slight digression. Let me just say this, that I saw McCorckle working with large groups, I saw other men working with small groups but I met the Commandant, Col. Miller. And Col. Miller in civilian life was the Dean of Boys at the New York Military Academy. He was an educator by trade. And he said: "Yes, it's true, I take these guys right off the rifle range, and send them to group therapy. I pull them out of the drill period and make them go to group therapy, because," he said, "they're not bad soldiers because they don't know how to shoot, or because they don't know how to drill, they're bad soldiers because they don't know how to get along with people. And therefore I think that this group therapy is more important than the rifle range." Well, I saw this, I thought it was great, I took it back to Washington. It became standard procedure in all the rehabilitation centers, and it never worked anywhere except at Fort Knox. And the reason for it was Col. Miller. He understood it, he had the sense of it, and right now when I say that I'm boasting, absolutely boasting, because the only thing I've ever done for group psychotherapy is to hold an umbrella over it and keep the Philistines from destroying it. But you can't have it in any kind of an organizational way unless the guy at the top understands it and

knows it. If he's a doubting Thomas it wont get to first base. Now we're just getting ready to embark on a widespread training in group methods for our probation officers in New Jersey. But before I dare to do that I'm sending all the chief probation officers to a three-day group session with Saul Pilnick and his assistants, so that they won't be afraid of it anymore, they won't try to squelch it. And you do have to have an understanding administration in any kind of governmental or institutional use, and Col. Miller understood and therefore his people were able to function. Other superintendents or other Commandants who did not understand it never really got by.

Well, I thought it was great, I made up my mind that, whenever I'd get back to civilian life again, wherever that might be, I was going to introduce this technique into correctional work. And so I've been able to do that in a number of places. But the thing that surprises me so much is, that all of the years, and particularly since the war, the thing that characterizes the correctional prisoner almost more than anything else was the era. I mean, we had the era right after the Civil War which, in prisons was the industrial era where everything was centered on production. And then we came into the period when I came in, where everything was individualized treatment and we fell into the mistake of thinking that the only way you can benefit anybody was to see him yourself and then he had to get more and more of you, and they got to be more and more of them. So that the period, you might say, of the early 1930's was the period of classification, of individual treatment and the use of psychological tests, aptitude tests, and some attempt to fit a program, pretty sterile as you look back, of education, recreation, industry, and so forth, hoping that you didn't get a stupid guy into a job that required a bright man, and so on. But this era, since, I would say, since, World War II, has been marked by the introduction of some form of group psychotherapy into every aspect of correction. It came into the institutions first, now, as you saw this afternoon it's in probation in the Federal Government, Alex Bassin, of course, is using it with probationers for a long time over in Brooklyn, and it becomes the most, shall I say, respected tool in the correctional business, not only in this country. I have seen it in Japan, in England, in Sweden, in Denmark, in Belgium. I'm going over to Belgium the first of May for a session with people over there on probation.

I think that I would not be too far wrong if I gave just a little word of warning. There is no question but what the method of using peer group therapy is by far the most important thing we've had in the correctional field. But I think those of us who sponsor it or those of us who practice it have to recognize a certain danger. It has become a status symbol. I was saying to

somebody this afternoon, when I first came into the prison business, you judged an institution on two characteristics, its bread and how well the band played. And if you went to an institution where they had no band, you knew it was a very bad institution. And if you went to an institution where they bought their bread from a baker, you knew it was a very bad institution. Well now we've come to the point where there's such an acceptance of group psychotherapy, or the horrible expression guided group interaction, which, I must confess I'm responsible for. It was concocted entirely to bemuse the budget. I didn't dare to tell the budget director that we were going to have group psychotherapy 'cause he'd throw me out. And I was a little afraid of some of the psychiatrists, they might throw us out too, so I said: "Let's call it guided group interaction, and nobody'll know what we're doing." And to my amazement, I find that it has been translated into Japanese and it's generally accepted now as a term.

And I think we have to be on our guard that in any position in which we may find ourselves and which we can influence people who are doing this, to make sure that standards of training, standards of performance, are maintained. And people should realize that just getting a lot of people into a room to argue is not group therapy. I've seen some tragic things happen, I saw one psychiatrist lose his pants, the boys threw them out of the window and he had to go downstairs and get them. And I think if there is any danger at all, group psychotherapy is so well recognized now that it's becoming almost too respectable. I never thought I should live that long. Thank you very much.

NEW HORIZONS IN THE EXPANDING ART OF PSYCHOTHERAPY*

CALVERT STEIN, M.D., LL.B.

Life Fellow A.P.A., D.A.B. Psychiatry and Neurology, F.A.S.C.H., F.A.S.G.P. & PD, (M) American Academy of Neurology, Visiting Lecturer, Graduate Schools Columbia Medical and Springfield College, Consultant Neuropsychiatrist, Springfield Hospital

World wide population explosion is finally knocking on our own back door and focusing attention on great social issues that are of special concern to practitioners of the healing arts. These issues include various degrees of social integration, more equitable distribution of food and material goods, and the dignity and emotional needs of the common man.

Great governments and great religions are also rediscovering their role of leadership and responsibility for a pooling of natural resources and the need to recognize the universal truth that man is indeed his brother's keeper.

Higher institutions of learning are showing belated recognition of the shortage of competent professional personnel in practically all of the major specialties—engineering, technology, medicine, sociology, psychology, pedagogy and especially in the fine art of psychotherapy.

Now expanded to global proportions, our own society and its indefatigable leaders continue to flash the Beacon of Moreno leadership, ideology and techniques to all parts of the world. It is therefore both heartening and fitting that the annual programs of many of the national societies of therapists are regularly including reports and demonstrations of such "fringe" disciplines as psychodrama, music and dance therapy, puppetry, creative arts and crafts and hypnotherapy.

In my first inaugural address to this society last year, I expressed the appreciation of your officers for the expanding horizons of therapeutic skills, and the unsung and often unrecognized devotion with which you have so generously contributed your time and energy to come here at your own expense; to share with us your vast experience with marriage counselling and other domestic and personal problems, as well as with those unfortunate misfits, rejects and other maladjusted members of human society which even the psychiatrists, the neurologists and the psychoanalysts cannot or will not help.

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* Presidential Address to the American Society of Group Psychotherapy and Psychodrama, 24th Annual Meeting, Barbizon Plaza Hotel, New York City, March 19, 1965.

Many of your contributions have brought about great changes in the practical applications of dynamic group therapy; and to some extent, even in its philosophy, carrying the torch of therapeutic hope to some of the most unpromising areas of human problems. Belated recognition of our habitual professional pessimism toward these heretofore inaccessable misfits—the senile, the disabled and handicapped, the recidivist delinquent, the habitual alcoholic and narcotic addict, the hardened criminal, and even the maladjusted homosexual, has caused the leading therapeutic specialities to re-evaluate and to modify both theory and practice. Partly as a result of your contributions and research, there have even been some changes in our own organization. Herein, briefly, are some of these changes:

I. Group Psychotherapy, Psychodrama and Sociometry

Sociometry is no less important today, but is now considered as an integral part of basic training in group dynamics as demonstrations are focused more and more on therapy, on the protagonist and his personal needs. Group interaction and spontaneity are still very much in the foreground, but they have gradually taken over the center of the therapeutic stage from the director. The director is still the mainspring of the therapeutic program, but disciples of the Freud of Psychodrama are now less intent upon becoming second class or carbon copy Moreno's. Instead, they are encouraged to desist from flattery through immitation, and to develop their own particular directorial styles, incorporating such additional skills of their own as music or dance, histrionics in the various role-playing techniques, creative arts and even hypnotherapy as such whenever it may be indicated. However, unlike many other great leaders, the Sage of Beacon does not fight against these changes. He welcomes, encourages and applauds them even when they, at times, tend to play down the importance of the warm-up, lighting and other techniques of stagecraft. In short, like many a great military and social leader, Moreno preaches in effect: Let's get on with the job. Worry about the details later. Play it by ear and push for natural spontaneity. Pick up your clues and cues as you go along and remember that the responsibility of the group leader is to get as much as possible from as many participants as possible, and in as short a time as is available for the purpose of improving insight and strengthening self-confidence. As in all therapies, this responsibility is also a privilege in the eyes of one who loves his fellow men.

Nevertheless, in characteristic Moreno fashion, this indefatiguable giant of psychotherapy and his remarkable family continue to pioneer the Global Movement for Group Psychotherapy and Psychodrama with new and better

books, produce training films and promote the continuous theatre of psychodrama. These may take the form of three sessions daily with the same principals and director, and lasting for several days to a week, and in privacy if indicated, as the protagonists work out a domestic problem, for example. Or, it may be public using different directors who change every few hours and demonstrate a variety of techniques with changing open groups of participants.

II. Reforms in Psychoanalysis

Include waning use of the couch, discontinuance of approved training of lay analysts, increasing emphasis on short term analytical psychotherapy, and decreasing emphasis on an indeterminate "analysis." There is also diminished emphasis on the distinctions between the various psychoanalytic schools; and an increasing recognition of the common indebtedness which all schools of psychotherapy have to Charcot, Breuer, Freud, Stekhel, Ferenczi, Jung, Adler, Watson, Pavlov *and* Moreno, though few of them as yet know it, and still fewer would admit it. Renewed interest in the *here* and *now* and the *future* as well as in the past has been emphasized by such leaders as Anna Freud, Thomas French, Franz Alexander, Karen Horney, Clara Thompson, the Existentialists and, though still unknown to many of them, our own Zerka Moreno. The entry of qualified medical psychoanalysts to the examining staff of the American Board of Psychiatry and Neurology and to the heads of psychiatric departments of many of our best medical schools. The return of Clinical Hypnosis via hypnoanalysis, allegedly but never completely abandoned by Freud has already reached new heights of efficacy in the hands of such leaders as Lawrence Kubie, Ainsley Meares, Bernard Raginsky, Louis Wolberg, Herbert Spiegel, Margaret Bowers, Erika Fromm, Fredericka Freytag, Milton Erickson *and* J. L. Moreno, although he is actually quite modest about it, perhaps because of his preference for less subtle induction techniques. Like Kildaire of World War II fame Moreno was usually there before most of them. Finally, there is the bold but belated emergence of the analyst from the protective sanctity of the ivory tower to the adventurous and threatening exposure of some form of group psychotherapy. This is one of their latest admissions that conventional psychoanalytic therapy can be too long, too expensive, and not necessarily any more effective than any other therapeutic modality. Small and closed groups are the rule, along with as little direction or structuring as possible. Psychodrama is generally considered to be a dirty word, and the constant bugaboo of the leader is the emergence and problem of management of non-verbal aggression. Spontaneity, as we know it, is not recognized as a high speed "free" association. Psycho-

dramatic "acting out" is usually restricted to verbalized dialogue and non-verbal communication may be glibly and superficially "analyzed" by some of the more aggressive and vocal members of the group. Since the "director" or group leader persists in a relatively passive role, psychological traumata may be accentuated for some members of the group as often as they are relieved. Simple Role-Reversal, which would afford an opportunity to put oneself in the other fellow's shoes, and to blow off steam in a synthetic situation and without continuing to feel too much guilt is, unfortunately, not a feature of current psychoanalytical group psychotherapy. Nevertheless, even here, some signs of change are beginning to be felt as a result of sporadic requests for our demonstrations.

III. The Clinical Psychologists

With or without a Ph.D., are doing most of the actual group psychotherapy in schools, clinics, hospitals, correctional institutions and vocational training centers. While a sixth year of clinical training is being added to their requirements for a Master's degree, and requirements for the Doctorate keep escalating, most of the training programs seem to favor non-directive and non-dramatic techniques in which the group leader restricts himself to inane and repetitious echoing of the various challenges which he seeks to avoid. In this area, he is not alone. Most physicians and psychiatrists likewise prefer the relative safety of a one-to-one relationship in the private consultation room. These are also the therapists who do not yet know that the clinical psychologist has long since left the research laboratory, that he no longer confines himself to psychometry, and that he is often a leader in the production of first class personnel selection programs, and readable textbooks on "Abnormal Psychology," as well as producing excellent teaching films on psychopathology and psychotherapy for students and laymen. Clinical psychologists belong to many of our national organizations—Orthopsychiatric, Psychosomatic, Clinical Hypnosis, and are frequently guest lecturers even with that oldest conservative body, the American Psychiatric Association, where he is as eager to learn as he is capable of teaching. His chief drawback is the same as with any other therapist whose work forces him into daily contact with bordering specialists, such as pastoral, legal, social and medical counsellors. Unfortunately, too many of these other specialists are even more uninformed on the particular skills of the psychologist as he often is on theirs.

IV. Other Therapies

Unfortunately, space does not permit more than a brief mention of the coming of age of the certified psychiatric social worker as a first class psy-

chotherapist in his (and her) own right; the shifting emphasis in the national societies of clinical hypnosis from techniques in stage hypnotism to refinements both in induction and in hypnotherapy; and the rather new efforts of medical and dental schools to offer graduate courses in clinical hypnosis, psychodynamics and psychotherapy for qualified dentists, physicians, and psychologists.

V. Common Denominators in Psychotherapies

As we travel ever eastward toward the rising sun, in our restless search for new horizons in the art of psychotherapy, we inevitably return to our starting point, since the earth is still basically spherical. The common denominators of all great therapies are based on human needs for faith and confidence, for freedom from hunger, cold and danger, for the opportunity to ventilate or express grievances and to prevent anxiety from being channeled into physical outlets by timely abreaction or other constructive physical outlets when possible.

Regardless of whether the therapeutic agent is confession and catharsis before a Delphian Oracle or a Sacred Temple where hypnotic sleep is quickly induced, and even surgery may be accomplished during the night long trance, or the psychodramatic stage of experiential learnings of life, the lessons are the same:

For some clinical entities, such as many a borderline character disorder, the failures and successes are statistically comparable regardless of which type of therapy is used. For others, such as most marital and domestic problems, there is no better vehicle than psychodrama with a sympathetic director and in a group of one's peers; while in many a psychovisceral or psychosomatic conversion reaction, a single session in hypnoanalysis may suffice to reveal enough insight and to release accumulated tension into less destructive outlets.

Most encouraging of all is the fact that while many therapeutic disciplines loudly proclaim their differences and specific advantages, most of them nevertheless, continue to explore and exploit their common psychodynamic denominators and to expand their horizons of therapeutic usefulness to those who seek their help.

VI. The Challenge of Prevention

Perhaps the greatest of these psychodynamic common denominators is the fact that the sociopath and psychopath, and most of our other misfits are not born with their problems. Their problems are made for them as well as by them. One of the greatest challenges in therapy is Prevention. This calls

for a massive revision in our gross educational system. I, therefore, call upon this society of ours, the American Society of Group Psychotherapy and Psychodrama to lead the way in demanding a gross revision in our total educational system. It is time to place much less emphasis on the names of Ancient cities and the dates of the defeats or victories of their generals, and much more emphasis on the elementary lessons of how to get along with one's family, one's playmates, one's job, and one's own particular self. Our society needs fewer and better movies, Television, books and comics. Our society needs simultaneous training courses in group psychodynamics in psychotherapy and psychodrama for teachers, parents, *and* pupils from kindergarten through high school. The lessons of pre-school and primary years need to be continued in terms of teaching personal and moral as well as cultural values, and better habits for maintaining them. We already train our boy and girl scouts in first aid for accidents. We even train policemen to deliver babies in taxi cabs.

We need training courses for marriage, and periodic check-up examinations on childraising, even more than we do for a license to drive a motor vehicle. Psychiatric clearance is being required in an ever increasing number of areas—for health insurance, for military service, for civil service appointments to a police force, for school teachers' tenure, for railroad retirement and many others, but is seldom required for marriage, with one exception that I know of, namely, the Roman Catholic Church which asks for a possible history of mental illness before giving pastoral approval.

The task is huge; and millions of workers will require special training and inducement for this great objective: to deglamorize those misfits who rise to Hitlerian power, or even to lesser local gangster notoriety; to deemphasize the pitiful fallibility and inadequacies of the private lives of the cinema "greats," and to accentuate those positive values in our daily lives that will help humanity to keep pace with technology.

ROLE THEORY APPLIED TO LIFE INSURANCE SELLING

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1. INTRODUCTION

Everybody professionally connected with training, particularly the training of salesmen has heard of or even practices role-playing. Techniques and results vary greatly. Evaluations of the method are controversial, lacking a consistent theoretical framework. To formulate such framework is attempted here. Role theory, that is various theoretical perspectives developed by psychologists under that heading, was applied in a two years study of life insurance salesmen. The original action-oriented study observed how Agents contacted Prospects. Next followed attitude surveys of agents, insurance buyers and non-buyers, analysis of prospecting and selling techniques, selection and training systems for agents, and roleplaying experiments with selected groups of salesmen.

2. PERFORMING A ROLE

Meeting another person, what we enact and how we express ourselves constitutes our performance. Depending on the particular situation and our objective we try to make certain impressions, evoke specific reactions. To the extent to which our expressions or expressiveness create the desired impression, our performance has been effective. If we want to be liked, but arouse dislike, wish to appear sincere, but meet with incredulity, desire to amuse but arouse boredom we have failed. We can chose our roles or what we want to enact, to the same extent as we can chose friends, occupations, social situations. Once the choice is made, the role we perform is prescribed for us by the expectations of those with whom we want to have effective encounters. So as we move through different social scenes we put on various pre-determined behavioral masks; we become persons.[1]

[1] "Persona" (Latin) means mask. Role theory as a psychological perspective on human behavior became prominent with the writings of J. L. Moreno in "*Das Stegreiftheater*, 1923 and *Who Shall Survive?*, 1934, and the writings of George Herbert Mead in *Mind, Self and Society*, Chicago, Illinois, University of Chicago Press, 1934. The theory in its many ramifications and applications in research is summerized by Theodore R. Sarbin, *Role Theory* in Gardner Lindzey's Handbook of Social Psychology, Vol. 1, Chapter 6, Cambridge, Mass., Addison Wesley Publishing Co., 1954. For a more recent formulation see Erwin Goffman, *The Presentation of Self in Everyday Life*, Edinburgh, Scotland, University of Edinburgh Social Sciences Research Centre, 1956.

3. Roles of Salesmen

If markets are viewed as social scenes, the direct selling act is a species of the general social encounter. To be effective here means that the other person will buy from us. Selling is expressive behavior, creating impressions about the product which induce the buying act. There has to be saleability, product utility, buying interest. But if "creative" is an attribute of the selling act, the implication is that the product does not sell itself, that buying interest is only latent, that there are countervailing buying resistances. Role theory perspectives are particularly pertinent in situations where creative selling must precede buying. These selling skills are scarce and not easily definable. Though only an extension of general social skills creative selling has not proved easily trainable, nor identifiable in selection tests. The common proposition that "creative salesmen are born" reflects this, too the general experience that creative salesmen are successful in any line of selling. This means further that, whatever we identify as the ability of salesmanship exists independently of special product or market knowledge, which develop with time and specialization.

Sales training has recognized the special skill involved here. The prevailing practice is to codify sales tracks which usually in dialogue form illustrate the "best" sales approach or technique. Getting the "best" is empirically assured by making these sales tracks reflect the experience of the most successful salesmen. To the extent to which these tracks meet the expectations of the would-be buyer they constitute effective role scripts. One flaw is that the really effective salesman, the "natural," does not know usually why he is successful. Even where the sales track makes a perfect role script this can not assure effective enactment.

4. The Life Insurance Salesman

The novice acquires occupational skill through a perusal of manuals and personal instruction. The insurance companies and the licensing authorities focus the trainee's attention on the technical nature of the product. The life isurance contract is a compendium of empirical and mathematical data wrapped in a legal package. Its precise, sober, even somber language seemingly prescribes the role characteristics of the agent. He has to posses analytical and verbal skills to explain the complexity of the product. He must be able to discover highly individualized insurance needs and match these with his company's contracts.

As prospective representative of a long-range fiduciary relationship the agent must convey an image of absolute integrity and financial conservatism. He must display unqualified convictions on the social functions of life insurance. He has to appear sincere and a model of discretion as the potential recipient of confidential business and family information.

Possessing these personality characteristics and following proven sales tracks should ensure occupational success. But profiles of successful and unsuccessful agents, of sold and unsold prospects show many inconsistencies. Superior product knowledge does not assure selling success. It often inhibits the selling act. By the same token the sold prospect, praising the expertise of his agent is often totally ignorant about the nature of his policy. Prescribed qualities of sincerity, conservatism, conviction stand in strange juxtaposition to the galaxy of agents' success stories which demonstrate the art of simulation, dissimulation and sheer showmanship.

Following their employers' expectations many agents demonstrate their convictions early in their career by selling their relatives, best friends or just themselves. Though this can well be advantageous to all parties concerned it often typifies early occupational failure. For once this uniquely "natural" market is saturated the agent no longer finds prospects with whom he can demonstrate his beliefs without encountering major resistance.

Recruiters of agents usually pre-select on such personal attributes as "liking people," "sympathy," "warmth." Such characteristics are needed to counter-balance the appearance of self-interest which every selling attempt projects. But where these qualities constitute basic attributes of the Agent's private self they often lead to personal over-involvement with the customer. This type of salesman takes genuine care of all his prospect's needs, except the one of selling him insurance.

Public opinion surveys show that the average family has come to accept life insurance as a budgetary necessity. Life insurance agents enjoy higher public prestige than most other groups of salesmen. The national sales literature abounds with true stories of the Million-Dollar-A-Year life underwriters. For this elite, regardless of the companies they represent or the policies they handle there is no dearth of prospects, no market saturation, no competition. These salesmen's income and social status match that of top executives. Having agents of that caliber means lower selling costs for the company and eventually lower premiums for the policy buyer. To achieve this insurance companies invest heavily in selection and training. Yet of the newly started agents a bare fifty percent survive the first year, twenty five percent the

second, though on an average one sale per week more than assures occupational survival. To explore this incongruity one has to turn to the life insurance prospects and buyers.

4. The Life Insurance Buyer

Financial protection and savings constitute basic product features and the demand for these accounts for the continuous growth of the industry. Yet life insurance has remained a perpetually "unsought" commodity requiring direct, hard, order-getting selling. Notwithstanding its name life insurance belongs to the death-associated products and occupies here a rather unique place. Cemetery lots, tomb stones, undertaker services do not necessitate pre-need buying or selling. After the event, at any rate these goods will be sought out by surviving relatives. Life insurance, however, must be sold on a pre-need basis. This requires the buyer to anticipate his own death; to perceive it as a certain, though time-wise unpredictable event. Emotional resistance against such perception is generic and deep-seated in our culture.[2]

Mass-marketing of life insurance against these resistances and taboos has been accomplished partly through product masking. Reference to death is meticulously avoided. The product is differentiated along "living" values. The insured buys savings for himself, income for his wife, college education for his children, mortgage-payment protection on his home. But product-masking is no cure-all. At best it indefinitely postpones the dreaded awareness. Moreover such masking usually shifts resistance from product to salesman.

The resolution of these resistances constitutes the agent's primary task. Informing prospects of available coverages, matching individual needs with existing provisions are secondary. The primacy of the resistance problem is insufficiently appreciated. Consequently there is little understanding for such apparent contradictions which show on the one hand that the public attributes quasi-professional status to the agent, but reacts negatively, even with hostility to the visit of the particular agent. It is not the particular person but the anticipated topic of discussion which evokes emotionally painful associations. The intensity of these emotions is only heightened by our efforts, as rational persons, to suppress these associations.

The life insurance purchase provides too counter-vailing positive asso-

[2] The strength of this taboo is most neatly indicated by the fact that behavioral scientists, traditionally least affected by such restrictions, have only recently turned to "Death" as a relevant topic; see *The American Behavioral Scientist*, May, 1963, pp. 58-70, also footnote 5, p. 9 and footnote 4, p. 90.

ciations; the gratification of protecting one's family, fulfilling the role of provider. These sentiments are re-inforced by the mores of our culture. Similar to the Last Will life insurance also extends our control beyond death, gratifying the wish for omnipotence. Similar to the tombstone the life insurance policy provides a symbol of survival. The very anxieties aroused by the product thus can be resolved through its purchase.

The selling encounter typically takes place in a welter of mixed and submerged emotions. Anxiety aroused by death perception is accompanied by guilt feelings for not being able to face reality. There is ego inflation with the appreciation of one's provider's role and the value of one's financial replacement. Then comes the letdown with the awareness that this value can be realized only after one is no longer here. All this is covered-up and desensitized by the verbal mechanics of the encounter which enables both contestants to rationalize away the emotional ambiguities. With our emphasis on rationality few will admit the flourishing here of primitive magical thinking. Yet what often lies behind the violent rejection of life insurance is the notion that one must not gamble against oneself; the unpredictable event would become certainty if made the contingency of a bargain; death must not be tempted. Others again will associate with the insurance premium a symbolic sacrifice which indefinitely postpones the dreaded event; the transaction assures peace of mind.

6. The Agent's Role—Resolving the Prospect's Resistance

Agents are trained to counter verbal objections, such as "not interested in insurance," "no time to see you," "don't need it," "have'nt got the money." But the verbal objections only mask the real resistances which the agent has to explore. Has the prospect enough ego strength to face reality? Can his anxiety be sufficiently bound to present the positive gratification of the product? Is he disposed towards a positive magical solution which the salesman may usefully support: If you buy the policy you will stop worrying." If he is disposed towards negative magic the agent may have to dispel this through a seemingly iron-clad logic, "the rate our reserves are growing shows that our policyholders live much longer than expected."

The value of standardized sales tracks depends on uniform and predictable customers' interests. Though these interests should be identified early in the sales process they are not to be satisfied until prevailing resistances are first resolved. With the actively resisting prospect a listening, analytical salesman is needed, rather than one who aggressively pushes his presentation. Where resistance is passive—the customer listens eagerly, but chronically

postpones buying—the agent has to probe aggressively for the content of the resistances. With this type of selling standardized sales tracks are useful only in a limited way. They can attune the salesman to the possible range of prospects' resistances. They may serve to develop general attributes functional to whatever role the agent will assume.

The usefulness of the tracks ends here. The salesman does not perform before a captive audience, even though individual resistance patterns may be of the passive type. Pre-conceived, fixed roles, mechanically rehearsed in training sessions prove effective only by chance. This is the rationale of the widely proclaimed averaging principle, according to which the salesman should tell his story to the largest number of prospects, with the assurance that some will be receptive. This point-of-view leads to waste of selling time and manpower. It also causes the resentment of customers, confronted by hordes of insurance salesmen applying mechanically different gimmicks.

Superior salesmen abandon these sales tracks and take their cues from each individual prospect. As with boxing or chess the effectiveness of each move depends on correctly anticipating the opponent's counter-move. Perceiving the opponent's role must precede enacting one's own. If the latter does not evoke the expected response it has to be changed on the basis of new perceptual information. Creative selling does not consist of presenting predetermined sales talks, nor can sales training be adequate if it solely depends on rehearsing these talks. Observational or perceptual skills have to be sharpened. Spontaneity has to be developed, meaning the ability to respond adequately to a novel situation.[3]

This emphasis should not preclude discovering typically favorable selling situations and developing roles effective in such situations. For example, earlier described resistances will be easily resolved if the sales encounter follows on the prospect's recently experiencing the death of a person close to him. Incisive events in the life-cycle such as marriage, birth, even their anniversaries induce time orientations and consciousness of adult responsibility.

For another example of favorable prospecting situations, life insurance customers look for "personal" and "professional" attributes in their relationship with the agent. Similar to our relation with physician or attorney we are reluctant to expose ourselves to untested strangers when intimate or vulnerable experiences are involved. The agent who solicits new customers is on this score at a distinct disadvantage. This can be reduced through techniques such as "referred leads" or "nest prospecting" which at least give a semblance

[3] J. L. Moreno, *Sociometry and the Science of Man*, Beacon, N.Y., Beacon House, 1956, pp. 108-109.

of a pre-existing relationship. In these situations the salesman selects the role which best will meet the customer's typical expectations. Though the latter can not be securely predicted, the salesman's role pre-determination will at any rate assure him the advantage of the opening draw.

7. Role Conflicts

The earlier cited rate of occupational failure (to which should be added the high incidence of occupational arrest at below optimal performance) can be explained in terms of role conflict. In the jargon of the theory we have first "*Role-Role Conflict*"; discrepancies between the agent's role expected by the buyer, as opposed to the role prescriptions originating in his Company. From the latter's rational product perspective the utility of the insurance contract is actuarially determined and should be self-evident to the customer. The agent, therefore, does not sell, but only solicits applications or writes policies. Prospects' resistances are ignored. The emotional intensity of the selling encounter is covered up by the legal-mathematical logic of the product. This perspective applied to recruitment and training ignores the salesman' primary role—resolving the customer's resistance. Indoctrination of agents is confined to maximizing knowledge and belief in product and company. These together with maximal personal effort are presented as guarantees for a successful selling career. All this, however, beclouds the agent's perception of his real role. The prospect's anxieties, aroused by the product and projected on the agent are now introjected by the latter. He feels the customer's rebuffs constitute rejections of his person: "the company and the product are alright, so it must be me."

At a different level there are "*Self-Role Conflicts.*" Agents too are subject to death-associated anxieties with ensuing defensive, escapist and magical devices. They will compulsively avoid certain types of prospects in certain places, at certain times. They will only present certain types of policies, discuss only certain features. Their private taboos may extend over any actual or assumed group attributes. Some can sell only to younger, others only to older people, their own sex or the opposite. In their prospecting activities some feel only at ease if away from their home-community, others feel paralyzed if away from it. Some approach only personal acquaintances, others shun all but total strangers. Here also belong the seemingly bizarre practices by which canvassing agents bind their anxieties; skipping in some magical sequence, blocks, floors, telephone pages, in the belief this somehow will reduce rebuffs.

Into the same class of conflicts fall the rigid assumption of and compul-

sive adherence to a single role regardless of its appropriateness for the particular prospect or prospecting situation. Here the salesman is emotionally detached to the extent of being unable to establish minimal rapport with his customers. By contrast he over-identifies with the customer to the point where rendering services for monetary considerations becomes repugnant. Here too belong the agents who chronically over-mask the product, always present one and the same mask, or no mask at all, regardless of what the particular encounter may require. The "over-masking" agent will deny to the last that he is selling insurance. When finally compelled to identify the product he feels derobed and defeated. The "one-mask" man can operate with one formula only, say, the "Social Security Benefits" approach. He becomes so frozen in this move that he cannot cross over to insurance selling, even when the moment is most auspicious. The "no mask" agent refers to the rate book at every contact, or "brings the hearse to the door" regardless of the prospect's pre-disposition.

The conflicts depicted above are not primarily caused by personality problems. We all have private experiences which make us less rational in certain situations, less effective with certain types of people. Proper selection, training and market allocation can reduce the ill-effects of these sensitivities on occupational performance. But the more of these blocks the individual brings to his job the more his role-variability will be impaired; the fewer will be the situations in which he can be effective. Training techniques can disconnect or dissociate these harmful sensitivities. They can also build up those private experiences which are functional to the occupational role. For example, there will be people and situations which the salesman, as a private person will avoid. As an agent he must treat them as if they were just "prospects" or just "selling situations." This "as if" dimension, the ability to treat a person or object as if they were something else is required of all professional behavior. It is a condition for selling to become professional.

A basic condition for resolving all these conflicts is role consciousness. The salesman must at all times be aware that he is performing. He must observe his particular role in every situation and evaluate its effectiveness. Inability to correctly analyze the cause of one's failure is a chronic problem of failing salesmen—"I followed the sales track, made the proposal . . . the prospect wasn't interested . . . didn't have the need . . . . Subsequently this prospect bought an identical policy from another agent." Perceiving his own role is just as important for improving selling performance as is observing the role of the customer.

8. Role Theory and Role-Playing[4]

The theory applied here to direct-selling data provides a new perspective on role-playing. Like the professional actor the salesman must convey the impressions required by his role. The actor has to express himself in each role so that he sounds believable. He must appear sincere, regardless of how the particular role matches his private self. This requires that during the performance the audience should minimally be conscious of watching only a play.

In some situations the insurance salesman will put on the mantel of authority. In others he will display qualities of warmth and intimacy. With others, again he will express himself with professional detachment and matter-of-factness. Usually some combination of all these and other role-attributes will be required. The salesman may have to simulate sincerity, objectivity, or indifference. He may have to dissimulate persistence, aggressiveness, pecuniary greed.

At least in one important way does the salesman have the more difficult task. For the actor play-wright and producer set the role. Moreover, during the performance the audience is expected to remain passive. The salesman performing before the sovereign customer must shift and improvise his role to meet the prospect's prevailing reactions. Therefore role-playing as a training device must also develop perceptual and analytical faculties. In actual selling the final proof of the salesman's role-playing effectiveness lies in the customer's response. In the training situation trainer and training group have to act as judge and jury. They will compare their own perceptions with those they see interpreted by the performer and decide whether the latter acted out effectively the role he had chosen. In these judgments the person enacting the prospect constitutes the key-witness. His own responses attest to the salesman's effectiveness.

The unavoidable make-believe atmosphere is less of a problem here than in more conventional role-playing sessions. There is less emphasis on sales-track and more on spontaneity, less on selling the product and more on selling the performance. What the salesman says or does is less important than how he says or does it. The role-playing session then is no more play or game than the real selling situation. The role-playing partners need not

[4] R. Corsini, R. Blake, and M. Shaw, *Role Playing in Business and Industry*, The Free Press, Macmillan Co., 1962. Norman R. F. Maier, *Psychology in Industry*, p. 111, Houghton Mifflin Co., Boston, Mass., 1964.

know more about each other's intentions and strategy than is known in the actual selling encounter. Both situations resemble rope-pulling contests in which each contestant tries to maintain his own position, while forcing the other out of his. The only real difference then between selling and training situations are the stakes involved. These too can be equalized. For the trainee who does not show progressive accomplishment in role-playing will not hold promise in creative selling. At this point role-playing becomes a selection or screening device.

It is part of this training to induce transfering relevant emotional experiences from unrelated roles. For example, the trainee may not express effectively the required protective attitude towards the prospect until he applies the emotional experience he acquired in his role of father. Such transfers from "self" to "role" from previously learned or internalized roles to yet-to-be-learned roles occur commonly and more or less unconsciously. With role theory this becomes a conscious, pruposive process usable in training. Complementary to this bridging of private experience and occupational skill is the blocking of private associations which hinder occupational performance. There are the earlier mentioned blind spots which the otherwise effective salesman may have in regard to certain personality types or groups. Personal happenings, unrelated to his business may have created interfering inhibitions, prejudices, fears. Role-playing techniques identify these vulnerabilities, expose their detrimental influence on occupational success, and induce the trainee to dissociate his business role from these limiting private experiences.

In working out these problems improvement in performance is only in part effected by rational explanation or persuasion. Role-playing becomes a vehicle by means of which the participants become aware of their problems and enabled to find spontaneous solutions. This heightening of self-perception and self-improvement is induced by techniques such as role-reversal, where the inter-acting players exchange roles whenever performance problems arise. Such reversal has the looking-glass effect of making the inadequate performer see his role through the position of the other. At this level the training system acquires a third dimension; developing the trainee's personality in addition to determining his suitability and imparting specific occupational skills. The role-playing methods assume here a psycho-therapeutic function within a primarily occupational context.

TREATING THE ALCOHOLIC WITH PSYCHODRAMA

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Psychodrama, though but one form of group psychotherapy, has proven to be of great benefit to the alcoholic patient. The flexibility of the phychodrama method and its varied techniques encourages an almost immediate emotional involvement through action and experience which frequently has been difficult to obtain in the diagnosed alcoholic, who is often withdrawn, reticent, hostile, isolated, lonely, angry and in need of social education.

Most social scientists agree that the term "alcoholism" is a general one describing several factors of social behavior associated with excessive drinking. In addition to the social factor there is consensus that there is a constitutional liability factor and a personality or psychological factor (Jellinek, Fox, Tiebout, Mann). There has been much written about the subject with speculative and contradictory indications; there are many who accept that alcoholism is a disease entity (1) or a symptom of a disease (2), others that it may be the result of undersocialization or deviant behavior (3).

I am in agreement that alcoholism involves excessive drinking and the loss of control of assumption and that it is a public health menace, and certainly it has the earmarks of an insidious progressive disease. This paper is not concerned, however, with the recognition or labeling of alcoholism, but rather with the treatment—which I would like to call a treatment for life. I have discovered in over a four year span that there are as many types of alcoholic persons as there are different types of people everywhere. Consequently, members of the groups that I have been involved with have become part of a therapy program with only one factor tying them together, that of having trouble with alcohol. The members of my group are employed men and women or young adults and children who attend school, of an average to above average intelligence, family people, creative and extremely sensitive. At this writing there are about as many women alcoholics as there are male alcoholics in the group.

Before I begin to discuss my particular research I would like to present the discoveries I have made in searching for other programs involving the treatment of alcoholics or alcoholism with psychodrama. In my search for the previous uses of psychodrama with the alcoholic, and in thinking about

my experience over the past four years, I was struck with the fact that so little is known and so much misunderstood about the dynamics of each of the two. This is surprising to me since psychodrama is in my estimation of inestimable value in treating the alcoholic for it offers by comparison the most keen way to create a harmony and balance of one's mind and actions. In one part of my mind I can see where the psychodrama is similar to alcohol, with the exception that in alcohol the individual is using pathological means of dispelling painful memories, inadequate behavior of escaping or defending himself. In psychodrama he gains a more healthy satisfaction from his initial experience which is heartened not by the conviviality of the drinking crowd but by the sincere interest of the other participants in the psychodrama. "Pathological acting out is replaced by therapeutic and controlled acting out." (Moreno) Destructive irrational transference in real life is replaced by interaction, feedback and open discussion. On the whole the members of the groups change remarkably after a three-year psychodrama experience. They feel more accepted, more secure and therefore have greater self-esteem. They have a greater willingness to see other people as separate and distinct from themselves rather than objects to be manipulated or manipulative. They recognize others as having problems different from their own. They are more tolerant and less demanding and controlling with the development of a new ego strength. As their ego strength increases the individuals are much better able to handle their own tensions, learning that everybody has to cope with life, therein an increasing appreciation of other people as well as themselves. They are better able to enter into other social situations away from the group. They develop a real social sense.

Past Uses of Psychodrama in the Treatment and Management of Alcoholism

There has been a broad clinical use of psychodrama both as an adjunct to psychotherapy and as a therapeutic tool in itself. "The Psychodramatic Institute of New York inaugurated in 1944, under the direction of J. L. Moreno, a project for the treatment of alcoholism which for the first time in the history of the therapy of this addiction took full cognizance of the interpersonal and intergroup relationships implicit in the problem," as reported by Miles Tierney (4), who proposed a program of education for the alcoholic, the therapist and the community. He proposed to study the alcoholic in action, to investigate the behavior of the alcoholic in terms of the changing roles and counter roles, advanced drink by drink. During the same

period Weiss (5) invited Moreno and initiated an alcoholic rehabilitation program at the Veteran's Hospital in New York.

The use of psychodrama in the treatment and management of alcoholism had its most fruitful period in the forties. It was used as a part of a total push program or a group psychotherapy unit from 1948 by Evseeff (6); in 1949 by Kersten (7); and in a Veteran's Administration Hospital by Haber, Paley and Block (8). During the fifties it was used in a variety of settings; mental hospitals and Veteran's hospitals by Starr (9), Nichols (10), Hein (11) and Halpern (12), Haas (13), Minear (14); outpatient clinics by Halpern and Minear; training centers by Moreno and Weiner; state and V.A. hospitals by Daley (15) and Weiss; and on telivision by Minear as well as in private clinic by Murray (16) and Miller (17) and in private practice by Weiner and Fox (18).

In the more recent reports the psychodramatists are trained by Moreno or one of his students (Starr, Nichols, Weiner, Haas, Murray) and the nature of the sessions have been spontaneous or directive therapy rather than impromptu therapy; more dynamic than informative. In all the processes there is indication that no matter what level of psychodrama is used the process has endeavored to help the "learner" know how to learn more effectively so that more of his experiences away from the sessions could lead toward learning and change.

Psychodrama has been used in this field most often with a group. Dr. Hein, however, has used psychodrama techniques with hospitalized alcoholics in an "a deux" situation. He found the mirror technique most effective and felt through psychodrama he was able to reach deeper levels more quickly. He also indicated that psychodrama was particularly good with depressed and suicidal people, with the periodic alcoholic and with the psychotic. He indicated that through psychodrama he could help the patient who could not "get out of himself" by training the patient for better situations through new knowledge. He also found it helpful for diagnosis (1948).

Psychodrama has been used for significant others in the alcoholic's life, either as a spouse or relative group. Nichols reports that in many instances the spouse learned "how to handle" the alcoholic more effectively. Weiner and Fox point out that the spouse or relative often learns for the first time in a psychodrama group how he may be contributing to the pathology of social interactions, and is often able to benefit in therapy although resistant. The role reversal technique and the mirror technique

as well as the behind-the-back technique were most fruitful with this group. Starr worked at the Peoria State Hospital two times a month with living-in alcoholics. She found that psychodrama provided vividness of experience which assisted in helping and explaining feelings and behavior. She did not feel that a group should have a special type of psychodrama for the alcoholic, for in working with the alcoholic she discovered it was more like dealing with a group of neurotics or a group of more seriously disturbed individuals. Haber, et. al., emphasized that role playing was one of the most successful techniques in the rehabilitation of the alcoholic and describes in detail the program. Haber indicates that attendance is voluntary and rapidly increased from ten the first week to the entire ward during the second week. Situations were chosen with three goals in mind: 1) to help patients deal with reality problems; 2) to encourage community spirit, group identification, ward citizenship and better patient personnel understandings; and 3) to develop effective re-education to resolve deep seated conflicts. At first six patients volunteered to participate in the program but soon most of the others, as well as the ward personnel, participated. This was an all male group. They did not use the men to play the women's roles, but instead used the ward secretary and the ward nurse as auxiliary egos. They indicated that "in the role playing there is little of the glib intellectualization that plagued many of the group therapy sessions previously . . . discussion which follows (the action episode) is fresh, spontaneous, effective and meaningful." Rossi and Bradley (19) report on two ten-patient groups, each with men and women, meeting twice weekly open-end fashion. Patients entered the group by self referral or by their particular counselor. The meetings usually lasted 1½ to 2 hours with the starting procedure changing from time to time. About half the professional staff participated actively as therapists. The group was lead by a psychologist with counselors, an industrial therapist worker, two chaplains and a research psychologist as co-therapist. They indicate that "in the improved and motivated groups the effect of the hospital program may have been that of a catalitic agent promoting awareness of strengths which were then utilized in everyday life." Kersten reports that psychodrama was used as an insight giving technique and was well received and helpful. Forrest and Glatt (20) worked with male and female groups using psychodramatic presentations derived from social work reports. A social worker was the director. They report that the knowledge gained about individual patients in these meetings proved invaluable "in dealing with them both whilst they were still in the hospital and after their discharge, and greatly assisted the social worker in her role as intermediary

between patients and their relatives and prospective employers. Much time was saved and valuable information gained from discussing common as well as individual social problems. . . ." They also held Sunday afternoon meetings with relatives and friends. Miller used hypnodrama and psychodrama in dealing with problems "of marked anxiety, dependency and depressive symtoms." Through a series of re-enactment episodes he developed insight and independent and mature relationships as well as developing leadership and personality changes. He suggests that "the essential thing is to understand the underlying causes of the alcoholism so that therapy can be adapted to the individual needs." Cabrera (21) (1961) holds psychodrama meetings on a monthly basis for each group of patients as an exit test where one patient plans to leave the hospital and dramatizes being received by members of his family, being taken to his home, seeing his alcoholic friends and what he does about it and how he will try to seek employment and what the reaction of the employer will be. He states that: "The patients obtain a great deal of benefit from the situation, giving them a great deal of insight and motivation and helping to understand themselves better." Haas, in working with large groups of patients, did not have the full cooperation of an entire staff. She used psychodrama in a conventional form and in a skit form, but found that there was a great deal of passive aggresive hostility. She stated that: "My overall feeling is that psychodrama is a valid therapeutic tool for use with alcoholics providing that a maximum flexibility and spontaneity be maintained and a minimum rigidity be erected as a barrier to a creative solution. The paramount consideration would seem to be a more forthright handling of resistances as they arise." She felt her failure in psychodrama was due to a pre-ordained hostile, authoritarian and hierarchal set up where fear and passive aggression characterized interpersonal relationships. Consequently the potential for psychodrama to provide an alcoholic with an adequate rehearsal for reality could not be overrated. Halpern has pointed out that in an out-patient alcoholic clinic "in the year and a half that psychodrama has been used at our clinic, not only in helping the patients directly but in aiding the individual therapist with the valuable diagnostic information which comes from seeing the individual function in a more complete and dynamic way in which the nuances of his interaction with others is more clearly seen than it is possible to see in individual therapy. We feel that while psychodrama cannot be considered as a substitute for individual therapy it is an excellent therapeutic device with alcoholic patients." Minear who also worked with alcoholic patients, found it successful not only as a

therapy in a rehabilitation program but also as a program of public education. Through a series of scenes and skits put together for television the patients from the clinic enacted case histories in psychodrama and found by using real patients in actual situations seen in silhouette "the action and expression were quite spontaneous, the emotionalism was not feigned, the oneness of the group, the sympathetic interpretation of the problem and the acceptance of the star were completely sincere." It also demonstrated the use of psychodrama as a therapeutic technique. Fox (22) comments that "to give greater depth of feeling to the group therapy experience, psychodrama has been used and found to be quite effective. In psychodrama the patient is given a chance to discover his "spontaneous self." He has the opportunity to act out his conflicts, his dreams, his memories, his present life experiences, his fantasies. He can relive his past experiences as they were, or as he saw them, and relive them as he wished they had been, and he can enact future scenes or experience old scenes in a less distorted manner. Role playing, role reversal, the use of auxiliary egos or doubles, the "behind the back" technique, the enactment of fantasy, give real insight into the true feelings and attitudes of the patient and those close to him." Weiner (23), in commenting on the same group, feels that psychodrama was most useful in treating the near-complete or incomplete personality, whose emotional relationships are intense but diffuse, who has no lasting relationships in any group, and who considers himself alone, misunderstood and separate. This individual cannot successfully take the role of the other or perceive the generalized other in his daily living process, for he only has a specialized but generalized conception of himself. In treating the alcoholic it is necessary to break down his distorted, emotional, isolated framework and build up his social role conceptions as well as strengthening his psychological defenses. I believe that psychodrama reaches out to the individual, goes beyond other therapeutic methodologies, and proves to be more successful in probing deeper to the source of conflict and frustrations disclosing valuable data and at the same time providing the individual with modes of acting through the power of practice, reliving and retraining whereby he may gain greater personal freedom. Psychodrama gives the participants heightened encounters wherein mutual feelings of trust and support are generated and wherein group members develop courage to show their covert attitudes, guilts and ways of living. We were not only treating drinking patterns but general behavior as well.

Some mention should be made about the use of role playing and psychodrama in the prevention, education and treatment in the community

and work settings. Presnel (24) has used role playing in an industrial setting with much success. Weiner has used psychodrama to educate community members, position, and personnel towards the question of alcoholism, as well as working in industry treating alcoholic workers on their job.

In summary one might say that investigators have contended that the psychodrama: 1) gives a greater depth of feeling to the group therapy experience; 2) enables the patient to discover his spontaneous self; 3) activates the patient's unconscious to bring forth conflicts, fantasies, memories, past life experience and emotional phenomena; 4) develops the need for motivation; 5) provides an atmosphere where the patient can try, succeed and fail—to learn by experience, rational thought and action; 6) removes subconscious inhibitions and develops problem solving ability; 7) teaches patients to work out and solve their own problems; 8) helps set realistic goals; 9) develops insights and reassurance; 10) intensifies the patient's affectivity—reduces excessive intellectualization; 11) trains for family, work and community roles; 12) provides rock bottom; 13) decreases the transference reaction; 14) develops personal freedom; 15) helps educate patients to the addiction or disease of alcoholism; 16) provides the opportunity to develop family roles and changes; 17) lets off steam and rage; 18) develops and explores the self concepts; 19) restores or eliminates old roles as needed; 20) intensifies reality; 21) develops and encourages community spirit, group identication and citizenship; 22) betters patient-personnel understanding; 23) educates; 24) re-educates; 25) modifies isolated behavior by reducing social deprivation and anxiety creating conditions; 26) develops emerging social situations; 27) changes self concept in terms of picking up other cues and expectations as well as own; 28) narrows grandiose feelings and in its place develops responses to reduce conflicts; 29) provides an educational method with a high quality of feedback; 30) repairs the loss of love and affection of parents, guardians, spouses through death, separation or disinterest; 31) reduces the effect of social deprivation; 32) trains how to live; and 33) develops the courage to be.

Comparison in Relation to LSD-25

Approximately eighteen to twenty members of the group experienced between one and three LSD-25 sessions and from discussions with them it is interesting to note that their reactions as to whether or not such a treatment was of benefit to them was similar to their attitude towards psychodrama. Each had gone through at least twenty-five to two hundred or more

psychodramas. Those who found the psychodramas of no benefit also found LSD of no benefit. Those who were uncertain about psychodrama were uncertain about their LSD experience, and those who had anything from fairly good effects to marked benefits also felt the same way about psychodrama. In discussing this with three members of the group in particular, one girl stated the following: "The LSD was of marked benefit but only the first treatment was successful. I have found that over the course of time that the LSD treatment in conjunction with two years of psychodrama therapy was the climax that put everything into focus and enabled me to completely abstain from the use of alcohol as an escape." A second member of the group felt that he had a marked benefit from the LSD but gets more out of psychodrama when he has his own. He felt that in the LSD he was out of control and was somewhat frightened and indicated that "there is a great freedom from both experiences. What is important, one, people; two, the atmosphere; three, a will . . . you have to want and need to go through the experience. It's a matter of readiness and timing." He indicated that under the LSD and after the LSD he felt as if he had been cut up for an exploratory operation and never sewn together. He also felt that he needed two psychodrama sessions to find the parts of him that he lost and to help him find parts of the puzzle so they could be put together. A third member of the group felt that under LSD he felt a face-to-face awareness of himself and that you "feel you're not the person you thought you were." He felt a loss of control and the emergence of the same "Mr. Hyde" personality that he experiences when drinking. With psychodrama he feels that it is "the only way to get to know what makes you tick . . . it makes you want to live and want to be. It teaches and develops."

On the whole the LSD experiences and the hailstorm of insights gained were not lasting to the majority of the members of the group. In many instances, individuals who felt that they had died or been destroyed continue their experience under psychodrama developing their own repair. Two other comments might be of interest, both are from individuals who assisted in LSD experiences. The first is a member of the group who had been a member of the psychodrama since its beginning. He stated that he felt that the psychodrama made him more sensitive to being with and sharing the LSD experience with other people. This writer also monitored the experience and feels that the LSD-25 as a therapy and as a conscious expanding method, as it was used in this group, had one strong limitation and that is that only a minimal amount of expansiveness was possible in that the experience of the patient under LSD is one of isolation and aloneness, even

though he may be having psychic experiences. It is active emotionally but passive interpersonally and therefore is not as lasting as the same type of experience in psychodrama where the individual is organically socially emerging. I found that there was an extreme closeness between me and any member of the group's experience where I was not present. It's ironical to note however that when the feelings of the LSD are re-experienced in the psychodrama there was no difficulty of communication. Ward (25) has pointed out that: "Impressive in both techniques is the amount of spontaneity that human beings are capable of under favorable conditions. In psychodrama spontaneity is encouraged and at times almost demanded. It is not unusual for a patient who is rigid and defensive in individual therapy to become alive in the spontaneous climate of the psychodrama stage. With LSD the stimulus is chemical, and the individual is freed or forced to experience a great outpouring of feeling often far beyond his conception of his own emotional capabilities. Sometimes the patient becomes so overwhelmed by the unexpected extent of his own spontaneity that he experiences acute (fortunately temporary) panic because of his own "lack of control." However, such feelings are usually followed by a feeling of great peace, a result which is also similar to many successful psychodrama sessions." Fox (26) states: "Though I had used group psychotherapy for seven and eight years before the psychodrama I have become increasingly impressed by the results we are obtaining now by the use of the psychodramatic techniques . . . In trying to determine in my own mind the reasons for our good therapeutic results I have come to feel that it is due to the fact that there is an actual living through of events, attitudes and emotions. In doing so there seems to be a truly remarkable realignment and reassessment within the individual. Various techniques which allow reliving of old experiences can make changes in the individual of far reaching import. This re-experiencing can take place occasionally in the psychoanalytic set up, frequently under hypnosis, with the LSD-25 experience but most profoundly of all, I believe, with the psychodrama. All of these techniques can be concurrently used with a marked shortening of the period of therapy."

Where results have indicated that LSD has been a successful treatment in chronic alcoholism it was with patients who had undergone various methods of therapy for years, including members of A.A. The authors of these various researches have interpreted their results on the basis of self-awareness and self-acceptance. I would like to hypothesize that the experience might have been one big bender whereby an individual met his rock bottom, or met death itself and was able to create a new life by destroying

the old one. What it may all boil down to—is comparison of methods, and the beforementioned words may be as the conversation between Alice and Humpty Dumpty:

"When I use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean—neither more or less."

"The question is," said Alice, "whether you can make words mean so many different things."

"The question is," said Humpty Dumpty, "which is to be master—that's all."[1]

Description and Discussion of This Research

In reporting on this program of psychodramatic sessions with private alcoholic patients over a four year period, the results are interpreted through analyzing over 400 psychodrama sessions with 300 alcoholics, as well as over 50 psychodrama sessions with the "spice" of alcoholics. The program was first started on a bi-monthly basis and within one year became a weekly group meeting. At one time there were three groups each consisting of eight to twelve individuals of both sexes who met once a week for two or two and a half hours, or until the session was ended. A description of the groups have appeared elsewhere by Fox and Weiner.

The group is composed of people not really indiscriminately chosen, but also not particularly chosen. They have one thing in common . . . a problem with alcohol . . . they either are alcoholic or are married to an alcoholic. In the beginning the groups were segregated. We had three groups, one composed of alcoholics, another a mixed group of alcoholics and non-alcoholics and a third group of non-alcoholics related to alcoholics. We began to realize that a mixed group was satisfactory as long as everyone agreed to be the "victim" (the protagonist and be hit over the head). In this way we soon discovered that the same problems could be handled a number of ways, and each member of the group could profit by seeing himself mirrored or by reversing roles with the other gained knowledge of what it might be like to be in the other person's shoes.

There are so many articles written about what works for the alcoholic and they have all been interested even if contradictory. McNamara has discussed what happens when the spouse and the alcoholic accept the disease concept, indicating some negative reactions of the wife not participating in therapy but leaving the treatment to the expert; the alcoholic may

[1] *Through The Looking-Glass* by Lewis Carroll, Chapter 6.

consider himself sick and not responsible and abnormal. Other therapies are for the hostile alcoholic, the lonely alcoholic, and so it goes. In our group we separate the learning stages into groupings. Once the patient comes for treatment he is first placed in a group therapy centering around what is alcoholism, both as a disease and as an effect. Various theories are advanced —addiction, poor learning skills and means of controlling drinking heading toward sobriety—and discussed. Antabuse is used for those who would like to use it, hypnosis is available to others who wish to learn how to relax, LSD has been tried by some individuals, some are attending A.A. meetings, and individual analysis and group therapy may also be used.

Once the patient enters the psychodrama group he is involved in a therapy that is not synthetic and which often involves direct confrontation, bodily contact, fantasy and is always on a conscious and consciousness expanding level. In the group we have men, women, young adults and children who are present because they have trouble with alcohol. Whatever else they are is not clarified except in the action and interaction of the group. The group becomes a therapeutic community and is similar to Moreno's public sessions in that anyone may or may not show up, but those who do become responsible for what happens. Often the director becomes a co-director with a member of the group who feels he knows better what is happening. As Moreno (27) states: "The psychodramatic method has a technique which might have furthered the cause of psychoanalysis, *the technique of the auxiliary ego or auxiliary therapist.* In the psychodramatic situation the chief therapist or analyst, if you wish, has associate therapists, so called auxiliary egos, on hand, who are permitted to enter into closer, more intimate relation with the patient. The immediate target of transference then switches from the therapist himself to the auxiliary egos. He is now far less involved in the potential interactions. The auxiliary therapists, moreover, are not just other analysts or observers like himself, but represent intimate roles and figures in the world of the patient, past and present. They are not artificially introduced, bystanders or onlookers interfering with the customary secrecy of therapeutic procedure —in *this* variation of the technique there is *no* group or audience present. The auxiliary egos are like assistants in a surgical operation, an integral function in helping the patient to present and solve his problem. They are, therefore, not only on the side of the chief therapist but even more on the side of the patient; the danger of transference "love" is towards him, to an extent, at least, milder or transformed because it is a part of psychodramatic technique to permit the feelings of love and hate *overtly* to be

expressed by the protagonist as well as by the auxiliary therapists. As in scenes between husband and wife, father and son, etc., he is not only *not* fearfully frustrated in both, but encouraged to bring them out as would happen in a living context."

One of the most comfortable as well as the most subtle concepts in using psychodrama as a therapeutic device is that the patient is never alone. Not only does he have a group, a director and a therapist to guide him in the interaction of his world and thoughts but he has also extensions of himself (trained auxiliary egos or members of the group) who are able to be duplications of the patient so that the patient has a "double" to represent him in whatever interaction he is exploring. This double establishes an identity with the subject and for the subject. The subject is able to share his covert as well as his own overt behavior and thoughts with another who is himself, with whom he can discuss feelings, intellectual and emotional, and gain not only insight but understanding and love for himself. This double will also challenge the patient to get up more courage, to think more clearly, to have more or less ambition but most of all to be the most effective personality and come to terms with himself. He will also, this double, help by going through the actions with the patient, fight, discuss, love and establish identity with important others. I should like to mention at this point that these sessions were primarily problem centered with individual centered concepts.

These sessions were designed to create support. A fundamental support, not a support of simpering gush and acquiescense but a support of greater personal integrity through challenge, sharing, analyzing and replaying.

In my psychodrama work with the alcoholic, one fact is clear over and over again. The sober alcoholic faces the same difficulties we all face with the difference added that he must also come to his own terms with the "stigma." Not all alcoholics feel stigmatized, but a substantial number do regardless of the disease concept. My work has been with the diagnosed alcoholic. It has not mattered whether or not the member of the group accepts this label. What has mattered is that he wants to learn how to live more satisfactorily and realistically.

What we have been working with has been how to handle our imaginations in our environmental situations—nature and society. Frye (28) has pointed out that man has a practical sense and a creative sense of what might be done with a given situation. In a Moreno-psychodrama group the "tele" factor is predominant and is the ingredient making possible the transformation of escape methods and defense methods into productive means of

using human potential. Briefly the tele factor is a measurable disposition or feeling toward another and as Moreno states: "the interpolation of auxiliary therapists tends to decrease transference tension between chief therapist and patient and to increase the tele communications between them."

I feel that the psychodrama sessions I have directed have been successful because of the feeling of love and support that was generated through acceptance and non-acceptance in appropriate situations. The auxiliary egos were not professional people but were members of the group who learned, as auxiliary egos and as group members and protagonists, just how to have feelings again and what to do with them. Everyone in the group maintained the same status, therapist and all. There was no authority, but rather there were participants. One of the highlights of the psychodrama is that it diminishes the difference between therapist and patient thereby creating an atmosphere of true feelings and real reactions, for one does not have to be perfect in order to survive. If love is a special way of feeling, then this was the force in the group, because everyone learned how to feel, how to take disappointments and how to be. As Fine (29) has pointed out, personality reintegration is developed through conscious and/or actional levels. By experimenting with non-verbal aspects of psychodrama, he has found, and I support his findings, that intended and unintended emotional expressions and non-semantic communications and non-verbal directorial and auxiliary tactics and techniques are of a great assistance in regulating psychodramatic involvement, experimentation and training that extends itself into the community behavior.

There isn't any one form of the psychodrama—there are many forms and I feel it is safe to say that over this four-year period we have used just about every form and every technique. The most effective techniques are the auxiliary chair, self presentation, the double, role reversal, mirroring and the Magic Shop. We have used the rehearsal form of psychodrama in role training an individual to be able to refuse the first drink that is offered to him after sobriety. On a deeper level, we have assisted in ridding the individual of "ghosts" by providing the deceased relevant others to reappear, permitting actions and words that were never said to be actualized and providing at the same time an integration of the abandoned other into the life force. At another time we have prepared individuals for successful divorces as well as for successful marriages. We have dealt precisely with the problem of alcoholism by giving life to Antabuse, to Alcoholics Anonymous, to alcohol, to suicide, to the future and permitting

an extension of living with each one of these or with all of these. We have developed menas of psycho-sexual maturity, we have dealt in the areas of death, life, the intoxicated group member and in immediate social problems. We have had no set schedule or procedure in those sessions. Very often we have extended the therapy hour-and-a-half to two hours in these sessions, or for as long as was needed to complete the experience. We have gone out into the actual community, assisting in getting jobs, acting as spectators in a play, and sharing social experiences. There has been a great deal of permissiveness on the part of the therapists to become members of the group and to have their roles understood. These are but some of the points of our action.

Quite frequently we have sessions revolving around being a little child who has lost the love and affection of one or both of his (her) parents through death, divorce or just plain disinterest. In most instances the "child" becomes socially isolated, feeling "the pain" of deprivation of the guidance and support needed to make an adjustment in the complex world around him. In one session the "child" acts confused, perhaps frightened and always "wounded." One evening we had a "little boy" (age 45) run away from his "rejecting mother" who was nursing a young baby. He "ran away because" he was unloved . . . and he ran and sat on a low table (he later expressed it was a log) and cried for his "Daddy." When "Daddy" appeared he asked why he died and left him. The "Daddy" embraced him. The "child" clung to the Daddy and they kissed and hugged and cried together. Suddenly the majority of the people in the room ran to Daddy and all felt he was their Daddy. He hugged them all. Later he explained that he felt they were all his children and he was perplexed that he might not reach them all, but was happy that he tried.

At another session a writer in the group confronted a member of the group who had been his former psychiatrist. The following week he came in very angry because this psychiatrist had chided him on being an alcoholic and an actor instead of a person. We made the wall the Doctor and the writer smashed a cup against it.

Another member of the group in trying to communicate with his wife kept asking her to tell him the truth about himself. In a psychodrama session he was told "Let us hear you talk to her this way." He did, saying repeatedly, "Tell me the truth, just the truth, that's all I want to hear." It became obvious to him as well as to the group that despite his vergal willingness to listen to his wife, he held his hands extended with a pushing

motion toward her whenever he said "Tell me the truth" and in practice continually blocked her off, giving her no chance to break through to him.

In another scene it was obvious to the group, because both the husband and wife were in therapy, that the only justifiable action at the moment was for the couple to separate. But the wife could not do this. Stepping in, as she did when the moment seemed to call for something to be done, the director took the role of the women's two-year-old daughter, but in this case a two-year-old who was trying to share some of the feelings of her parents, even though she couldn't talk about them because she did not have the words. The mother turned immediately to the "little girl." There followed one of the most touching sessions with mother and "child" actually clinging together and crying over the necessity to part from the father. The mother hated to face the parting because she was afraid of the distortion she was giving the child about the father. The session helped enable her to face the necessity, to make the parting and as a result the couple had a chance to develop by themselves, away from each other.

Another member of the psychodrama group for one year, Oscar, was a young man of thirty one. In the one year period he had gone from being overweight, lethargic and never working to taking part in the therapy sessions, making friends right and left, working at a job, and thinking well of himself.

I'd like to mention one more session where a case of Folie a' Deux became apparent. Such a case involving alcoholism was encountered. It involved a married couple—a very domineering husband and passive wife who shared years of alcoholism together. First she was requested to leave the room during his session and then he was asked to do the same. He became very angry after the session was over, refusing to come back to future sessions. In his next drinking bout she didn't join him but remained sober and was able to handle the situation adequately. She feels this was due to the psychodrama which gave her role training as well as insight into the home situation.

There is a great deal of "humor" in psychodrama which also provides the cohesion for therapy, at the same time serving other purposes as you will note in the statement that my co-therapist[2] in the group was fondly, or not so fondly, called Dr. Antabuse while I was called Miss Needleman. In addition to humor there is a great deal of the dialogue and an expression

[2] Dr. Ruth Fox, New York City.

of imagination, either in terms of fantasy or inventive techniques. As an example of this imagination and inventiveness I would like to mention a particular session in which Joe, a member of the group, was feeling very depressed over his business and financial situation. He was particularly lethargic and couldn't seem to make up his mind about anything. Two other members of the group, Charley and Dick, got up and hand-in-hand tried to snap him out of his low mood, but could not seem to elicit any response. Finally Charley climbed over an end table and opened up the window as high as it would go. He and Dick promptly sat Joe down on their arms and told him "We are going to lift you up one time, and a second time. When we say 'three' and lift you up for the third time you either say 'up' or 'out.' Make up your mind because if you don't say 'up,' out that window you go." He said "up" quite loudly on the third count and the episode snapped him out of his depression.

Regardless of what the tensions of the day had to offer the members of the group come and set themselves ready for action which may turn out to be professional, creative, or problem-solving—it depends on the group. As Meigniez (30) has said: "The psychodrama group sees the group chiefly as the place where psychodrama will arise, and where it is possible then to lay the groundwork for development (permissive climate, solidarity). But psychodrama is an invitation to incorporate existential relations *on the level of the imagination.* The tensions of the group are certainly experienced but with regard to another situation. There again, contrary to the group-centered-group, there is encouraged the creation of a mediation between the existence of the group and its consciousness."

What it adds up to is greater strength to live a "normal" life. Probably we encourage the group to live, maybe because we do take chances in the therapy and with each other.

Often the action episode of the psychodrama supplied therapy or experience or both. Often there is a profound inner "transformation" accompanied with a new ability on the part of the patient to respond in a situation as required. This change may occur so quickly that the patient is unaware of the change until he recognizes and others recognize, that he is acting differently. This may be well considered a change in his spiritual makeup—a development of his spontaneous creativity. This may be accrued to the patient through his ability, either as a protagonist or an auxiliary ego, to lose his self and become a free flowing individual reacting to his environment through action rather than through intellectualization with new responses preceeding frozen responses. We could say that the alcoholic finds

himself in the same predicament that Caligula does in Camus' play (31) in that he feels "a periodic tension between the lust for isolation and the longing for an authentic encounter that moves the action forward." Psychodrama enables the alcoholic to have that authentic encounter and moves the action forward. This is accomplished, not through analysis, but by creating conditions in a climate which makes it possible for the alcoholic to discover through his own willingness, his own potentialities. This action portion provides conditions for the development of spontaneity in order to 1) create insights; 2) change behavior; 3) improve performances; and 4) to actually become involved and live through a real experience. Psychodrama sensitizes individuals to their own behavior, and by developing this kind of awareness within the alcoholic we develop his considerations and values in a sphere of action and lessen his need for absolute control through developing his spontaneity. It establishes inherent skills so that he can recognize and give support to the groups—his reference groups—which will give him a greater equality of status, influence and liberation.

There were some remarkable changes for people in the groups. They felt more accepted and more secure with greater self esteem, less hostility and anxiety and more trust and faith in others; they developed a greater willingness to see other people as separate and distinct from themselves rather than objects with problems different from their own; they were able to objectify themselves and develop means of socialization with increased ego strength and a greater sense of self with an increasing appreciation of the dignity of themselves and relevant others and they develop a more real social sense with abilities to enter into social situations away from the group. The treatment was a matter of adequate interpersonal testing and training with an emphasis on the process of gaining compliance with one's self, as well as others, through understanding the "exploitation of values," through clarification of expectation and an increasing awareness of the presentation of self. This was done in the milieu of developing freedom.

The success of these groups is partially due to the creativity of the individual members who became co-therapists, thus adopting a new status role and practising behavior patterns in a miniature society. Psychodrama encourages an almost immediate emotional involvement through action and experience which frequently has been difficult to attain in this type of patient who has often been refused as a patient because of his willingness to accept defeat through withdrawal, reticense, hostility, isolation, relentless self reliance, and ignorance and has a deep need for social reconnection.

The psychodrama offers a suitable approach for research in interpreting alcoholism as a problem in adjustment and learning as well as a disease problem.

In some of these sessions the individual became aware that alcohol may have assisted an adaptation of self to the environment but did not offer stability. In the psychodrama the individual learned means of stable adaptation and the psychodrama method was accepted because psychodrama did not have a definite meaning to the participants, it did not seem to be a therapy but rather a means of developing existential behavior as well as an opportunity to deny the problem and yet receive help. The conversion to therapy became automatic and was consistent with the values of others. Another significant factor in the use of the psychodrama as a therapeusis is that the therapeutic aspects are more consistent in terms of our "American belief" of individual responsibility as a value. There have been many writers commenting on the democratic essense of psychodrama, among them Twitchell-Allen (32), Fink (33) and Weiner (34). Many patients refer to their group as the class where each has the responsibility of developing the potential of himself and others and where he trades in ignorance for education and where he can develop his sense and his imagination in dialogue. In the psychodrama the individual participates in a system of checks and balances wherein freedom and liberty and recovery is believed by the individual, and is actually true, to be developed by himself—and not as the pawn of the therapist. He receives therapy by helping others, either in his own role or in the role of a significant other whereby he may ventilate rage, love, hostility, anger, compassion, or depression in a socially accepted atmosphere and is helping someone else. This is similar to the twelve steps of A.A. In the psychodrama, responsibility is put on the shoulders of the group members and the members of the group feel greater responsibility for each others actions and their own actions and change provides a framework wherin feelings of helplessness can be counter-acted.

The psychodrama is a spontaneous presentation of the inner self. The alcoholic is himself in action, and since we work in groups the alcoholic sees himself as he actually is and not as he verbalizes or fantasizes himself to be. The action psychodrama brings to focus life movement, non-verbal behavior and feeling and therefore permits breakthrough to memory blocks, painful or disturbing emotional conflicts, repressions and unconscious awareness—sometimes in a dramatic shock or suddenness, but more often through the ease of being without anticipated and personal thoughts. It is a communication that breaks through barriers of language, status, culture and

intelligence because it is a social communication using words, gestures, sounds, movement, bodily contact, and in some cases the senses of taste and smell. It is a provocative methodology stimulating and almost demanding a response with little or no resistance on the part of the players in the situation. It may be a corrective, a therapy, a role training device, an education instrument—it is always an experience. It is sometimes an entertainment, an excitement, a violent social or individual protest—it may be a spiritual confession or fellowship. In the psychodrama reality, fantasy, the forbidden, the restricted and the actual may be acted out and given importance. It may be a rehearsal of roles in order to perform adequately in future situations, such as the ability to refuse a drink. It is also a clarifier. It is a reminder of what can be if an individual has the courage to react to social conventions through a developed spontaneity. In some ways it is a substitute for alcohol, but with a difference—psychodrama in many ways sustains on a healthy level what alcohol provokes on a pathological level. Tender feeling can be expressed in an uninhibited way as trust develops through experience. It may serve as a self-punishment permitting the individual to escape guilt, but the self-punishment in psychodrama is turned to a feeling of worthiness rather than unworthiness, and the self-punishment becomes a corrective when the alcoholic learns other behaviors and feelings of success. The alcoholic is sensitive and cannot cope with frustration. Psychodrama and psychodramatic experiences can develop means of coping. It is an educational means of who the alcoholic is. Through experience and feedback, rather than just talking about it, the alcoholic becomes a target for shifting skills and abilities. The constant inner battle between passivity and agressiveness, grandiosity and actuality, maturity and egocentrism and mood swings can be explored. Basic problems of family situation, work situation, and community reactions can be acted out and the alcoholic can watch where reactions are immature, egocentric and self-centered.

It is important to realize that the psychodrama deals with many factors at once; the influence of the immediate surroundings of the individual, past present, fantasized and future, and the environmental factors. It dispenses with the transference situation. It acts as a social contact and a development of self rootedness and identification. It cuts through resistance to therapy, it deals with the acceptance of death, infantile passive defense mechanisms, suspicion, withdrawal, rigidity and masochism by permitting these feelings to be acted out. It deals with the delusions as well as the actualities of changed body images and economic status and

it permits aggressive forces to be utilized and symbolic interaction to be expressed.

> "If each of us can be helped by science to live a hundred years,
> what will it profit us if our hates and fears,
> our loneliness and remorse
> will not permit us to enjoy them?
> What use is an extra year or two
> to the man who 'kills' what time he has?"[3]

Psychodrama sessions, I believe, replace remorse, loneliness, desolation, despair, inadequacy and poor presentation of self with feelings and abilities of freedom, correct assessment and ability to act without fear. It may even permit the dry alcoholic to develop a lasting new philosophy of life.

It is my belief that the psychodrama is so successful in the treatment of the alcoholic because this methodology demands immersion of the total person—mind, personality and body—into contact with reality in a spontaneous action wherein the individual is in contact with his unconscious, developing skills through ridding himself of himself in practicalness and concreteness without "thinking" but in terms of self-forgetfulness and action. The learning process accrues itself to the individual not by being shown by an authority but by enabling the alcoholic to "get the feel" of the spontaneous way of life through adapting and developing his individual peculiarities. He develops a new sense if accurate alertness of all the senses —perception and action become one, independent of a conscious purpose. He develops a spontaneity close to that of the growing child.

In conclusion I feel that the psychodrama, above all, challenges the alcoholic into action and stops him from becoming a spectator to his autotelic moving pictures of life into a dynamic adventure of living. By exploring the alcoholic's social roles and skills we explore his life not only in therapy but we have extended our psychodrama into life itself—in situ—by attending important functions of individual members of the group.

A member of one of the psychodramatic groups stated one evening: "After I stopped drinking, what I needed to do was start feeling again. Psychodrama has done this for me. It has left the intellectualization and has propelled me into action." If I were to conjecture on this statement I would affirm that psychodrama creates within the individual a greater freedom than he has known before. In his presentation of himself in scenes

[3] David Neiswanger, The Menninger Foundation.

constructed of his everyday life, fantasies and past recollections, we can in psychodrama reach where the ordinary methodologies cannot venture, for psychodrama is as close to living as we as creative therapists can achieve. Not only is it a therapy but it is an experience where insights can be gained and skills developed on the spot in an almost immediate reassessment of living and life action. Perhaps we can modify or change the Japanese proverb that reads:

First the man takes a drink
Then the drink takes a drink
Then the drink takes the man
Then the man has a fall

and add:

Then he picks himself up
And he makes himself whole again.

In closing I would like to state how much I enjoyed working with my groups and take this time to extend my sincere gratitude and appreciation to the members of the groups and to Dr. Ruth Fox.

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THE BEHAVIORISTIC ASPECT OF PSYCHODRAMA[1]

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In a surprising aside that provides a matrix for this paper, J. L. Moreno noted that "a constructive rapprochement is possible between psychodramatic techniques and some of the current therapeutic philosophies, not only with psychoanalytic theory but also with Pavlovian conditioned reflex principles."[2] There have been other forebodings of this position, little noticed: "A sociometric test is first of all *an action and behaviour* test of individuals in a group," says Moreno in *Sociometry in Action*.[3] The reader is also referred to Moreno's *The Spontaneity Theory of Learning*.[4]

Inasmuch as "Pavlovian conditioned reflex principles" can be taken to refer to the general system of "learning theory" and its derivative, "behaviour therapy," such a "constructive rapprochement" seems for several reasons difficult. In the first place, in terms of philosophy, psychodrama is a development of Moreno's theory of "creativity and spontaneity." Like its source, psychodrama is in part intuitive and in part operational, and it describes a "self" that is creative, purposive and striving, one that may be viewed as from within the theoretical framework of Spinoza and Leibnitz. In contrast, learning theory is essentially empirical, its terminology attempts to be behavioristic and operational, and it describes a "self" that is no more than systems of responses to stimuli, one that may be viewed as from within the incompatibly different theoretical framework of Locke.

Second, in terms of goals, a rapprochement seems unattainable because psychodrama is interlaced with volition and gregariousness, and as a therapy psychodramatic group psychotherapy concentrates on enhancing "spontaneity" and social learning. Behavior therapy, however, attempts to narrow complex interpersonal and emotional problems to principles of learning derived in the laboratory, and it has so far concentrated thera-

[1] The writer has profited from the critical comments of George De Leon, Lloyd H. Silverman, and Howard White, and these are gratefully acknowledged.

[2] Moreno, J. L. Fundamental rules and techniques of psychodrama. In J. H. Masserman & J. L. Moreno (Eds.), *Progress in psychotherapy*. Vol. 3. *Techniques of psychotherapy*. New York: Grune & Stratton, 1958. Pp. 86-131. P. 127.

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peutically on reducing anxiety, mastering uncomplicated motor responses, and removing or ameliorating symptoms. Third, the feasibility of a "constructive rapprochement" appears precluded by the elusive nature of the conditioned reflex principles underlying the entire structure of the learning theory and behavior therapy system. In a comment still pertinent today, E. R. Hilgard observed that "there are no laws of learning which can be taught with confidence. Even the most obvious facts of improvement with practice and the regulation of learning under reward and punishment are matters of theoretical dispute."[5]

Despite these contraindications, to attempt a rapprochement is compelling for psychodramatists because learning theory is an incontrovertibly important and productive focus of recent psychology. Its theoretical uncertainty aside, learning theory has generated (1) new methods of teaching, by means of programmed texts and teaching machines; (2) more intensive techniques for ideological "brainwashing"; (3) additional precision in psychopharmacological and psychopathological research; (4) B. F. Skinner's impressive attempts to describe all of human behavior and design a behavioristic utopia; and, perhaps most notable (5) behavior therapy itself. Regarding behavior therapy, some of its practitioners claim near 90% effectiveness for their techniques and, even more astounding, they report on hundreds of cases that have been followed up and which provide at least partial support of their claims. It thus behooves psychodramatists to follow up on Moreno's implication and explore the potentialities of their preferred techniques as reconstructed in terms of theoretically unsettled—but empirically grounded—behavior therapy: The potential educational and therapeutic effectiveness of a "behavioristic" psychodrama is impressive.

Fortunately, there are objective indicators that a constructive rapprochement of the psychodrama and behavior therapy systems is possible. Moreno's recent comment[6] on work of the behaviorist H. J. Eysenck reveals many more similarities in general approach than differences: (1) Both Moreno and Eysenck in effect agree that it is therapeutically inefficient to dwell on speculative "dynamics" and to neglect to review the patient's pertinent learning history. (2) In essence both theorize that any behavior must be freed from avoidance, repression, suppression, and unawareness in order to be performed, either symbolically or directly, prerequisite to being most effectively strengthened, altered, or ended. And (3), both are more

[5] Hilgard, E. R. *Theories of learning.* (2nd ed.) New York: Appleton, 1956. Pp. 457-458.

[6] Moreno, J. L. Behaviour therapy. *Amer. J. Psychiat.,* 1963, **120**, 194-196.

concerned with a behavioral criterion of educational or therapeutic success than with diffuse and shakily measured criteria involving "unconscious processes" and "insight." It is in the light of these similarities in technique that an ultimate rapprochement begins to appear feasible as well as worthy of the attempt.

What seems to be the most efficient procedure to start reconciling the two systems is the one that will be followed here. First, the major *techniques* of psychodrama, as applied in a group psychotherapy context, will be described in terms of the focus, philosophy, and vocabulary of behavior therapy; then behavior therapy techniques will be reviewed from within the psychodramatic perspective. In effect this paper will begin the rapprochement of the systems by presenting a partial "role reversal" between behavior therapists and psychodramatists so as to delineate what can be considered to be the behavioristic aspect of psychodrama.

Psychodramatic Techniques in Behavioral Terms

The following is a description of six of the more important psychodramatic techniques translated somewhat loosely into the theoretical framework of a hypothetical and composite learning theorist, behavior therapist, or behavioristically oriented counselor or therapist. The techniques are listed in the order in which they could be readily used in a typical "personal-problem-centered" psychodramatic group psychotherapy session. Because the techniques overlap and are here described only in their simplest form, the classic psychodramatic literature should be consulted for more extensive descriptions using original psychodramatic terminology.

1. *Warm-up* usually begins the psychodramatic session, especially if the group has not already been "warmed up" by previous rewarding interaction. In this technique the director encourages mutual introductions, banter, interaction, relaxation, and self-revelation by all present, and typically serves as a nurturant, prestigious, and unpunishing model for these behaviors himself. His immediate goal is to elicit from group members a large number of cues for positive reinforcement (e.g., physical touching, smiling, "acceptance," "respect") and to discourage the elicitation of cues for punishment (e.g., words or scowls of disapproval, withdrawal, staring boredly into space). The ultimate purpose of this technique is to create a setting where each participant's behavior is "spontaneous" and not supplanted by behaviors that attempt to avoid the anticipation of noxious stimulation from others. (Thus, "spontaneous" behavior, a goal of psychodramatic therapy, can be defined, at least partially, as behavior that is

not avoided, repressed, or suppressed by a superfluous fear of punishment.)

2. *Problem-presentation* involves the director's rewarding of the participants' revelation of personal problems for the group to solve. Again the director serves as a model himself, is honest and self-revealing, and evidences as well as acknowledges that as-yet unsolved or insoluble personal problems are ubiquitous and continual. The problem of one participant is ultimately agreed upon by the group's total consensus as most congruent with or parallel to a problem of their own whose solution would be useful. That participant becomes the "subject" (protagonist) of the session and his problem serves as the focal problem (unless it leads to a more interesting problem, which in turn becomes the focus). Thus, psychodrama can be defined at least partly as a series of techniques for learning the solutions to specific, manageable, interpersonal problems. (The focal problem should have the interest or at least active acquiescence of the entire group, rather than be based on any kind of minority-punishing majority vote, because boredom or antipathy on the part of even one participant, who may not even be otherwise hostile, is still communicated as punishment to those who actively participate: Although antipathy and hostility can, of course, be used to "therapeutic ends," they will often curtail the classes of behavior toward which they are directed before they can be usefully channelled.)

3. *Self-presentation* has the subject describe the setting and enact, directly or descriptively, the roles of himself and others who participated in the most recent and in important manifestations of his problem. Gradually and covertly the director diagnoses the relevant elements of the "cue-response-reinforcement" system that represent the problem. That is to say, as more and more crucial scenes are enacted—possibly with the assistance of other participants—the essential characteristics of the pathogenic setting (cue), the behavior (response) that is maladaptive, and the subsequent reward and punishment (reinforcement) become identifiable. In terms of Moreno's classic definition of one aspect of spontaneity, the problem thereby becomes more clearly defined as to whether the subject needs to learn "a novel response to an old situation or an adequate response to a new situation."

A procedure within this technique, analogous to free-association, is that of *soliloquy*: it comprises the subject's impromptu speaking out of problem-focused thoughts for purposes of diagnosis by the director, the group, and himself.

4. *Role-playing* is the panoplied technique that is the crucial differentiator of psychodrama from other forms of group therapy or training.

In it the subject learns through the human capacity—perhaps predisposition—to learn by assimilating all or parts of the roles of real or symbolic models and by receiving selective reinforcement from other real or symbolic characters. By manipulating person, place, and time, and by using himself and others ("auxiliary egos") to play diverse roles and characters in a theoretically endless variety of staged imagined settings, the subject can learn a vast number of skills and a great diversity of information. The many procedures within the role-playing technique typically overlap in practice:

a. *Auxiliary ego* involves the selection of group members to play the roles of real or symbolic characters. The subject selects the auxiliary on the basis of his resemblance to the original or ideal character, i.e., whether he presents cues, responses, and reinforcements to which the subject can respond with relative genuineness. (To maximize the verity of the cues and the effectiveness of the reinforcements, the subject briefs the auxiliaries regarding their roles and corrects them if they deviate, but the auxiliaries are always instructed to incorporate their own emotions into the role. Encouraging the auxiliary to respond with his own natural feelings in addition to portraying the character authentically does not lower the subject's estimate of the validity of the impersonation but typically, surprisingly, seems to increase it: Playing a character, displaying emotional openness, and at the same time appearing life-like, seem relatively easy, and this can be explained by the observation that considering age, class, culture, intelligence, sex, status, and type of relationship, most cue-response-reinforcement systems overlap extensively; thus by being artless, the auxiliary also becomes more authentic.)

b. *Doubling* is a procedure in which an auxiliary (or several) is directed to play (physically) alongside the subject and other characters. These doubles at first only match their characters' behavior, thereby getting the "feel" of the character by a sort of James-Lange process. But shortly thereafter the doubles drop simple mimicry and, within their roles, begin spontaneously to articulate and enact unspoken feelings, thoughts, or wishes that the auxiliary senses the character detrimentally avoids, represses, suppresses, or is simply unaware of. Conversations, including mutual cueing and reinforcing, can take place between the doubles as well as between the double and his character. R. J. Corsini has noted that inasmuch as doubles think alongside their characters, raise questions, and repeat and clarify their characters' behavior, they are tantamount to personal, traveling Rogerian (non-directive) therapists, of the sort Rogers realy seems to advocate.

c. *Role reversal* is a procedure in which the subject exchanges places (including physical location) with an auxiliary playing a character. This procedure is used when it becomes necessary for the subject to portray the character (1) so that an auxiliary could subsequently portray it more accurately; (2) to facilitate the subject's appreciation of the behavior of a "misunderstood" other in relation to him; (3) to permit the subject to interact with himself so as to "see himself as others see him"; and (4) to learn all or portions of the character's role, in order for the subject to selectively cue and reinforce himself more efficiently.

d. *Mirror* is a procedure in which an auxiliary plays the subject and extends the subject's modes of response to new situations as well as reproduces parts of the subject's already seen performance. The subject watches from the audience and evaluates the nature and adequacy of his responding as he sees himself portrayed. He can also use "himself" as a model for his own future behavior.

e. *Spontaneity training* is a procedure that is based on the principle that to the extent facility in human relations is a skill it can be improved with practice. Guided by the director, the audience, auxiliary egos, and himself, the subject learns those aspects of spontaneity that involve his (1) responding to new cues with adequate behavior and new roles (the "orienting reflex?"); (2) responding to old cues by securing and developing novel behavior and rewards for himself; and (3) judging and rewarding adequate elements of his own behavior in the absence of the group or of other reinforcing persons or things.

f. *Magic shop* involves the subject's indication of his often covert reinforcement hierarchy during his bargaining with the all-powerful magic shopkeeper for the fulfillment of his most precious wishes. The subject can then be given the opportunity to enact himself after the wishes have been granted so as to evaluate the effectiveness and merit of some of his fantasied behavior and reinforcements.

g. *Future projection* is a procedure in which the subject and auxiliaries anticipate future problems and practice potential solutions by playing scenes set in the future.

In general role-playing is a crucial and versatile learning device. It has its origin in that aspect of "play" that is the universal problem-anticipating and problem-solving device of children and animals: In one sense psychodrama may be viewed as an extension of the "natural" learning of "play" that is adapted to solve more complex and difficult problems. During psychodramatic play, in contrast with much of life, the subject is permitted

to practice solutions of these problems in a life-like setting but where the punishment for failure is substantially reduced. (In view of the wide range of applicability of the role-playing technique, investigating the extent to which role-players can and do replicate rather than distort their characters' behavior is a pivotal research task for psychodramatists.)

5. *Catharsis* is a clinical procedure that requires the director to set up the extinction of a conditioned response, usually emotional, by encouraging its emission in the absense of the unconditioned stimulus, usually aversive. In the psychodramatic literature this term also has been used to describe instances of "counterconditioning," as when the aversive cues for a conditioned emotional response no longer elicit it because they have become associated with rewarding stimuli such as "group support." When extinction or counterconditioning does not readily occur, the director should look to which reinforcements (functioning here as "secondary gain") keep the response system effective. (Catharsis would not alone be sufficient for effective behavioral change if the subject could possibly undertake other behavior considered undesirable ("symptom substitution") so as to secure any of the rewards consequent to the extinguished or counterconditioned response. Ideally, then, new and adequate behavior to secure the previously contingent rewards of the removed behavior should be taught unless an attempt is made to reduce the reinforcement value of the rewards; otherwise the subject may turn to repressed, suppressed, or as yet untried undesirable behavior to secure those rewards.)

6. *Group participation* occurs throughout psychodrama but as a specific technique it may be thought of as providing the fitting termination of the psychodramatic session. Throughout the session the group members had functioned in concert and as individual participants in cueing and selectively reinforcing the subject's successive approximations of adequate emotional and motor behavior—as audience, actively or passively, and from the stage, usually as auxiliaries. In return for their participation they had been rewarded with the opportunity to enact, overtly or in their seats, the exploration of and the solutions to some of their own congruent and parallel problems. Now they are called upon to react to the entire session in terms of what behavior and discriminations they have learned, for their own purposes, from their participation and from the experiences of the subject. In this technique the participants function not as analysts—this is often punishing and unconstructive—but as "co-experiencers." The fact of the applicability of the subject's experiences to their own may be for the group the most powerful reward for their presence and participation. For the subject, being

informed of the utility of his travail from the point of view of the others can be substantially rewarding.

This technique includes the ending of the session with mutual and self rewarding by the director, subject, and participants for any effective learning demonstrated by anyone during the session that is relevant to more effective coping with potential problem situations. Whenever possible verbal labels are given to whatever has been learned and "rules" are formulated to serve as compact guidelines for the more efficient generalization and discrimination of cues and for the more skillful generalization and differentiation of behavior in confrontation with the larger world outside.

To conclude: Learning theory suggests that the advantage of psychodrama over, say, traditional psychotherapy, is that psychodrama has a far greater potential to (1) generate vivid, life-like behavior and cues, thereby maximizing the utility of response and stimulus generalization; (2) condition a *total* behavioral response—physiological, motoric, and ideational—rather than one merely verbal; and (3) dispense the powerful reinforcements of (a) enacted models and other characters, who in real life or in fantasy have already dispensed reinforcements, and of (b) group approval and disapproval, rather than the reinforcements of only the individual therapist. In this light, the psychodramatic director, guided by continual feedback from the total group consensus, has the responsibility to combine, time, and order his flexible techniques so as to (1) help create near-veridical behavior and dramatic settings; (2) focus on the problem at hand; (3) maximize the subject's and the group's ease and efficiency in participating and learning; and (4) exploit the potential of the group setting to provide a complex array of interpersonal contexts. From the point of view of the potential rapprochement, and despite the divergent theories maintained by most psychodramatists, the basic principles underlying psychodrama can be seen to be like those of behavior therapy an indeed of all psychotherapy: In the words of learning theorist J. B. Rotter, they are "the same rules as that of learning to avoid a hot stove, to solve problems in arithmetic class, to acquire a foreign language, or to learn to eat with a fork instead of one's fingers."[7]

Behavior Therapy Techniques in a Psychodramatic Framework

The following is a description of six of the better publicized behavior therapy techniques illustrated by examples that would suggest their relevance

[7] Rotter, J. B. *Social learning and clinical psychology*. New York: Prentice-Hall, 1954. P. 335.

to the interests and repertoires of psychodramatics. The techniques are arranged roughly in the order in which they are salient in the behavior therapy literature; it should be noted that they overlap extensively because of their use of identical learning principles.

1. *Reciprocal inhibition* is based, according to behavior therapist J. Wolpe,[8] on the principle that "*if a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety responses will be weakened.*" Although the nature of the "bond" that is weakened is unclear, responses that have been most frequently used by Wolpe to countercondition (or to inhibit) anxiety have been assertion, relaxation, and sex. The psychodramatist in effect employs this reciprocal inhibition technique when he presents cues known to elicit anxiety and requires the subject to act, for example, in an assertive, positive manner in their presence: After repeated pairing of the cues and responses, the cues for anxiety would be expected to become the cues for conditioned assertiveness. By the same counterconditioning process these anxiety-evoking cues can be rendered ineffective by conditioning them to elicit the "good feeling" associated with group support or the sexual approval of an auxiliary ego. (To the extent that extinction and counterconditioning are alike, and to the extent that "good feeling" functions as do assertion, relaxation, and sex, this technique is analogous to the psychodramatic technique of *catharsis.*)

A psychodramatic illustration of reciprocal inhibition is provided by Wolpe as follows, although what he calls "Moreno's original psychodrama" is of course not as limited as he describes it:

> A kind of "psychodrama" is employed in the consulting room with certain patients who find is unusually difficult to commence the practice of assertive behavior in their day-to-day relationships (patients who, as previously noted, tend to have low self-sufficiency scores). Unlike Moreno's original psychodrama, it does not consist of making the patient act out his *existing* attitudes in the relationships. Instead, with the therapist taking the role of some person to whom the patient ordinarily reacts with excessive anxiety, the patient is directed to behave in a new, usually aggressive manner, in the expectation that thereby the anxiety that tends to be evoked will be reciprocally inhibited. If the patient deals successfully with this relatively mild "play" situation, it is a steppingstone toward dealing with the real person. Another

[8] The quotations that follow are taken, with permission, from J. Wolpe, *Psychotherapy by reciprocal inhibition.* Stanford: Stanford University Press, 1958. Pp. 71, 118-119, 194, xi, 199.

application of the idea of psychodrama is found with people who become very tense when "put under pressure" by the demands of others, as, for example, when being questioned. Tension from this source can often be diminished by giving the patient fairly difficult arithmetical problems and then "barracking" him while he is trying to work them out, *having told him beforehand that the more he is pestered the more he is to delay giving his answer.* It is easy to see how the new reaction pattern may inhibit the old.

From Wolpe's description it appears that anxiety can be reciprocally inhibited within the psychodramatic technique of *role-playing,* as Wolpe has illustrated, and also during the techniques of *warm-up, problem-presentation, self-presentation, catharsis,* and *group participation,* provided the subject receives rewards from others, as typically manifested by whether he "likes" them. With regard to the anxiety-inhibiting properties of the variable "liking," Wolpe has made the following observation: "In the absence of systematic information I may mention that I have a strong clinical impression that patients who display strong positive emotions toward me during the early interviews are particularly likely to show improvement *before* special methods for obtaining reciprocal inhibition of anxiety are applied."

2. *Systematic desensitization* has been described by Wolpe mostly as a variant of reciprocal inhibition using counterposed relaxation, as in the following description:

In this, relaxation is used to counter the effects of anxiety-evoking stimuli; paralleling in an obvious way the method of therapy in animals, described above. The patient is given preliminary training in relaxation by Jacobson's method (1938). Meanwhile an "anxiety hierarchy" is constructed. This is a list of stimuli to which the patient reacts with unadaptive anxiety. The items are ranked according to the amount of disturbance they cause, the most disturbing items being placed at the top and the least at the bottom. The patient is hypnotized and made to relax as deeply as possible. Then he is told to imagine the weakest item in the anxiety hierarchy—the smallest "dose" of phobic stimulation. If the relaxation is unimpaired by this, a slightly greater "dose" is presented at the next session. The "dosage" is gradually increased from session to session, until at last the phobic stimulus can be presented at maximum intensity without impairing the calm, relaxed state. It will then be found that the patient has ceased to react with his previous anxiety to encounters in real life with even the strongest of the once phobic stimuli.

The psychodramatist thus uses an analogue of this desensitization technique whenever he counterconditions anxiety by employing (1) psycho-

dramatic or hypnodramatic scenes (in place of imagination under hypnosis); (2) individual and group support (in place of direct physiological relaxation); and (3) the subject's own selection of the situation to be portrayed (in place of the anxiety hierarchy). An example of desentization that could represent a psychodramatic application of this technique has been described by Wolpe as illustrative of "fortuitous therapeutic effects in life":

> An experience I had with my little son when he was four years old affords a compact illustration of the therapeutic process outlined above. He was in the habit of jumping on the lawn from a wall three feet high. But having on one occasion fallen and hurt himself he was for months after afraid to jump again even though he watched younger children cheerfully do so. One day I persuaded him to jump while I held his hand. At the next three or four jumps my grip became lighter and lighter, and thereafter I did not hold him at all. Then I gradually increased the distance between us when he jumped. By about the 12th jump he did not care whether I was there or not, and was never again afraid of jumping from this wall. Such experiences are undoutedly very common. They parellel quite closely the therapeutic experiments described in Chapter 4 in which a neurotic cat, inhibited by fear from eating in the experimental cage, eats if the food is given to him by the human hand, and is enabled thereby to eat in the absence of the hand.

Presumably Wolpe's son was thereafter able to jump from other walls as well. In relation to these walls, and perhaps to belabor the obvious, his experience on his own lawn could be considered as desensitization in a psychodramatic setting.

3. *Operant conditioning* is a technique that comprises essentially four procedures: (a) *Reward* involves the application of positive reinforcement so as to strengthen desired behavior. (b) *Avoidance* (or *escape*) involves a set-up whereby desired responses, when emitted, avoid (or terminate) aversive stimulation. (c) *Punishment* is the setting up of aversive stimulation to be the consequent of undesired behavior; in order to avoid punishment, the undesired behavior is hopefully "suppressed." (d) *Extinction* weakens undesired responses by omitting the reward that these undesired responses formerly secured. These four procedures are used continually throughout all of the techniques of psychodrama by the director, the group, and the subject. The effect of at least one of these procedures is theoretically necessary for any learning ever to take place.

Reward is the most common, possibly the most effective, procedure in this technique and involves the application of positive reinforcement upon the emission of the desired behavior—immediately, if possible.

Wolpe has termed what is in effect the procedure of rewarding successful attempts to respond adequately in role-played fear-provoking scenes as *behavior rehearsal.*

Because the conscious attempt to dispense "rewards" in a self-conscious setting can be on occasion excruciatingly ineffective, however, it is perhaps important to note how the general point that reinforcers are variable and tricky: Previously successful applications of rewards may, for example, become labeled "attempts to manipulate" by sensitive subjects and subsequently have the effect of punishment. Previous punishments may, for example, yield an attention-getting consequence and become "reinterpreted" to function as reward. Subcultures, diagnostic groups, and individuals, and the same individuals at different times, will differ in their potential reinforceability by a given stimulus. Furthermore, reward and punishment and cueing can be communicated with extreme subtlety: In any psychodramatic session all participants, undetectably and "unawares," positively and negatively reinforce each other by faint behaviors such as those described by J. Marmor: "the expression on the therapist's face, a questioning glance, a lift of the eyebrows, a barely perceptible shake of the head or shrug of the shoulder," "uh-huhs," "silences," "tone of voice," and "shifting postures."[9] In general, the psychodramatist can best assess the existence of a reinforcement potential for stimulus events not as a function of his sincerity or of their distinctness, but only if the behaviors on which they are contingent manifestly occur with greater strength.

The general utility of the operant conditioning technique for psychodramatists is suggested in the following prescription by learning theorists A. Bandura and R. H. Walters: "Should one wish to produce discriminative social learning, the best procedure would undoubtedly be to set up actual or symbolic social situations and repeatedly reward desired responses to these stimuli, while punishing undesirable responses or letting these go unrewarded."[10]

4. *Discrimination training* is a technique that is essentially the application of operant conditioning procedures. It focuses on rewarding the

[9] Marmor, J. Psychoanalytic therapy as an educational process: Common denominators in the therapeutic approaches of different psychoanalytic "schools." Paper presented at Academy of Psychoanalysis, Chicago, May, 1961. Quoted in L. Krasner, Reinforcement, verbal behavior and psychotherapy. *Amer. J. Orthopsychiat.*, 1963, **23**, 601-613. P. 608.

[10] Bandura, A., & Walters, R. H. *Social learning and personality development.* New York: Holt, 1963. P. 248.

proper generalization and discrimination of those cues that establish the proper setting for the behavior that ultimately secures maximum reward. This technique thus teaches the subject the "reality" versus the "pleasure" principle: he learns to discriminate cues for insubstantial immediate rewards, perhaps ultimately followed by punishment, from cues for more substantial rewards that are delayed to a point in time where their reinforcing value appears nil. (Because *discrimination training* also involves the accurate labeling of the subject's own behavior ("insight"), it can, on occasion, involve some inadvertent punishment, so it must be handled gingerly in order to retain the subject's docility.)

5. *Shaping* is another technique that involves an arrangement of operant conditioning procedures. Wheras *discrimination training* focuses on effectively discriminating from among competing cue patterns the one that would most probably effect maximum reward for a given response, *shaping* focuses on establishing a proper response by building up and paring down behaviors that successively approximate the desired one. The goal of this technique is to elicit those generalizations and differentiations of behavior ("skills") that secure maximum reward in the context of a fixed pattern of cues.

6. *Emotive imagery* is a technique so far described as used only with children, where anxiety is counterconditioned and behavior is reinforced by the rewards associated with support and approval from characters in a fantasy. A. A. Lazarus and A. Abramovitz[11] illustrate its use in the case of a 10-year-old boy with excessive fear of the dark who refused to enter a dark room or use the bathroom alone. The first interview was devoted to "testing and the development of rapport," and toward the end of that interview the child indicated a fascination with two radio serials: *Superman* and *Captain Silver*. Lazarus and Abramovitz continue:

> A week later, the child was seen again. In addition to his usual fears he had been troubled by nightmares. Also, a quarterly school report had commented on a deterioration in his schoolwork. Emotive imagery was then introduced. The child was asked to imagine that Superman and Captain Silver had joined forces and had appointed him their agent. After a brief discussion concerning the topography of his house he was given his first assignment. The therapist said, "Now I want you to close your eyes and imagine that you are sitting in the dining-room with your mother and father. It is night time. Suddenly, you receive a signal on the wrist radio that Superman has given you.

[11] Lazarus, A. A., & Abramovitz, A. The use of "emotive imagery" in the treatment of children's phobias. *J. ment. Sci.*, 1962, **108**, 191-195. P. 193.

You quickly run into the lounge because your mission must be kept a secret. There is only a little light coming into the lounge from the passage. Now pretend that you are all alone in the lounge waiting for Superman and Captain Silver to visit you. Think about this very clearly. If the idea makes you feel afraid, lift up your right hand."

An ongoing scene was terminated as soon as any anxiety was indicated. When an image aroused anxiety, it would either be represented in a more challengingly assertive manner, or it would be altered slightly so as to prove less objectively threatening.

At the end of the third session, the child was able to picture himself alone in his bathroom with all the lights turned off, awaiting a communication from Superman.

Apart from ridding the child of his specific phobia, the effect of this treatment appeared to have diverse and positive implications on many facets of his personality. His schoolwork improved immeasurably and many former manifestations of insecurity were no longer apparent. A follow-up after eleven months revealed that he had maintained his gains and was, to quote his mother, "a completely different child."

Thus ends the description of the case. The emotive imagery technique would differ from the typical psychodramatic enactment of the same situation in two ways. First, the psychodramatic scene is not necessarily terminated if there is anxiety because the subject may wish to practice responding adequately even if anxiety were felt: In a typical psychodrama the subject calls off the scene on the same basis he enters into it—when he is ready, so that he will learn to be self cueing and self rewarding as well as anxiety-free. Second, again to strengthen self-dependency, a rigid hierarchy is not constructed beforehand but the subject selects the scene to be played (or discontinued) on the spot. Which of the two sets of procedures—emotive imagery or traditional psychodrama—is more effective has yet to be determined, but the utility of role-playing with fantasied characters so as to extend behavior therapy principles to more complex social situations is indicated.

To conclude: Behavior therapists have on occasion used role-playing effectively but they have not yet fully exploited the potential of psychodrama for helping them extend their competence beyond that of a therapy that focuses on reducing anxiety, mastering uncomplicated motor responses, and removing or ameliorating systems, to that of a treatment for complex interpersonal issues. Similarly psychodramatists would profit from experimenting with the potential of the learning theory and behavior therapy system for enhancing their effectiveness by operationalizing and refining otherwise intuitive procedures and by providing in effect a precise method-

ology for combining, timing, and ordering the cue-response-reinforcement steps within each procedure. A "behavioristic" psychodrama, synthesized from the two systems, can be seen to provide, at least theoretically, a precise and broad vehicle for exploring and treating a large variety of subtle and complex behavior control problems within their societal contexts. A rapprochement of the two systems would thus appear, to use Moreno's terms, both possible and constructive.

SUMMARY

Despite differences in philosophical basis and goals, and despite the unsettled nature of learning theory, a rapprochement between the psychodrama and psychodramatic group psychotherapy system and the learning theory and behavior therapy system was begun. Six basic psychodramatic techniques were described from within the behavior therapy framework, and six prominent behavior therapy techniques were reviewed from within a psychodramatic emphasis. The synthesis of the two systems—"behavioristic" psychodrama—was hypothesized as providing a useful repertoire of precise behavioral control techniques.

GROUP THERAPY AND THE TRAFFIC VIOLATORS[1]

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In recent years group therapy methods have been applied increasingly to a wide range of human problems and groups previously thought relatively inaccessible to therapeutic intervention. This paper has been prepared to report the author's experience with the use of group therapy methods in the rehabilitation of serious problem drivers. The subjects for this study are individuals who have previously had their driver's permits revoked because of frequent and/or serious violation of the traffic laws of the District of Columbia. In addition, approximately eighty percent of the group have police records in connection with other non-traffic criminal offenses.

Prior to this experiment the method of treatment for this group consisted of a series of lectures on safe driving practices organized along relatively authoritarian lines. Because of doubt about the efficacy of such methods in altering attitudes and subsequent behavior, the present experimental study was devised to test the effectiveness of group psychtherapeutic treatment in the rehabilitation of this group.

THERAPEUTIC METHOD

Groups of from fifteen to thirty members are assigned to attend a series of three two-hour sessions conducted at one of the local colleges in the Washington area. In order to elucidate the procedures followed and the group reactions to them, the sessions will be described individually together with a discussion of the underlying rationale.

At the beginning of the first session the therapist is confronted with a relatively hostile group which has been required to participate. Past experience has led the group to expect a formal meeting in which they will be a passive lecture audience. Contrary to their expectations the therapist does not preside and teach material. Rather, he focuses upon the group members themselves encouraging them to ventilate their feelings about being in the situation and their underlying hostility and resentment over their past treat-

[1] This investigation was supported by a PHS research grant, AC-0064-03 (formerly RG-7958), from the Division of General Medical Sciences, National Institutes of Health, and the Division of Accident Prevention, Bureau of State Services, Public Health Service, and was carried out by the Driver Behavior Research Project at George Washington University, Washington, D.C.

ment at the hands of the police and traffic enforcement agencies. The therapist makes no effort to dispute the feelings of the group members attempting only to convey a genuine concern and interest in helping the members. Previously bottled-up grievances gain expression as a result of the non-judgmental attention of the authority figure represented by the therapist. Support for the members is also derived from hearing others who feel the same respond the same way and admit similar feelings and difficulties.

After a period of varying duration in which the group primarily gives vent to its anger and resentment, there is an increasing tendency which persists throughout the three sessions for the members to more critically examine their attitudes and feelings toward driving and the authoritarian control system.

In order to facilitate emotional recognition of their own attitudes as contrasted with the attitudes of the police who are seen as most directly responsible for their difficulties, the group is asked to play the role of a policeman with the therapist playing the role of the violator.[2] Typically the group is at first resistant to this suggestion but with encouragement individual members are able to assume the suggested role in connection with a simulated traffic violation. In playing the role of the policeman, the group members find themselves reacting in much the same manner that they have earlier criticised in the police. Typically this leads to further discussion on their part of the need for some type of regulation and an increased tendency to share responsibility for their behavior.

The second session begins either by some continuation of the discussion of the previous week or by the therapist then or later in the session telling a brief story of an individual frustrated in his work who later displaces his feeling of frustration in the driving situation. After the brief anecdote the group is asked to describe what has happened in the story and encouraged to talk about parallel feelings which they have had which have made them less adaptive in their driving behavior. The group discusses these and frequently offer to one another alternative modes of handling everyday frustrations less likely to create difficulties for them. In doing so the members seem to show increasing insight into their own displaced aggressions and alternative modes of dealing with them. Since the therapeutic goals of the group are, of course, quite limited no attempt is made to deal with the origins of these feelings in a highly individual depth oriented way.

[2] Some psychodrama and role playing experiments with problem drivers have been made by J. L. Moreno and described by him in *Psychodrama, Vol. I,* 1946, p. 127; see also Zerka T. Moreno, "Sociogenesis of Individuals and Groups," *Int. Jnl. of Sociometry and Sociatry,* Vol. III, 1963, p. 32.

The latter portion of this session utilizes a brief description of the circumstances of a civil suit arising out of a minor automobile accident. The group is asked to play the role of a jury in discussing the case not only in its legal aspects but also from the standpoint of encouraging identification with the larger society of which the group is a member.

In the final session the group is encouraged to further adopt a problem solving approach to the demands of the driving task by being given a variety of brief driving situations with which to deal. Again no specific solutions are offered. The problems are deliberately kept quite brief with the burden of elucidating them and analysing both the psychological and physical demands implied being left to the group.

Discussion

Clearly the above outlined series of sessions departs in some measure from the usual forms of group therapy yet retains some significant common elements. The goals are considerably more restricted than is true in other therapeutic situations. In this sense the process may be viewed as a limited sector therapy. While the therapist exercises some direction with respect to choice of subject matter particularly in the second and third sessions, he continues throughout to subordinate himself, for the most part, to the group. He is essentially permissive, allowing the group to set its own pace and to a considerable extent its own direction. At no point does he function as an authority in the usual sense. It is assumed that, even though the group member has been diagnosed as in need of therapy, he carries within himself forces that impel him toward growth. While the growth with which we are principally concerned is toward a preater social responsibility in a limited area, it is an area of real social significance.

Schematically there appear to be three essential steps in the current process. (1) Ventilation phase: during this phase the individual is able to ventilate his feelings of underlying hostility which in turn makes him better able to (2) recognize and accept the fact that he has an individual problem; the group with its power to sanction, prohibit, control, accept, and reject the behavior of its members facilitates the recognition and acceptance of problems on the part of its members. In this sense the group functions both as individuals with shared problems and as a microcosm of the larger society in which the problems have developed. Finally, (3) the group assists its individual members in finding more adaptive, socially acceptable means of dealing with the problem area.

Unlike the usual authoritarian context in which retraining of this type is conducted, the individuals involved or affected by the problem combine in

a common effort to deal with their concern. They themselves provide methods for dealing more adequately with the specific problems involved. By contrast, the more usual methods imply a continuance of earlier methods of chronic frustration, the enforcement of an authoritarian discipline, a skeptical attitude toward the participant, and appear to have a strong tendency to reinforce reactions of opposition and hostile defense from the violator. The present method encourages a mutual interest and cooperation, a submission to the general code (represented by the group itself) and an identification with the ideal of the community.

Results

An experiment is currently underway to determine objectively the effectiveness of this therapeutic regiment in reducing later violations and accidents in the treated group. A total of 2200 subjects will have been exposed to the experimental treatment by the close of the experiment. They will be compared to 1500 control subjects who have had similar administrative treatment but have not participated in the group sessions. Assignment to the experimental or control groups is being carried out on a competely random basis. Because it will require several years for the completion of this study only preliminary data and clinical impressions can be reported at this time. Despite the relatively large size (from the usual group therapy standpoint) of the groups, 84 percent of the members report actively participating. Most of the group (94%) report a favorable reaction to the program. Nine out of ten of the participants report that the program is likely to help them in their future driving.

On a more clinical basis the degree of interest of the participants is indicated by the interest on their part in bringing relatives and friends to the sessions as well as the tendency in later sessions (beyond the first to informally report favorable reactions to the program. Many report that this is the first time that they have ever thought about their driving in relation to their other attitudes and feelings.

In the past the sessions have been conducted by psychologists with background and training in group therapy. It is hoped that ultimately the sessions can be conducted by personnel with only limited training in the specific methods outlined rather than requiring trained psychotherapists. The results to date suggest that methods like this may have future usefulness in dealing with other limited problem areas of social significance.

THE JUDGMENT TECHNIQUE IN PSYCHODRAMA

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Employing specific, structured techniques in psychodrama would seem overly restricting since the director can normally operate better on the basis of general principles, trusting the group process and his own spontaneity to evolve scenes which each individual situation requires. Still, the "behind-the-back,"[1] the "magic shop,"[2] the "empty chair"[3] and such bag of technical tricks, if not used in a wooden or mechanical way, are often helpful. They are especially useful with patients who become more inhibited rather than freer when they are required to structure their own scenes. If nothing else, these techniques increase the director's confidence by giving him something to fall back on when his own spontaneity lags. Even psychodrama directors do not have infinite tolerance for ambiguity. With this apology I should like to describe a particular scene which I have found provocative in a large number of groups.

The sense of being judged is often mentioned as an inhibiting feeling even when no actual punishment is expected. For this reason, one of the essential characteristics of nearly all forms of psychotherapy is that they be "non-judgmental." Many patients continue to see themselves in a defendant-judge relationship even when the therapist has been consistently non-evaluative. He remains alert for fantasied signs of acquittal or conviction from the therapist. Rather than rely on the therapist's acceptance alone to overcome the patient's apprehensions, the protagonist in psychodrama is encouraged to explore the judgment situation by role reversal. This can be done by placing him in the role of the judgmental figures in his life or by the use of partially hypothetical situations such as courtroom scenes.[4] The example here is from the powerful symbolism of religion—the tribunal of divine judgment. Most protagonists tend to be diffident at

[1] Introduced by J. L. Moreno as a mirror technique; described by R. J. Corsini, *Group Psychotherapy*, Vol. 6, 1953.

[2] See J. L. Moreno, *Psychodrama*, Vol. I, Third Edition, p. X-XI; also Z. T. Moreno, "A Survey of Psychodramatic Techniques," *Group Psychotherapy*, Vol. 12, 1959, p. 13014.

[3] Rosemary Lippitt, "The Auxiliary Chair," *Group Psychotherapy*, Vol. 11, 1958. J. L. Moreno, *Psychodrama*, Vol. I, First Edition, 1946, p. 3; Third Edition, p. 3.

[4] Moreno, "Psychodrama and the Psychopathology of Interpersonal Relations," *Sociometry*, Vol. I, 1937, p. 45-46. "Psychodrama of an Adolescent," *Sociatry*, Vol. II, 1948, p. 7.

first about role reversal with God and they are therefore permitted to remain nominally in their own role but to act as a sort of advisor to Him in deciding the destiny of the people in his life who make application for entrance to heaven.

The timing of the scene is important since it usually requires considerable warm-up and much knowledge of the protagonist's immediate emotional status. For this reason, it is best used late in the session, often as a climatic scene. Considerable discussion time should be left after such a scene since it frequently mobilizes guilty and depressive emotions which must then be resolved with the help of the group. As will be seen, this scene it especially applicable with protagonists who are suppressing emotion, especially hostility, which the director feels is ready to be exposed on the psychodrama stage.

The scene may begin as follows: An auxiliary ego is selected to take the role of God. "God" then takes the protagonist to the back of the stage or on to the balcony. He explains to the protagonist that, unfortunately, he has died but that, happily, he has been living in heaven where he will spend eternity. He then explains that the person against whom the latent hostility is directed has just recently died and is now at the door of heaven applying for admission. "God" explains further that he has not yet decided the fate of the applicant but he makes the alternatives clear: heaven, which may be described in terms which the auxiliary feels would be most favorable in the protagonist's values, or hell, which may be described briefly as being filled with the horrors of physical torture, etc. "God" may then ask the protagonist for his advice as to where the applicant should be sent. Even when the protagonist feels conscious hostility to the applicant, he nearly always advises "God" to have the applicant admitted to heaven. Occasionally, the protagonist will hesitate about advising that the applicant should be admitted because he does not want to share his company for eternity. This fear may be explored itself or it may be alleviated simply by telling the protagonist that in the expanse of heaven privacy is available to everyone and that the two of them may live their own versions of paradise without ever seeing each other.

Another auxiliary ego in the form of a soul-hungry Satan waits eagerly on the side of the stage while the auxiliary taking the role of the applicant approaches the bar of justice. "God" now explains that only one impediment stands in the way of allowing the applicant into heaven—he has not repented his sins. He may have stubbornly insisted that he lived a life of perfection or he may have pretended repentance by some insincere confessions but he has shown no evidence of honest acknowledgments of his

misdeeds. "God," however, is still willing to be convinced. He agrees to permit the protagonist a given period of time to bring the applicant to repentance and win his admission. The period of time is set at 5 or 10 minutes to give a note of urgency to the protagonist's task but the time limit need not be adhered to if the scene becomes productive. While the protagonist may have been reticent about taking the applicant to task for his faults in a realistic scene, in this situation his guilt feelings become even stronger if he *fails* to confront the applicant effectively with his complaint since he would thus condemn him to damnation.

The protagonist now tries, in one way or another, to convince the applicant that he has been selfish, cruel, neglectful, etc. Whatever he is accused of, the applicant denies and demands proof. He asks when he has ever done such acts and forces the protagonist to leave the level of generality and recount specific instances. The applicant then minimizes and rationalizes these incidents, insisting that they were not really sins at all. The protagonist is thus not only encouraged to recall these significant events but to allow himself to appreciate the full emotional significance of them in his attempts to influence the applicant. If the protagonist wavers in his rhetoric, satan moves closer and pulls on the applicant's arm. The stage which has been in a soft blue light flashes red. From the events which the protagonist uses to confront the applicant, later scenes can be developed.

After the maximum catharsis has been achieved, the applicant breaks down and confesses to the accusations. He may ask for the protagonist personal forgiveness. Granting this, usually helps relieve the protagonist of some of the residual guilt which his outburst may have caused. The applicant is always admitted to heaven in the end.

According to the time available, as many of the significant individuals in the protagonist's life as possible apply for admission to heaven. One by one, his parents, his wife, his boss, his children, etc., place themselves under his scrutiny. "God's" final judgment may be delayed until the end and given *en masse*. Just before the judgment, the protagonist may stand above and behind a semi-circle of the people in his life and in a sentence or two summarize to each of them in order how, in his view, they have fallen short. In another variation, despite the seeming illogic of it, just when the protagonist has finished with the last applicant and is fully warmed up to his role of the incisive critic, he is told that he himself has "died again" and is applying for admission under the same conditions. Most protagonists have no difficulty in this separation of the ego and are often able to be quite constructively self-critical.

The subsequent discussion may follow many directions but is usually

best heavily weighted with emphatic testimonials from other group members who have had similar emotions. Analytic interpretation by the therapist or by the group members is discouraged until the initial residue of guilt feelings has been dealt with.

The director must make a judgment about the protagonist's readiness to face the material which the technique may expose. The technique is contraindicated when the potential material would be too threatening for the protagonist to integrate. He will either resist totally or will feel increased guilt and anxiety after the session. A second contraindication is the case of individuals with overt paranoid attitudes. Instead of exposing new material, these patients simply use this opportunity to further reinforce their blaming defenses. When the situation inadvertently arises, it can often be turned to advantage by reversing the roles of the protagonist and applicant.

In actual practice, of course, the scene cannot and should not follow this rigid format. One sullen young man, for example, detested his mother so intensely that, when asked where she should be sent, he coldly consigned her to hell. The director then asked him to prove his case to God by extracting a confession from his mother so that he would have a basis for condemning her. The same kind of scene followed, during which the protagonist had an opportunity to examine the nature of his long cherished hostility to his mother. After the cathartic effect of the session, he relented on his decision to damn her and, having worked off his anger verbally for the moment, he lost his sullen look and with a smile decided that he might forgive her as long as he would not have to live with her. Another protagonist insisted that the middle ground of purgatory was the only appropriate place for his sister.

The reaction of religious protagonists to this scene has been interesting. Many of them, especially religious psychotics, who do not easily distinguish reality from the psychodrama fantasy, are deeply offended at the whole idea of such a blasphemous enactment. They may refuse to participate. It rarely helps to interpret this attitude since the religious defense is so strongly rooted in consensual validation. It is best to allow such individuals to remain in the role of observers. Healthier religious people are often excellent protagonists with this technique since the religious content of the scene has deep emotional associations for them. One clergyman learned much about himself from his behavior while indulging himself freely in the ultimate grandiosity of the God-role.

PSYCHODRAMATIC RULES, TECHNIQUES AND ADJUNCTIVE METHODS

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The growing demand for skilled workers in psychodrama has awakened us to the need to structure a comprehensive statement of fundamental rules[1] in the practice of this method, and a brief survey and explanation of the numerous versions of psychodramatic intervention. Other surveys of methods have described some of these,[2] but a number of basic rules to serve as guidelines for the practitioner are vital.

RULES

I

"The subject (patient, client, protagonist) acts out his conflicts, instead of talking about them."

To this end, a special vehicle or psychodrama stage may be used, though the process may have to take place in any informal room or space whenever no such specially designed vehicle is available. Ideally, the special vehicle makes for more intense involvement. The process requires further a director (or chief therapist), at least one trained auxiliary ego (though the director may be forced to act also as an auxiliary ego where no one is available). Maximum learning is achieved whenever such trained assistant-therapist-actors are used.

It should be borne in mind that psychodrama may be applied as a method of individual treatment—one patient with one director and auxiliary ego, or one patient and the director. Where it is applied as a method of group treatment, other patients in the group may very well serve as auxiliary egos for one another. In this fashion even individual-centered sessions involve in action other members of the group, who, in turn, derive therapeutic benefit from this auxiliary ego function. This further intensifies the learning of all those present.

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1 See J. L. Moreno, Chapter on Psychodrama, *American Handbook of Psychiatry*, Basic Books, New York, 1959.

2 Zerka T. Moreno, A Survey of Psychodramatic Techniques, *Group Psychotherapy*, Vol. XII, 1959.

II

"The subject or patient acts 'in the here and now,' regardless of when the actual incident took place or may take place, past, present or future, or when the imagined incident was fantasied, or when the crucial situation out of which this present enactment arose, occurred."

This is also true of situations which have not and may not ever take place. One of the notable experiences in psychodrama is the ineffectual, weak, incomplete and distorted fashion in which recall and re-enactment are produced. This has been experimentally verified by the immediate re-enactment of scenes which took place only five minutes earlier, using the identical persons involved in the original scene. Both verbal and action recall, as well as interpersonal perception were impossible to reproduce, even though all actual partners tried systematically and honestly to recapture "what actually happened."

The subject speaks and acts "in the present," and not in the past, because the past is related to memory and speaking in the past tense removes the subject from the immediacy of experience, turns him into a spectator or a storyteller rather than an actor.

The inability to recall perfectly indicates that such recall is a practical impossibility, absolute recall does not exist and correct reproduction is a hardly attainable ideal. Furthermore, spontaneity and "presentness" are subjugated to correct reproduction and thus disappears. To release spontaneity and increase presentness in the here and now, the protagonist is specifically instructed to make time his servant, not his master, to "act as if this happening to you *now*, so that you can feel, perceive and act as if this were happening to you for the first time."

III

"The subject must act out 'his truth,' as he feels and perceives it, in a completely subjective manner (no matter how distorted this appears to the spectator)."

The warming up process can not proceed properly unless we accept the patient with all his subjectivity. Enactment comes first, re-training comes later. We must give him the satisfaction of act completion first, before considering re-training for behavior changes.

IV

"The patient is encouraged to maximize all expression, action, and verbal communication, rather than to reduce it."

To this end, delusions, hallucinations, soliloquies, thoughts, fantasies, projections, are all allowed to be a part of the production. Again, restraint has to come after expression, though it should never be overlooked. Without, however, getting expression in toto, restraint can at best be only partial.

V

"The warming up process proceeds from the periphery to the center."

The director will, therefore, not begin with the most traumatic events in the patient's life. The commencement is on a more superficial level, allowing the self-involvement of the patient to carry him more deeply towards the core. The director's skills will be expressed in the construction of the scenes and the choice of persons or objects needed to assist the patient in his warming up.

VI

"Whenever possible, the protagonist will pick the time, the place, the scene, the auxiliary ego he requires in the production of his psychodrama."

The director serves as dramaturg in assisting the protagonist. The director and protagonist are partners; at one moment the director may be more active, but the protagonist always reserves the right to decline the enactment of, or to change a scene. Furthermore, when the interaction between patient and director becomes negative, the patient resisting the director as well as the process, the director may: (1) ask the patient to designate another director—if more than one are present; or (2) ask the patient to sit down and watch a mirror production of himself by auxiliary ego or egos; or (3) turn the direction over to the patient himself, who may then involve others in the group as auxiliary egos; or (4) ask the patient to choose another scene; or (5) explain to the patient why he chose a particular scene and, even though it may not be carried out now, the patient should understand his rationale in making the choice; or (6) return to such an enactment at a later time if he continues to believe the patient needs this; or (7) insist upon its enactment if he believes that the benefits to be derived thereby for the patient are greater than his resistance.

VII

"Psychodrama is just as much a method of restraint as it is a method of expression."

The repressiveness of our culture has attached to "expression per se" a value which is often beyond its actual reward. In such methods as role reversal, or enactment of roles which require restraint, retraining and/or

reconditioning of excitability lies a greatly underestimated and disregarded application of psychodrama.

One thinks here especially of the chronic bad actor in life, the delinquent or psychopath, whose ability for self-restraint has not been strengthened by his warming up to stresses in life.

VIII

"The patient is permitted to be as unspontaneous or inexpressive as he is at this time."

This may seem to be a contradiction to the Fourth Imperative above, but only apparently so. Thus "maximizing of expression" may also refer to the patient's inability to express, his withdrawal, his submerged anger, etc. First we must accept this inability, and assist him to accept himself; gradually we try to release him from his own bonds by various methods as asides or soliloquies, the use of the double, etc.

The fact that a patient lacks in spontaneity is not a block to psychodramatic production. That is the reason for the existence of auxiliary egos who are trained to support, assist and strengthen the patient. Thus, also, have developed techniques as the soliloquy, the double, the mirror, role reversal, etc. The person who is unable to be spontaneous as himself, in his own roles, may become extremely spontaneous in role reversal as his wife, father, baby, pet dog, etc. His expressiveness will grow as his spontaniety increases. Expressiveness at any price is not necessarily spontaneous. It may be a cover-up for genuine feelings, as for instance, by producing a steady flow of words and actions. A patient may be entirely spontaneous, for instance, while sitting quietly in a chair, or observing others around him.

IX

"Interpretation and insight-giving in psychodrama is of a different nature from the verbal types of psychotherapy."

In psychodrama we speak of action insight, action learning, or action catharsis. It is an integrative process brought about by the synthesis of numerous techniques at the height of the protagonist's warm up. Psychodrama is actually the most interpretative method there is, but the director acts upon his interpretations in the construction of the scenes. Verbal interpretation may either be essential, or entirely omitted at the discretion of the director. Because his interpretation is in the act, it is frequently redundant.

X

"Even when interpretation is given, action is primary. There can be no interpretation without previous action."

Interpretation may be questioned, rejected or totally ineffective. The action speaks for itself. Furthermore, interpretation is colored by the orientation of the individual therapist. Thus, a Freudian will interpret from a different framework than an Adlerian, Jungian, Horneyan, etc. But that does not in any way change the value of the production itself. It merely puts interpretation into a lesser rung of importance. At times, indeed, interpretation may be destructive rather than constructive; it may be that what the patient requires is not analysis, but emotional identification.

XI

"Warming up to psychodrama may proceed differently from culture to culture and appropriate changes in the application of the method have to be made."

It may be impossible to start a psychodrama in the Congo by verbal exchange; it may be necessary to start with singing and dancing. What may be a suitable warm up in Manhattan may fall flat in Tokyo. Cultural adaptations must be made. The important things is not how to begin but what we begin.

XII

"Psychodrama sessions consist of three portions: the warm up, the action portion and the post-action sharing by the group."

Disturbances in any one of these areas reflect upon the total process. However, "sharing" may at times be of a nonverbal nature, a silence pregnant with emotion is often the most suitable way of sharing with a protagonist, or going out to coffee together, or making plans to meet again, or whatever.

XIII

"The protagonist should never be left with the impression that he is all alone with this type of problem in this group."

The director must draw from the group, in the post-action discussion phase, identifications with the subject. This will establish enchorages in the group for mutually satisfying relations among group members, increase cohesion and broaden interpersonal perceptions.

When there is no one in the audience who openly identifies with the

subject, the protagonist feels denuded, robbed of that most sacred part of himself, his private psyche. Then it is the task of the director to reveal himself as not merely in sympathy with the protagonist, but as being or having been similarly burdened. It is not analysis which is indicated here, but love and sharing of the self. The only way to repay a person for giving of himself is in kind. This will frequently warm up other persons in the audience to come forward in a similar manner, thus involving the audience in a genuine warming up which once more includes the protagonist, and helps to establish closure.

XIV

"The protagonist must learn to take the role of all those with whom he is meaningfully related, to experience those persons in his social atom, their relationship to him and to one another."

Taking this a step further still, the patient must learn to "become" in psychodrama that which he sees, feels, hears, smells, dreams, loves, hates, fears, rejects, is rejected by, is attracted to, is wanted by, wants to avoid, wants to become, fears to become, fears not to become, etc.

The patient has "taken unto himself" with greater or lesser success, those persons, situations, experiences and perceptions from which he is now suffering. In order to overcome the distortions and manifestations of imbalance, he has to re-integrate them on a new level. Role reversal is one of methods par excellence in achieving this, so that he can re-integrate, redigest and grow beyond those experiences which are of negative impact, free himself and become more spontaneous along positive lines.

XV

"The director must trust the psychodrama method as the final arbiter and guide in the therapeutic process."

This imperative is so universal that it finds confirmation among psychodramatic director-therapists. When the warm up of the director is objective, the spontaneity of his presence and availability to the needs of the patient and the group, or, conversely stated, when there is no anxiety in his performance, then the psychodramatic method becomes a flexible, all embracing medium leading systematically to the heart of the patient's suffering, enabling the director, the protagonist, the auxiliary egos and the group members to become a cohesive force, welded into maximizing emotional learning.

Techniques

Soliloquy

A monologue of the protagonist *in situ*, for example, the patient is preparing to go to bed, combing her hair, speaks to herself: "Why don't I cut my hair short again? It is such a nuisance, this long hair. On the other hand, it really suits me better this way and I don't look like everybody else."

Therapeutic Soliloquy

The portrayal by side dialogues and side actions, of hidden thoughts and feelings, parallel with overt thoughts and actions.

Patient is confronting her superior, who has called her on the carpet for participating in civil rights demonstrations. The auxiliary ego as the superior, asks her to account for her whereabouts the previous evening. Patient tells her she went to visit a sick friend. Auxiliary ego states she has evidence that this is not the truth. Director stops the overt action, asks patient to express how she feels, explains that "her superior" won't hear her and will not react, since she could not have known what was going on inside of her in the real situation. Patient states: "I really *did* go to that demonstration; she can't really do anything to me because I have tenure, but she can make it unpleasant for me." Director: "What do you want to do?" Patient: "Give her a raspberry, but of course, I can't." Director: "Here you can." Patient belches lustily. Director asks her now to continue the scene as it was and end it on the reality level.

Self-Presentation

The protagonist presents himself, his own mother, his own father, his brother, his favorite professor, etc. He acts all these roles himself, in complete subjectiveness, as he experiences and perceives them.

Self-Realization

Protagonist enacts, with the aid of a few auxiliary egos, the plan of his life, no matter how remote this may be from his present situation. For instance, he is actually an accountant, but for a long time he has been going to singing lessons, hoping to try out for a part in summer stock in musical comedy, planning eventually to make this his life's work. Alternatives may be explored: success of this venture, possible failure, the return to his old livelihood, or preparing for still another one, etc.

Hallucinatory Psychodrama

The patient enacts the hallucinations and delusions he is at present experiencing (though they may not be so designated by the director). Patient portrays the voices he hears, the sounds emanating from the chair he sits on, the visions he has when the trees outside his window turn into monsters which pursue him. Auxiliary egos are called to enact the various phenomena expressed by the patient, to involve him in interaction with them, so as to put them to a reality test.

Double

The patient portrays himself, an auxiliary ego is asked also to represent the patient, to "establish identity with the patient", to move, act, behave like the patient. The patient is preparing to get up in the morning, he is in bed. The auxiliary ego lies down on the stage alongside of him, taking the same bodily posture. The double may start speaking: "What is the use of waking up? I have nothing to live for." Patient: "Yes, that is true, I have no reason for living." Auxiliary ego: "But I am a very talented artist, there have been times when life has been very satisfying." Patient: "Yes, but it seems a long time ago." Auxiliary ego: "Maybe I can get up and start to paint again." Patient: "Well, let's try and get up first, anyway, and see what will happen." Both patient and auxiliary ego get up, go through the motions of washing, shaving, brushing teeth, all along moving together as if they were one. The auxiliary ego becomes the link through which the patient may try to reach out into the real world.

Multiple Double

The protagonist is on the stage with several doubles of himself, each portraying another part of the patient, one as he is now, another as he was five years ago, a third as he was when at three years of age he first heard that his mother had died, another how he may be twenty years hence. The multiple representations of the patient are simultaneously present and act in sequence, one continuing where the other left off.

Mirror

When the patient is unable to represent himself, in word or action, an auxiliary ego is placed on the action portion of the psychodramatic space. The patient or patients remain seated in the group portion. The auxiliary ego re-enacts the patient, copying his behavior and trying to express his

feelings in word and movement, showing the patient or patients "as if in a mirror" how other people experience him.

The mirror may be exaggerated, employing techniques of deliberate distortion in order to arouse the patient to come forth and change from a passive spectator into an active participant, an actor, to correct what he feels is not the right enactment and interpretation of himself.

Role-Reversal

The patient, in an inter-personal situation, for instance, with his mother, "steps into his mother's shoes" while the mother steps into those of her son. The mother may be the real mother, as is done in psychodrama in situ,[3] or may be represented by an auxiliary ego. In role reversal, the son is now enacting his mother, the mother enacting the son. Distortions of inter-personal perception can be brought to the surface, explored and corrected in action. The son, who is still himself, must now warm up to how his mother may be feeling and perceiving himself, the mother, now the son, goes through the same process.

A mother of an eight-year-old girl, after showing how they argue for ten minutes every morning during the winter as to what clothing the child should wear to school, is asked after their own roles have become clear, to take the role of Kay; Kay is asked to take the role of her mother. They are instructed to change place in space, to assume the role of the other, the posture and position each had.

Kay stretches a foot in the role of her mother, shows authority and certainty, whereas in her own role her anxiety was very evident. Mother now has to subdue her ebullience and restrain herself to be her somewhat withdrawn daughter. Both open their eyes wide at the image each holds before the other. Mother remarks when this scene is ended: "Am I really as aggressive as Kay portrayed me? My poor Kay!"

Future Projection

The patient portrays in action how he thinks his future will shape itself. He picks the point in time—or is assisted by the director to do so—the place and the people, if any, whom he expects to be involved with at that time.

The patient is studying to be an English major and has his bachelor's degree; he has been working on his M.A. for almost eight years, is unable to

[3] J. L. and Z. T. Moreno, The Discovery of the Spontaneous Man, *Psychodrama Vol. II*, Beacon House, 1959.

complete it. The future projection shows him three years hence, teaching his first course in English at the university. The entire audience is his class; he is asked to face them and inspire them with the beauty of the English language. "My name is Mr. Johnson; it is a very ordinary and yet beautiful name. I should like to welcome you here today, by asking you all to introduce yourselves to one another. But remember, that name stands for you. Try to present it in such a way that it sings, that it reaches out to the other as if to say 'here I am, who are you?' "

Dream Presentation

The patient enacts a dream, instead of telling it. He takes the position he usually has in bed, when sleeping; before lying down and taking the position of the sleeper, he warms up to the setting separately. The director asks him when and where he had this dream, to describe the room, the location and size of the bed, the color of his pajamas, whether he wears top and bottom, or sleeps in the nude, whether he sleeps alone, with the light on or off, window open or closed, and how long it normally takes him to fall asleep.

The patient is asked, in the lying down position, to breath deeply and evenly, as he does in sleep, to move in bed as he does ordinarily while asleep, and lastly, to relax and let himself drift off. The final instructions of the director are: "Try, without telling me about it, to visualize in your mind the beginning, the middle, and the end. Do you see it? Just answer yes or no."

When the patient has fixed the various images somewhat in his mind's eye, the director asks: "Where are you in the dream? Do you see yourself? Yes? Then step out of the dream. What are you doing, walking, swimming, sitting, running, what?" Patient: "I do not see myself, I am in the dream." Director: "You are acting, doing something?" Patient: "Yes, I am flying, over the rooftops of houses." Director: "Do you see the rooftops? Get up and start to take a position resembling flying, here, stand on top of this table." Patient climbs on table, leans forward somewhat. "Yes, I see the rooftops, in fact, I'm hardly able to fly over them, sometimes it seems I'm going to crash into them." Director: "Where are these buildings and what are they?" Patient: "This is a residential section, in fact, as I realize now, this is the suburb where I live!" Director: "Do you see your house?" Patient: "No, but I seem to sense this is my section." Director: "Are you the only one who is flying? Are you alone?" Patient: No, I am carrying a bundle in my arms." Director: "In both arms, or only in one? Look at your arms." Patient

looks down at his arms which appear to be carrying something, then drops his left arm, says: "My right arm." Director: "What is in the bundle, do you know its contents?" Patient: (Looking intently at his right arm, crooked around an object, amazed): "It's a baby." Director: "Whose?" Patient: "My parents'; it's my baby sister, we are 18 years apart in age." Director motions to an auxiliary ego to come upon the stage to represent the baby. The baby is asked to kneel in such a way that the top of her head is approximately at the height of his right elbow, and the director asks the protagonist to hold her as best he can. Director: "What are you doing there, flying with her?" Patient: "I am carrying her with me through life, protecting her from harm, but I'm not very sure that I am able to do this; I seem to have trouble keeping her aloft with me." Director: "Are you afraid?" Patient: "Afraid, but also very angry." Director: "Angry at whom? The baby?" Patient: "No, at fate. Why should I be saddled with this responsibility? She is my parents' child, not mine." Director: "In the actual dream, do you speak to your baby sister?" Patient: "No." Director: "Well, here you can." (This is a psychodramatic extension of the dream.) To auxiliary ego baby: "Talk to your older brother." Baby (auxiliary ego): "I am a bit scared flying this high. Do you hold me carefully?" Patient: "I am doing my best, but you are very heavy." Baby: "You won't drop me, will you?" Patient: "I can't, though frankly, I'd like to." Baby: "Why? Are you angry at me for being here with you?" Patient: "Not at you, but after all, I'm not ready for such responsibility yet, I'm just starting college, and you're just a tiny infant." Baby: "I like you, you are my big, strong brother." Director: "What happens next in the dream?" Patient: "I clutch her and the dream just fades off." Director: You do not see any conclusive ending? Concentrate for a moment." Patient: "No, I just wake up in a cold sweat." Director dismisses auxiliary ego, returns patient to the position of the sleeper, back in bed. Director: "You wake up in a cold sweat." Patient: "Yes, I'm thoroughly soaked."

Re-training of the Dream

Director: "Sounds like a very frightening dream. Obviously, you wish it had not ended this way." Patient: "I even wish it had never started!" Director: "Yes, of course. You see, in psychodrama, we can 'change the dream.' When you are there, at night, things happen to you which appear to be out of your control. But, after all, it is you who produced the dream, because of your fears and anxieties. We believe that if we can help you to

change your dream pattern, to train your unconscious, so to speak, the next time when you are dreaming, your dreams will change in character, you will be in better control. Now, let's see how you wish to change your dream." Patient: "I don't want to have this dream at all." Director: "Yes, I can see that, but what would you like to do instead?" Patient: "I would want to have a good talk with my parents." Director: "Fine, let's have a good talk with your parents. Get up, and pick a mother and father from the group, two auxiliary egos to represent them. Patient does so, and sets up the livingroom of their house. Patient now confronts his parents: "Gee Mom, Dad, I know you have both been very ill in the past year, and, being the oldest son, I feel terribly burdened by the responsibility of the two younger kids, especially about Alice. Timmy is already older and not quite such a problem, but Alice is just a little infant." Director: "Tell them as brutally as possible what is on your mind; after all, these are not your 'real' parents, merely stand-ins. They will not be hurt by anything you say or feel or do." Patient: (blurts out) "Why the devil did you have to go and have a menopause baby? Don't you think you have enough complications? Mother works, the housekeeper is terrible, she doesn't even speak English, is my kid sister going to learn broken English? And don't you care what she eats? That dope can't even cook, all the kid gets is cereals and mashed banana." Now mother and father respond, try to soothe the patient, the role reverses with them, and finally, feels more reassured that his parents still have the major responsibility for the child.

This is the unique contribution of psychodrama to dream therapy, to go into enactment over and beyond the actual dream, including actual and latent material, but even more, to retrain the dreamer rather than to interpret. Interpretation is in the act itself.

Therapeutic Community

This is a community in which disputes and conflicts between individuals and groups are settled under the rule of therapy instead of the rule of law. The entire population, patients and staff alike, are responsible for the welfare of every other person, participate in the therapeutic process and have equal status.

Adjunctive Methods

Hypnodrama

Hypnosis is induced on the psychodrama stage portion. The hypnotizant is free to act, to move about, and is given auxiliary egos to help oortray his drama. Hypnodrama is a merging of hypnotherapy with psychodrama.

Psychodramatic Shock

The patient is asked to throw himself back into the hallucinatory experience while it is still vivid. He does not describe it, he must act. He puts his body into the position in which it was then, in the space he was in, at the time of day or night when this actually occurred. He may select a staff member to recreate the hallucinatory involvement.[4]

The patient may show resistance against being placed again into the horrifying experience from which he has just emerged. His natural bent is to forget, not to talk about it and to leave it behind. He is full of fears that his newfound freedom may be shattered. The mere recall frightens him, and the idea of enactment still more. The psychodramatic director explains that it is to learn control, not a mere reliving, that this reenactment will help him build resources against recurrence.

Once the patient has warmed himself up again into the psychotic state, and has thoroughly enacted it, the director stops him, to assist the patient in the realization that he can construct his own inner controls.

Improvisation for Personality Assessment

The subject is brought into the psychodrama theater or the life situation without any prior preparation. The director has structured the situation in advance with the aid of auxiliary egos. The subject is then asked to warm up to the situation as he would do if it were actually happening to him.

The subject is told he is in his car, driving on the highway. He is alone. Suddenly he hears a siren and a policecar comes alongside, then ahead of him. The policeman stops him, walks over to him, demands to see his ticket and gives him a tonguelashing because he was driving 20 miles over the speed limit. He gives him a ticket for speeding.

Or: the subject enters a cafeteria. An auxiliary ego, obviously the worse for indulgence in alcohol, approaches him and asks for money.

Numerous sets of standard situations have been devised and they enable the director and group members to get a profile of the action potential of the individual which paper and pencil tests are unable to uncover.[5]

Didactic Psychodrama and Role Playing

Used as a teaching method, auxiliary egos, nurses, social workers, psychologists, psychiatrists, are taking the role of a patient, in a situation of

[4] J. L. Moreno, Psychodramatic Shock Therapy, Psychodrama and Group Psychotherapy Monograph No. 5, Beacon House, 1939.

[5] *Assessment of Men*, Office of Strategic Services, Rinehart, New York, 1947.

everyday occurrence. For instance, the patient who refuses to obey rules as they are applied in the hospital or clinic setting. The students learn to take both roles, those of a patient, as well as their own professional role. The training situations are structured according to typical conflicts with which they are familiar, or which they are likely to face in their professional roles. Several versions of how to deal with the obstreperous patient can be represented by various students. The patient is usually portrayed by an auxiliary ego, a staff member, so that real patients need not be involved.

Another teaching application is to have staff members sit in on actual patient sessions, becoming involved as seems necessary. In this event, the patient represents himself, the staff members themselves. Role reversal between staff member and patient will intensify learning, with each getting a new perception of their relationship and of the responsibility in being a staff member, and the agony of being a patient.

Psychodrama Combined with Narcosynthesis, LSD, etc.

Under the influence of drugs, the patient relives certain experiences or, after having undergone drug therapy, needs to integrate his menodrama as it unfolded inside of him, while he was unable to communicate those experiences.

There are two variables, the drug, for instance Pentothal Sodium, and the enactment of the inner worlds. The question here is which variable contributes what to the treatment.

Family Psychodrama and Family Therapy

Husband and wife, mother and child, are treated as a combine rather than alone, often facing one another and not separate, because separate from one another they may not have any tangible mental ailment.[6]

In the course of this approach the family members may reverse roles, double for each other, and in general, serve as each other's auxiliary ego.

SUMMARY

The important question which remains to be answered is the scientific evaluation of psychodrama. Does psychodrama, with or without group psychotherapy, beyond the subjective reports of therapists and their patients, produce behavior change? According to John Mann[7] forty-one studies have substantiated that fundamental changes in behavior take place.

[6] J. L. Moreno, *Group Psychotherapy, A Symposium*, p. 316, Beacon House, 1945. J. L., Z. T. and J. D. Moreno, *The First Psychodramatic Family* Beacon House, 1964.

[7] John Mann, Evaluation of Group Psychotherapy, *International Handbook of Group Psychotherapy*, Ed., J. L. Moreno, Philosophical Library, 1965.

PSYCHODRAMA IN ACTION

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The following text has been abstracted from a televised motion picture made at a large mental hospital in the USA. It has the character of a "psychodramatic exit test" with a few action notes accompanying the group process. The televised production was made by the author as Director and a group of patients entirely unrehearsed and communicated via closed circuit television to several thousand patients in the various wards of the hospital. The problem was are these patients ready for discharge? The exit test is a method by means of which to determine their readiness for returning to the community.*

MORENO: Oh, it's a pleasure to meet you. (Speaks to first patient, shakes hands.) What is your name?

PATIENT: Lauretta.
MORENO: Lauretta, oh that's a nice name, Lauretta. What is your job?
LAURETTA: Oh, I was a mother, and married.
MORENO: Married.
LAURETTA: About to be divorced.
MORENO: About to divorce, and what are you planning to do?
LAURETTA: Well, I want to leave the hospital.
MORENO: Then you will go back to work?
LAURETTA: Hm, office work.
MORENO: Have you children?
LAURETTA: Yes.
MORENO: How many?
LAURETTA: Three.
MORENO: How old is the oldest?
LAURETTA: Oh, he is 20, 21.
MORENO: What brought you here?
LAURETTA: Oh, a nervous breakdown, I guess.
MORENO: What is that?
LAURETTA: Well, I don't know, I just got awfully nervous.
MORENO: But did they bring you here or did you come voluntarily?
LAURETTA: No, it was a court order.

* Geographic location and names of people have been changed.

MORENO: What, the police?

LAURETTA: Hm?

MORENO: Hm?

LAURETTA: Yes, they came and got me in the car.

MORENO: What did you do?

LAURETTA: I didn't do anything, except get nervous.

MORENO: Oh, I see. And you? What is your name? (Moves to next patient, shakes hands, goes from patient to patient around the semi-circle, shaking hands and interviewing each one in turn.)

MARTIN: Martin.

MORENO: Martin, are you married or single?

MARTIN: I have been married three times, sir.

MORENO: How many times more do you plan to . . . .

MARTIN: Well sir, I enjoy life.

MORENO: Oh, I see (laughter). Tell me, what kind of work are you doing?

MARTIN: Now, while I'm here?

MORENO: Yeah.

MARTIN: I work here in the television studio.

MORENO: Television, and do you plan to go home?

MARTIN: I do.

MORENO: Do you think you are ready for it?

MARTIN: I do.

MORENO: Where would you go if you go home?

MARTIN: Chicago, I'm also on . . .

MORENO: To whom would you go? To whom?

MARTIN: I would like to go back home on my own. I was on welfare, county aid.

MORENO: Hm, but I mean, with whom would you live?

MARTIN: Oh, I room by myself.

MORENO: By yourself. Very well, my friend. And you, what is your name?

DOREEN: Doreen.

MORENO: What?

DOREEN: Doreen.

MORENO: Doreen. Indian name?

DOREEN: Irish, yes.

MORENO: Irish, and you want to go home? You think you are ready? How long are you here now?

DOREEN: Two years.
MORENO: Do you think you are ready to go home?
DOREEN: You bet I'm ready.
MORENO: You bet. To whom would you go?
DOREEN: Eh, I can go out with my family or else . . . .
MORENO: With whom would you live?
DOREEN: Well, my sisters.
MORENO: Where do they live?
DOREEN: In town.
MORENO: Yes, well and my pleasure to meet you.
DOREEN: Thank you.
MORENO: Where would you go if you go home?
RON: To my home and my folks.
MORENO: Who is that, Momma and Poppa?
RON: Mom and Pop, and my two sisters.
MORENO: Hm, where is that?
RON: Here in the city.
MORENO: In the city, do you think you are ready for it?
RON: Not yet.
MORENO: Not yet, but you'd like to go home for a visit?
RON: Yeah, I'm going home for a visit pretty soon.
MORENO: Pretty soon, how long are you here now?
RON: Four months.
MORENO: What is your work?
RON: Here?
MORENO: Outside.
RON: Outside I worked in a gas station for a while.
MORENO: Gas station. Hm, good. And you?
KEITH: Keith.
MORENO: How long are you here?
KEITH: I've been here a month or so.
MORENO: Do you think you are ready to go home?
KEITH: Not quite.
MORENO: What kind of work are you doing?
KEITH: I'm a draftsman.
MORENO: And if you go home to whom would you go?
KEITH: Stay by myself.
MORENO: You stay by yourself, you go to Papa, you go to sister, you stay alone unless you find a sweetheart, you?

LAURETTA: Family care.

MORENO: Family care, you're being divorced, and you?

HANK: By myself, I'm being divorced.

MORENO: Well now, as I'm looking at you I'm trying to find somebody from whom you could learn most. Now, for instance, you, what is your name? (Moves again towards Ron.)

RON: Ron.

MORENO: How old are you, Ron?

RON: Twenty.

MORENO: Now, you see Ron, and I'm also talking to the others, I will now go through a certain procedure with you Ron. Of course, I would like to do that with each of you. I'll tell you what it is. When the time comes and a person feels that he has stayed in a hospital for a certain amount of time, he wants to find out himself whether he is ready to go home. Whether he can confront life as it is, right, you understand? And so we would like to see. How are you for instance, how would you act if you go home. To your mother and father, right, let me see, now that is the problem. Right? You have to go home, you have to go back to work, and then of course you have to go back to the community where you live. Right? Now for instance, you, what is your first name again?

RON: Ronald.

MORENO: Ronald, well I'll tell you Ron. Imagine for a moment now, you say you are not sure whether you are quite ready. You would like to find out how ready are you, right?

RON: Yes.

MORENO: You may say, four weeks, six weeks, eight weeks, you may feel stronger that the time has come. We would like to find out now how good you are and we will ask you afterwards how you feel about such an arrangement. You, yourself, might find out you know. Alright. Now, where do you live?

RON: In Chicago.

MORENO: Where?

RON: North side.

MORENO: Where, what street?

RON: Grant Street.

MORENO: Grant Street. In a house of your own, with your parents?

RON: Yeah, we have our own house.

MORENO: You have your own house.

RON: Paid for and everything.

MORENO: Paid for forever. And so you go home. What kind of a house is it? I'll tell you now what it really is. What is your first name, again?

R: Ronald.

MORENO: Ronald, what do they call you at home?

RON: By my second name, Tim.

MORENO: I'll tell you now Tim, if you go home now, for instance, right now, whom would you meet at home? Who would be there when you arrive?

RON: Ah, my Mom and my sister.

MORENO: Your Mom, how old a lady is she?

RON: Oh, 58.

MORENO: 58.

RON: Oh no, my Dad's 58. She's 53, somewhere around there.

MORENO: 53 years old, and so, in which room of the house would she be when you come home?

RON: She is probably standing at the door.

MORENO: Alright, of course, she is waiting for you. She is expecting you.

RON: Of course!

MORENO: Alright, and so, I'll give you, as your real mother is not here and we want to test out how you would act, for instance, if you would really go home, we will provide you now with somebody towards whom you would really act as if she would be your mother. Do you see what I mean? Then, in doing that we would find out how you would act when you go home, and we can advise you if you are ready to go home or not. We would see how you act to her, how she reacts to you. It is of course not your real mother, but it is somebody who will try to pretend that she is your real mother.

RON: Then, I can't kiss her. (Laughter.) (It appears that the subject does not want to kiss his mother when he comes home or does he mean that he would not kiss the auxiliary ego mother, or that he does not want to go home.)

MORENO: Don't say that. You can do whatever you like, whatever you do in life itself, see Tim. The way you act towards her you should act here. Right? Be natural, do you understand?

TIM: Yes.

MORENO: And so you are here, how do you come home, by bus, by automobile, how do you get here?

TIM: By car.

MORENO: And so here you are, next to the house, where is your mother? Where do you expect your mother to be?

TIM: On the front porch.

MORENO: On the front porch, well maybe, this lady here, come forth, she will be your mother, right?

TIM: Right.

MORENO: Now and here you act towards her as if she would be your mother, and she will act towards you as if you would be her son, Tim, right? And now you are moving towards the front stage. And here she is. Come on.

TIM: Hi, Mom.

AUXILIARY EGO MOTHER: Tim, hi! (Opens screen door up, patient warms up fast, responds to her embrace and embraces her back.) Oh, it's so good to see you. Are you alright? Let's take a look at you, you got a little sunburn. What'd they do to your hair? (Strokes his head.)

TIM: They clipped it in the hospital.

AUXILIARY EGO MOTHER: They sure did. Did they shave it? Come on in, come on in. Want something to eat? (They walk into the house, stand by a small table which represents the kitchen table.)

TIM: No, I'm not hungry now. I'm going to watch TV.

AUXILIARY EGO MOTHER: Right from the start? I haven't seen you in all this time, and now you're going to watch TV? Bring up a chair. What would like?

TIM: (Sits down) How about some peanut butter sandwiches?

AUXILIARY EGO MOTHER: I thought you might like some. I got your favorite kind of peanut butter. Now where's the refrigerator?

TIM: Here (indicates the location of the refrigerator).

AUXILIARY EGO MOTHER: (Opens refrigerator door, takes out jar, bread, etc. and places them on the table.) How would you like to make it yourself, hm?

TIM: (Spreads peanut butter on bread.)

AUXILIARY EGO MOTHER: (Sits down on Tim's right.) Did they say you could stay home from the hospital?

TIM: I'm on a year's leave, and I might get my discharge then.

AUXILIARY EGO MOTHER: You're still a bit shaky. Why are you shaking? (Puts her hand on his right forearm which trembles noticeably.)

TIM: I don't know, being home, adjusting. . . .

AUXILIARY EGO MOTHER: Take it easy, what are you worried about?

TIM: I don't know if I want to be home.

AUXILIARY EGO MOTHER: Why don't you want to be home?

TIM: I want to get out on my own.

AUXILIARY EGO MOTHER: Well, do you think you're ready to get out on your own?

TIM: I don't know, that's the problem, I need your help for a while until I get my education.

AUXILIARY EGO MOTHER: We'll be glad to do whatever we can to help, but we'll have to sit down and discuss it.

TIM: Yes, that's right (very submissive).

AUXILIARY EGO MOTHER: You know you got into an awful lot of trouble before and we don't want you to get into that again.

MORENO interrupts: Tim, is that the way your mother acts?

TIM: No.

MORENO: Then reverse roles, you be your mother. (Tim and auxiliary ego get up and take each other's places.) All right Tim, now you are your mother, alright?

TIM: (Puzzled) How can I act like my Mom?

MORENO: Try it, you know her better than I do! Just try it.

TIM (as mother): (Bows his head, closes his eyes, screws them tight, then rubs his forehead. After a few moments he lifts his head resolutely, looks at auxiliary ego in the role of himself.) Hi Tim!

AUXILIARY EGO TIM: Hi Mum!

TIM (Mother): Glad to be home?

AUXILIARY EGO TIM: Don't know, I'm a little nervous.

TIM (Mother): Don't be nervous, you're home now, you can relax and take it easy and watch TV. . . . (As mother raises voice, is dominant and positive.) You have your own room, we had it painted and everything.

AUXILIARY EGO TIM: I appreciate you're having it painted and everything, but I'd like to get out on my own, get my education and make something of my life. I think I ought to have a place of my own, I'm grown up now.

TIM (Mother): Yes, I know, you have a desire for independence.

AUXILIARY EGO TIM: I can't be living here anymore.

TIM (Mother): We want to help you.

AUXILIARY EGO TIM: Why do you have to help me? Why can't I do it on my own? Other people do it on their own.

TIM (Mother): But you're not completely self sufficient!

MORENO: Reverse roles again.

(Tim and auxiliary ego change places).

MORENO: Continue from where you were.

AUXILIARY EGO MOTHER: But why do you want to be completely self sufficient? You're not that old yet. You're only twenty.

TIM: But I've got to get some confidence in myself.

AUXILIARY EGO MOTHER: Well, I know that but we're your parents, we want to help you.

TIM: Yes, but by dominating me you cannot help me. (Shows some strength for the first time.)

AUXILIARY EGO MOTHER: (After some silence, with a burst of indignation and a powerful voice.) Who dominates you, I don't dominate you!

TIM: (Aside to the Director), that's the way my Mom would act. (Laughter, also from the audience.)

AUXILIARY EGO MOTHER: Nonsense, I never heard of such a thing. Since when isn't a mother supposed to voice her opinion about her own child? Now what's going on, is this the kind of crazy idea you get there in that crazy hospital out there, that nuthouse?

TIM: It's not a nuthouse, and I may have to go back.

AUXILIARY EGO MOTHER: Well, I want you home! I think this is the place for you to be. Not out there, in the sticks! (Waves her arm.)

MORENO: You reverse roles now, you are your mother. (They change places again.)

TIM (Mother): I don't want you out there in the sticks. I want you home!

AUXILIARY EGO TIM: There you go again. You've got to have me where you can put your finger on me and push me; that's what I'm afraid of. The way you control me, that's what frightens me.

TIM (Mother): Every mother has the desire for her son to be a little boy and I think you're going to have to. . . .

AUXILIARY EGO TIM: I think you need some help. I don't want to be a little boy all my life. I want to grow up.

TIM (Mother): Maybe I'm nervous about Johnny and the other kids.

AUXILIARY EGO TIM: Because you're nervous, you're making me nervous.

TIM (Mother): Well let's try to get along at home.

AUXILIARY EGO TIM: (Looks away and turns body away from mother, withdrawing.)

TIM (Mother): Look at me (demanding, with vigor).

MORENO: Tim, get out of your mother's role and come over here. (Tim gets up and walks towards Moreno.) Now imagine for a moment that your mother is upset at the way you act and your father comes in. What is your father's name?

TIM: Ronald. (The son and the father have the same first names. This fact produces confusion in his behavior when he reverses roles with his father.)

MORENO: Your father comes in, sits there, and you are now your father and that is Tim (pointing to auxiliary ego). Right? Tim sits there, your father comes in, and you, where do you come from? What is your first name?

TIM: Ronald.

MORENO: What is your full names, Ronald?

TIM: Ronald Thomas.

MORENO: Ronald Thomas, your family name?

TIM: Ronald Tiding.

MORENO: Well Ronald Tiding, I'm pleased to meet you. I'm a doctor, Dr. Moreno, I met your son in the State Hospital where I was visiting and now that I have an opportunity to be here, I see that your son has come home. I like to become acquainted with you. Here is your son and please see what you can do with him. He's home, maybe to stay. He just had an argument with his mother. Do you have difficulties with your wife at times?

TIM (Father): Not really.

MORENO: Not really, she's a good woman? You love her?

TIM (Father): Yes.

MORENO: Is it your first marriage?

TIM (Father): No, my second.

MORENO: Why did you marry again?

TIM (Father): My first wife wanted to be a social climber.

MORENO: But you love this new one?

TIM (Father): (Smiling) She's not new. She's been around twenty-seven years.

MORENO: Is she younger than you are?

TIM (Father): Yes.

MORENO: How many children do you have altogether from these two wives?

TIM (Father): We have 5 children.

MORENO: How many do you have from the second wife?

TIM (Father): Oh, two.

MORENO: And what about Tim, is this his real mother?

TIM (Father): Yes, his real mother.

MORENO: Alright Tim. Tim is here and you are his father, now here he is. (Tim as father walks towards son who is sitting at the table.)

AUXILIARY EGO TIM: Ah gee Dad, I wish you'd get Mom off my back.

TIM (Dad): Want a cigarette? (Takes a pack of cigarettes out of his shirt pocket.)

AUXILIARY EGO TIM: (Impatiently) Not now, Dad, will you please sit down and listen to me for once?

TIM (Dad): Yes, yes. (Seems eager to help his son but at the same time not quite sure how to proceed. Tim's voice and behavior in the role of his parents differ markedly from that in his own role.)

AUXILIARY EGO TIM: I can't seem to get it through her head that I've got to stand on my own two feet and that I've got to get out there and get an education and make something of my life. I can't be her little boy anymore!

TIM (Dad): That's what we want to help you to do.

AUXILIARY EGO TIM: What, be a little boy? I don't want to be a a little boy!

TIM (Dad): No, no Tim (positive now), we want to help you grow up! (Very strong.)

AUXILIARY EGO TIM: But, she's dominating me and I get mad at you too because she dominates you; she shoves you around just the way she shoves me around!

TIM (Dad): No, I think it's mostly in your imagination. (Very determined and positive.)

MORENO: (To auxiliary ego who gets up and walks towards him) Now you are Tim's mother and you come in and communicate with your husband. To Tim: You are Tim Senior and this is your wife.

AUXILIARY EGO MOTHER: (Walking through the door) What do you think of that boy? The minute he comes in he starts telling me he's going to move out! He's telling me I dominate him!

TIM (Father): Calm down mother! (Head in hands, apparently somewhat overwhelmed, but still eager to keep matters in line).

AUXILIARY EGO MOTHER: What are we going to do with him? When is he going to grow up and understand that there are sons and there are mothers and they try to get along together.

TIM (Dad): Calm down.

AUXILIARY EGO MOTHER: I can't stand it! I don't understand him anymore. He used to be my little boy and he used to be a nice child.

TIM (To Moreno protesting): My mother's not that bad. (Audience laughter.)

MORENO: Then you reverse roles. (To auxiliary ego) You are Ron, Sr. (Tim and auxiliary ego reverse places.)

AUXILIARY EGO FATHER: How do you think he looks?

TIM (Mother): Fine, he's a fine boy.

AUXILIARY EGO FATHER: I know he's a fine boy; you don't have to sell him to me, he's my boy too, you know.

TIM: (To Moreno, protesting) My father's not that way, either. (Laughter from audience.)

MORENO: Reverse roles again. In fact, let's leave the auxiliary ego out. You take both parts, your mother and father. When you sit here, you are Ron, Sr., and when you sit there, you are your mother (indicates roles by chairs).

TIM: Am I Ron Thomas Tiding? (Is obviously having difficulty in keeping apart his own role from that of his father.)

MORENO: Yes, when you are here, and over there you're your own mother.

TIM: I'm Thomas.

MORENO: Now you are Ronald.

TIM: My father's name is Ronald Thomas.

MORENO: You are your father now, talking to your mother; Tim is not here now.

TIM (Father): (Has cigarette in hand, thumbnail between front teeth, mumbles is inaudible at times) We can't have him laying around the house, watching TV all day. He's been in and out of that hospital three times now. He's got to start preparing his future, get a job and take that electronics study course that he was talking about. (Looks up at Moreno, somewhat blank as to his next move.)

MORENO: Reverse roles. Sit in that chair now and be your mother.

TIM: (Moves over to the other chair, takes mother's role) You know what's right!

MORENO: (Motions for him to return to father's role, Tim does so.)

TIM (Father): Well, what do you have to say about it?

MORENO: (Motions to mother's seat again).

TIM (Mother): (Moves over.) I think it's a very good idea for him to get a job and an education by correspondence course.

MORENO: (Motions to father's seat.)

TIM (Father): (Moves over to father's seat.) O.K., it's a deal. I'll talk to him tomorrow about it.

MORENO: (Motions to mother's seat.) Finish it up now, as mother.

TIM (Mother): (Sits down) Want some coffee, honey? (Laughter from audience.)

MORENO: Let's have some coffee.

Evaluation by Moreno of Tim's Acting—Going Home Scene

When he acts *himself,* his voice is weak, his head bowed, he mumbles. When acts as his *mother,* his voice is loud, he raises his head, he looks at himself as portrayed by someone else, straight, he gets angry at himself. When he acts as his *father* versus his mother, his voice is almost inaudible, his head bowed, he does not look into your face, or that of his wife, he does not know what to say. He is most incompetent and evasive when he has to act as his father and mother jointly; he knows little about their relationships; he cannot make a decision for himself, he cannot accept the decision of his parents. He is at a loss. He does not know what to do with himself. He needs somebody who can guide him.

MORENO: Well now, Tim, come here. (Tim walks over to Moreno). You plan to get an education. You'll go to school, what kind of a degree do you want?

TIM: I want to be somewhere in the field of electronics.

MORENO: Electronics. Oh then, maybe you'll run this television station.

TIM: Maybe.

MORENO: Then I'll be glad to come back to this hospital and work with you. Well now, I'll tell you something Tim. There is of course another thing. We have seen you with your parents. We have become acquainted with them and seen how you act with them. But now the question is, before you came to the hospital, you had some work. Right?

TIM: Yes.

MORENO: What kind of work did you do?

TIM: Oh odd jobs, and gas station work.

MORENO: For instance, after you are home a week, you must go back to work. Do you plan to return to your old employment or will you try to get some new employment?

TIM: Yes, I want to get a job so that I can have money to take a correspondence course.

MORENO: Where would you try to get a job; would you go back to your old employer?

TIM: No, no.

MORENO: Why not?

TIM: Brings back old memories.

MORENO: Brings back old memories; what kind of memories do you have?

TIM: Well, the customers want so much service. And then they want trading stamps and if you are out of them you have to take their name and address, that sort of thing.

MORENO: But where would you get a job? Would you go to one of your old employers?

TIM: Well, it's the easiest for me.

MORENO: Alright, well then let's go there. What's the name of the man?

TIM: Jacob Laida.

MORENO: Jacob Laida's, what kind of a setup does he have?

TIM: He works for Shell Oil.

MORENO: He works for Shell Oil. Well, I'll tell you, how long ago is it that you worked for him?

TIM: About five months ago.

MORENO: Five months ago.

TIM: I've been in the hospital four months.

MORENO: What's his name again?

TIM: Jacob Laida. He's from Egypt.

MORENO: From Egypt.

TIM: Yea, he's out of Communist Egypt.

MORENO: God, out of Egypt; how do you get these very interesting men to work for?

TIM: I don't know. I'm just lucky, I guess. (Laughs, also laughter from the audience).

MORENO: Now what is his first name? Jack? You call him Jack?

TIM: Yeah.

MORENO: How old a man is he?

TIM: Oh, he isn't too old.

MORENO: Guess.

TIM: About 30.

MORENO: And so old Jack, now we have to find old Jack around here. Now here is a man who looks like Jack, doesn't he? (Picks one of the men patients to be Jack.)

TIM: Quite.

(Auxiliary ego Jack gets up and joins them.)

MORENO: Well Jack, here you are. Tim, set up the employment situation in the gas station. Now you give him the instructions, he works in a gas station, he has an office there?

TIM: Well to tell you the truth, I don't know. The Shell Oil Co. has taken over the station, I don't remember my other employer.

MORENO: But you would like to work for him?

TIM: Yes.

MORENO: So you will come to Jack and talk to him. I'll tell you now Jack, here you are. I'll tell you something Tim, considering that you know Jack, you take the part of Jack (motions to them and they change places). Tim you are Jack. Are you sitting down in your office?

TIM: I don't think he'll be sitting down though; he likes to stand up.

MORENO: No? Then stand up, that's alright, stand up. Let me look at you. How old a man are you Jack?

TIM (Jack): Thirty.

MORENO: Are you married or single?

TIM (Jack): Married.

MORENO: And do you like it in America?

TIM (Jack): Oh, it's lovely.

MORENO: Lovely, why do you like it here?

TIM (Jack): Oh, I came out of communist Egypt. It's wonderful. (Falling out of the role, in an aside to Moreno; he didn't talk about that).

MORENO: But you talk about it.

TIM: I used to ask him questions.

MORENO: (Correcting) You are Jack now, don't mix him up with Tim.

TIM: I'm all mixed up, I guess. (Rubs forehead.)

MORENO: You are Jack, right? Now here you are, why do wou stand up, why don't you sit down. (Tim sits down). No, I mean, you do whatever you do.

TIM (Jack): Oh, I've got the gas station organized now, I can sit down.

MORENO: Now everything is in order, what is here?

TIM (Jack): This is the backroom.

MORENO: Where's the gas?

TIM (Jack): Out there (motions with right hand).

MORENO: Oh, outside, and people are coming in and you hear the bell ring. You didn't hear the bell ring?

TIM (Jack): No.

MORENO: Well, it rang. Who is there, there's a man outside. You know who is?

TIM (Jack): No, I don't.

MORENO: Look at him.

TIM (Jack): Tim?

AUXILIARY EGO TIM: How do you do.

TIM (Jack): What's your name now?

AUXILIARY EGO TIM: Tim.

TIM (Jack): Oh, come in. (They shake hands). Sit down. What can I do for you?

AUXILIARY EGO TIM: I thought I'd drop by and see how things are going with you, and actually, to see if there's a chance of getting my old job back.

TIM (Jack): (Uncertain) I could put you on nights.

AUXILIARY EGO TIM: Oh, nights? I used to work days.

TIM (Jack): I had you on days and nights.

AUXILIARY EGO TIM: Oh, that's where I got mixed up, I guess.

TIM (Jack): Oh, what shift?

AUXILIARY EGO TIM: Well, that 4 to 12 shift sort of got me down. I couldn't go out and do anything on that shift. I mean, you're just kind of living close to the vest, as it were.

TIM (Jack): Well, I'll see what I got for you.

AUXILIARY EGO TIM: Well, could I start tomorrow?

MORENO: Reverse roles now, let's see now, is this how Jack acts?

TIM: Yeah, he's a very nice guy.

MORENO: He's a very nice guy. (They have now changed seats).

AUXILIARY EGO JACK: Well I'll tell you Tim, things have been a little slow lately. I could use some more help, but until things start coming up the way they should be, I'm afraid I won't be able to give you a job. Not for a while, but I'll certainly keep you in mind. I'm sorry to do the turnabout on it but you have such a sparkling personality you took me unawares here. I was ready to give you a job until I was able to consider what it was all about. Keep in touch with me and maybe the next time around I'll be able to put you on permanently.

TIM: I'll just keep looking, and then I'll be back.

AUXILIARY EGO JACK: OK Tim, good luck to you. (They shake hands, auxiliary ego returns to seat).

MORENO: Tim, I'm sorry you didn't get your job back. (Laughter). These communistic people from Egypt are rather tough, aren't they? They don't have communism there yet, you know.

TIM: (Rejoining Moreno) Oh no?

MORENO: Now tell me Tim, as we are here, what will you do next? You are now in the community, I want to see how you live. What will you do next? Try for another job?

TIM: Yes.

MORENO: What would you do now next?

TIM: Try another gas station.

MORENO: But what else could do? Where could you go?

TIM: A TV and radio shop. No, I don't know enough about that.

MORENO: What else could you do besides going to another gas station? What other kind of jobs can you do?

TIM: Oh, I can mop floors.

MORENO: Mop floors, let's mop floors. Then you would go back to the State Hospital and get employed there to mop floors?

TIM: Maybe I can get a job. . . . (Is now very confused, appears very tense and distraught).

MORENO: Where would you really go? Would you like to stay in town? Where would mop floors?

TIM: Do I have to stay in my home state?

MORENO: I don't know. How would you handle it?

TIM: I'd go to Hawaii and get a job as a private eye, as a detective . . . . No, that's dangerous work.

MORENO: You'd go to Hawaii? How would you handle that? How would you manipulate it? Do you have enough money saved?

TIM: No, I'd have to make some money first to make the trip (screws up his face).

MORENO: You'd make some money first to make the trip. So what would you do right now? You are here on the street, right? You cannot get that job; what else would you do?

TIM: Try another gas station.

MORENO: Another gas station. Well, but there are gas stations you've tried out already. Can't you try anything else? Think hard. Have you no friends who can employ you, a restaurant?

TIM: Oh yeah, that's right, a bus boy.

MORENO: A bus boy. What hotel is it?

TIM: No hotel; it's a restaurant.

MORENO: A restaurant, what's the name of the restaurant?

TIM: Bronson's.

MORENO: Where is it?

TIM: It's on North Main and Eighty-ninth.

MORENO: Alright, let's go there. Who do you know there, anybody?

TIM: No one.

MORENO: Do you think there's a woman boss or a man boss?

TIM: A man boss.

MORENO: A man boss. Well, now let us see. You are coming there and you find a boss. Um, that looks like a real boss. Would you be interested in running a restaurant? (Picks another male patient from the group).

AUXILIARY EGO: Of course.

MORENO: Do you know him, have you ever met the boss?

TIM: No.

MORENO: He's a total stranger?

TIM: He's the manager.

MORENO: In that store. Alright, you're the manager of that store. Alright Tim, you describe it.

TIM: Here's a counter and there's a cash register. (Motions as he describes the counter.)

MORENO: Alright (to auxiliary ego) you are the manager. (To Tim) And you are coming in.

TIM: There is a lady behind there; she's the cashier, she'd call us in cause I have to ask to see the manager.

MORENO: A lady behind here. Maybe Adeline, would you please take the part of the lady behind the counter? Come on. Here she is.

TIMS (Looks at cigarette in his hand) I couldn't be smoking.

MORENO: You shouldn't smoke?

TIM: Well, it wouldn't look good to ask for a job when I'm smoking.

MORENO: Oh, that's right. Somebody take the cigarette out of his hand. (A group member takes it.) Here is the lady and here is the manager, right? You are coming in.

TIM: Hi, do you think I can see the manager about a job?

AUXILIARY EGO: Well, I think you can. Just wait here a moment. (To auxiliary ego manager) There's a young fellow here who's looking for a job. Do you want to see him?

AUXILIARY EGO MANAGER: Be glad to.

AUXILIARY EGO: O.K. (To Tim) Will you come in?

TIM: Sir, uh, I was thinking that maybe I could get a job here as a

bus boy. A friend of mine worked here before and he was going to let me do it over the weekend, but I wasn't feeling too well and uh I think it would be a —— I know I could do a good job, uh I've had a little experience in a kitchen.

MORENO: Reverse roles. Let's see how you would do if you are the manager. You have to talk a little louder, you know Tim, to get the job and impress him better. (They change positions.)

TIM (Manager): Well, we're awful busy right now, why don't you come back later this afternoon?

AUXILIARY EGO TIM: I'll do that sir. My name is . . . .

MORENO: Reverse roles. (They change positions again.) Do it again. Tim, do it now. He is the manager again and you are yourself.

TIM: (Claps hands together, appears under stress.) Uh, do you think it would be possible that I could work here?

AUXILIARY EGO TIM: A little later on. Business is not too good right now. We might consider it a little later on.

TIM: Would you take my name down?

AUXILIARY EGO TIM: Glad to. What is your name, sir?

TIM: Ronald Tim Tiding.

AUXILIARY EGO TIM: Your phone number?

TIM: PL 6-4557.

AUXILIARY EGO TIM: Alright, thank you, and I'll keep you in mind, sir.

TIM: O.K., thank you, sir. (Relieved that it's over).

Evaluation by Moreno of Tim's Acting—Employment Scenes

The gas station owner offers him a job but when Tim reverses roles and acts as an employer, towards himself, he refuses himself a job. He reveals that he does not think of being worthy of being employed and earning living wages.

MORENO: Well Tim, don't you have any other resource? Do you have a girl friend?

TIM: No, not any more.

MORENO: What? What happened to her?

TIM: We broke up.

MORENO: When?

TIM: We were engaged.

MORENO: Why did you break up with her; what happened?

TIM: Uh . . . .

MORENO: What?

TIM: She talked about other guys all the time and it got on my nerves.

MORENO: Other guys?

TIM: Yea, she was bugging me. She took off the ring at times and went out with another guy, she was mad at me because I didn't have a car.

MORENO: She was engaged to you and you gave her an engagement ring? What's her name?

TIM: Her name is Monica.

MORENO: Monica. Is she still around, Tim?

TIM: She's supposed to be in a state hospital in Indiana.

MORENO: Did you telephone her?

TIM: Oh no, I got into this hospital before she landed there. She went and got engaged to another guy and when I landed in here she cracked up.

MORENO: She cracked up. Would you like to call her up at the other hospital, and see what she says?

TIM: Yeah, yeah that's what I've been wanting to do for a long time.

MORENO: Alright, telephone her. Go ahead. What is her name?

TIM: Monica Rodriguez.

MORENO: Alright, call up the hospital, see what she thinks.

TIM: Alright. Uh, could I somehow speak to Monica Rodriguez? I don't know what ward she's on or anything. You say she's here? Could I talk to her please? (Suddenly breaks down and sobs heartrendingly. Puts his arms on the table and his head on top of his forearms. Cannot seem to stop crying. Moreno goes over to him, gently strokes his head and talks soothingly to him.)

MORENO: What's the matter Tim? What is it Tim? Come on, tell me, what is it?

TIM: I don't want to . . . .

MORENO: She doesn't want to talk to you?

TIM: Yes, that's it, she wouldn't want to talk to me. She said those things—she said those things! (Gradually stops sobbing.)

MORENO: Yes, well I'll tell you something. She is there on the telephone. She wants to talk to you. Give her a chance Tim, here she is. (Points to auxiliary ego who picks up a phone).

AUXILIARY EGO MONICA: Who's that?

TIM: (Listens intently, starts to smile, wipes his tears off his face). This is Tim. You remember me!

AUXILIARY EGO MONICA: Sure I remember you. How have you been?

TIM: Oh, pretty good.

AUXILIARY EGO MONICA: How are you getting along?

TIM: Well, I'm here at the State Hospital, and I got a job in a TV studio and I may go on a visit home pretty soon.

MORENO: (Interrupts) Don't forget you are right now out of the hospital.

TIM: Oh, I won't.

AUXILIARY EGO MONICA: It's nice of you to call me. I guess I haven't acted very nice to you. Why did we get mixed up? What happened between us?

TIM: I don't know. I didn't have a car and you were pretty angry about that.

AUXILIARY EGO MONICA: That was stupid of me.

TIM: Well, I could understand your feelings. That's why I let you go out with Jim.

AUXILIARY EGO MONICA: You know it didn't work out with Jim either.

TIM: Yes, I heard about that.

AUXILIARY EGO MONICA: You know, I've been quite sick.

TIM: So have I. You think we could get back together again?

AUXILIARY EGO MONICA: Do you want to?

TIM: I'm not sure, but I'll come over to your place. Do you still live at the same place?

AUXILIARY EGO MONICA: I don't want us to get sick again over this.

TIM: No, I know how you feel.

AUXILIARY EGO MONICA: I did miss you though.

TIM: I missed you quite a lot, quite a lot. I really did miss you. I'm not sure I should come over again, I might start drinking again. I don't know if drinking's my problem or not, maybe it's you.

AUXILIARY EGO MONICA: It could be me and your drinking, both.

TIM: I didn't really drink that much. It used to mess me up in my job and everything else.

AUXILIARY EGO MONICA: I don't want to mess you up again.

TIM: No, I wouldn't want to hurt you anymore than I did, either.

AUXILIARY EGO MONICA: You messed me up pretty good too, you know.

TIM: I know. (Seems quite relaxed, at ease and frank with her.)

AUXILIARY EGO MONICA: We were really going it hot and strong there for a while.

TIM: Yeah, we were (laughs). It's funny.

AUXILIARY EGO MONICA: It's not funny!

TIM: No. I was real sadistic about the whole affair. Man, waking you

up in the middle of the night and giving you a bad time when you had to go to work in the morning. Maybe I just haven't grown up yet, maybe I shouldn't see you for a while.

AUXILIARY EGO MONICA: Are you still drinking?

TIM: (Aside) Man, I'm ready for a drink right now! No, no, on my twentieth birthday I cut a recipe out of a magazine and I'm going to have this special on my twenty-first birthday. It's called a guster ball, you make it with Schlitz, and maybe I can invite you to that party.

AUXILIARY EGO MONICA: I don't think I'm ready for any party just now.

TIM: (Does not answer).

AUXILIARY EGO MONICA: Are you working?

TIM: Uh, yeah, I've been looking for a job all day, and I'm pretty sure I'll get one, I've just got to keep trying. I still need a little support from my folks.

AUXILIARY EGO MONICA: I wish you'd come and see me when you're feeling better. But don't come when you're so upset, because you upset me too. I get upset too.

TIM: I guess I shouldn't call for a while. Well, after I get a job and a car, may be I'll drop by and we can go to a drive-in or something.

AUXILIARY EGO MONICA: Call me again then.

TIM: All right.

MORENO: Well Tim, I understand some of your difficulties now. You like that girl, Monica, right? And you didn't have a car and maybe you were cruel to her, what do you mean? You didn't warm up to her properly and make love to her?

TIM: Oh, I did, I did. That's where we got mixed up.

MORENO: Oh, I see. Did you get intimate with her?

TIM: Very.

MORENO: Very. Did she like it?

TIM: At times she called me filthy.

MORENO: She called you filthy. Love is not filthy, is it?

TIM: No. (Is very serious now).

MORENO: And then, what happened? You had no car. What did you mean by that?

TIM: Well, she always wanted to go places, which I understood, but I didn't have a car. And we was engaged at the time and she said she'd like to go out with Jim.

MORENO: Who is Jim?

TIM: Oh, he had a car and an airplane.

MORENO: Do you know Jim?

TIM: I only met him twice.

MORENO: What kind of a guy is he, is he older than you are?

TIM: Yeah, he was a pretty nice guy. She was older than me, in fact. She's twenty-two.

MORENO: Oh, Monica is older than you are. And Jim is older than both of you?

TIM: Yeah.

MORENO: Hm. And she liked Jim too?

TIM: She liked Jim very much. She got engaged to him after she broke up with me.

MORENO: After she broke up with you. But you went with her first?

TIM: I went with her first.

MORENO: She was a virgin when you met her?

TIM: Pardon?

MORENO: Was she a virgin?

TIM: No.

MORENO: No. But she became a virgin after you met her? Was she? (Laughter).

TIM: Now wait. She told me all about it.

MORENO: Oh, I understand. And so you were heartbroken after she left you.

TIM: Yes, in fact, that's when I really started drinking.

MORENO: That's when you started drinking. Where do you go drinking, in your neighborhood?

TIM: At first it was just in the neighborhood, and then a guy had this big Buick, so we cruised all around town and everywhere. There was a burlesque show and we had a good time there.

MORENO: You got drunk, hm?

TIM: Oh yeah, I got drunk. He had to drive. I didn't want to in my condition.

MORENO: That was wise. And now Tim, you are now back in the community. Would you go drinking now? You have talked with Monica. Do you feel like going to a speakeasy and drinking again? How do you feel really, be honest!

TIM: No, I wouldn't. After I cry . . . .

MORENO: Crying helped you. Do you often cry?

TIM: Yes.

MORENO: When she upsets you, huh?

TIM: When I get upset.

MORENO: Would you like to have her back?

TIM: Yes.

MORENO: Do you think there is a chance?

TIM: No, no.

MORENO: She broke off with Jim. You don't think there is a chance?

TIM: Uh, cause it would just drive me to the same old rotten crap all over again. (Here he gets tense again.)

MORENO: Is it the only girl you had?

TIM: No, no, no.

MORENO: You have others?

TIM: Yeah.

MORENO: But this is the one you love most.

TIM: Yeah, the one I love most. (Seems to be balancing on the balls of his feet, swaying, unhappy.)

MORENO: Italian?

TIM: No, she's Mexican, a lot of Indian in her 'cause she has high cheekbones.

MORENO: Wonderful! Beautiful girl!

TIM: Beautiful.

MORENO: Too bad, isn't it?

TIM: Yeah, it's rough.

MORENO: Imagine, you felt ready to get married to her, hm? Have you ever imagined that with her? What would you have had, a church wedding? What kind of a wedding?

TIM: Oh, we weren't going to have that. Because she's Catholic and I was going to change my religion for her, that's how much I loved her.

MORENO: You were going to become a Catholic and go to the priest, hm?

TIM: No, we weren't going to do that. We said it would be a simple wedding.

MORENO: A simple wedding. How did your mother feel about her?

TIM: Well, I brought her to our house with her sister one night. We felt gay and after they were gone my Dad said, "God, those two dames act awful giddy." And that hurt me, 'cause he didn't have a good impression of them.

MORENO: She didn't make a good impression on your dad.

TIM: No.

MORENO: What about your Mom?

TIM: Same difference.

MORENO: Same difference. Then you didn't have support from your family, hm?

TIM: No, I didn't. I didn't have any backing.

MORENO: Would you go back to Monica if she would have you?

TIM: No, I want to find another girl (more determined now).

MORENO: You want to find another girl. Well now, tell me now, Tim, and so that is your decision. You'd like to find another girl and you want to stop drinking.

TIM: Yes, 'cause I'll land back in here if I do. It happens every time.

MORENO: It happens every time. How many times have you been here?

TIM: This is my third time.

MORENO: Your third.

TIM: I was in General Hospital before.

MORENO: In General Hospital, and then you came here. Always drinking.

TIM: Yeah, everytime I started drinking.

MORENO: What do you drink when you drink?

TIM: I usually start with beer and then pretty soon we start buying a half-pint . . . . You know, I'm not an alcoholic, but it just gets me down and make me guilty about it.

MORENO: Tell me something, when you drink do you get violent?

TIM: Uh, no, no. I'm usually just a little depressed. I thought at one time there I might have gotten violent, but I didn't. I walked out of a bar. I felt the people were against me.

MORENO: Tim, here we are now. You are outside and you didn't land a job. What is the situation. Let's face it. You have no job.

TIM: No job.

MORENO: We have seen you now at home, how you act with your parents. We have seen you how you try to get a job, right? And we saw you how you try to communicate with Monica, to get her back to you, if possible. And then you decided the best thing for me is just to let it go, right? But now, in the community, do you have any friends? Do you go to church once in a while?

TIM: Yes, I go to church.

MORENO: To which church do you go?

TIM: I go to church here. Or, do you mean at home?

MORENO: You are at home now, you are not here.

TIM: Oh well, I'd go to the Baptist Church.

MORENO: The Baptist Church. You are a Baptist?

TIM: Yeah.

MORENO: You are a Baptist. To whom do you talk there, the minister?

TIM: No, I talk to the girls. I don't know, I shy away from them.

MORENO: From what?

TIM: From the Baptists. They're . . . they want to get . . . I like them . . . that's the only church I know. I don't want to go to another one.

MORENO: Is there any person in that church whom you trust?

TIM: Uh, yeah, Howard Williams.

MORENO: Who's that?

TIM: He's a good friend of mine.

MORENO: What's his name?

TIM: Howard Williams.

MORENO: Howard Williams. What is he, a minister there?

TIM: No, he's just another guy and he has a car.

MORENO: Well, I mean a minister, somebody whom you look up to, a father figure.

TIM: Oh, Mr. uh. (Has a hard time remembering anyone meaningful related to him.)

MORENO: Whom do you go to once in a while, to talk to him from your heart?

TIM: No one now. I haven't been there in a long time.

MORENO: But when you come back, you are now in the community. We would like to find out how you would act in the community, when you are back.

TIM: I'd probably talk to Mr. Long. He don't talk much, but I'd like to talk to him.

MORENO: He doesn't talk much.

TIM: No, that's why I'd like to talk to him, because he doesn't chew his mouth off.

MORENO: Is he a big man, an old man?

TIM: Yes, he's a nice man.

MORENO: What is he doing there?

TIM: Mr. Long?

MORENO: Yeah.

TIM: Uh, he goes to church, he isn't really no big hit, I don't think.

MORENO: Is he, does he have a function in the church; is he a minister there?

TIM: No, he's not a minister, but he takes care of the grounds and the youth.

MORENO: Is he an older man? How old a man is he?

TIM: Oh about forty.

MORENO: Do you talk to him once in a while about yourself?

TIM: Well, I never did get to talk to him much, that's why I'd like to talk to him. I'd like to get to know him. He's nice and quiet.

MORENO: Do you go elsewhere, to a club? Do you have any savings in the bank? Have you any money? (Tries to help Tim to find an anchorage in the community.)

TIM: I have three dollars in the trust here, but I drew all my money from the bank. I was saving up for a car and I got wild, you know, and I started blowing it on athletic equipment.

MORENO: And so you wouldn't go to a bank. You would go maybe to that Baptist Church. Is there anyone who means something, outside of your family, a very close friend?

TIM: No, the Brown's down the street. The guys are pretty nice guys, they're fraternal twins. They're pretty nice.

MORENO: Do you ever pray?

TIM: Yes, I get down on my knees quite often.

MORENO: Well, then get on your knees and pray. When do you pray, at night, by day?

TIM: At night.

MORENO: Do you go to a church, in a church when it's dark, then you pray?

TIM: No, I usually just pray whenever I feel like it.

MORENO: Well now, let's see how you pray when you feel like praying. Go on your knees and pray then Tim, and let's see. Whatever your prayers are speak them out loud that we hear them.

TIM: (Kneels at the table, puts his hand on his crossed forearms). Oh, Lord in heaven, hallowed by thy name.

MORENO: Louder.

TIM: Oh Lord in heaven, hallowed be thy name.

MORENO: Louder. Lift up your head so we can hear you.

TIM: (Lifts his head and has his eyes closed.) Please help me from this hospital. Please help me to be strong so I can fight off evil influences.

MORENO: To whom do you pray?

TIM: I pray to the Lord, Jesus Christ.

MORENO: To the Lord, Jesus Christ. He hears you. You pray to him. Let's all pray with Tim.

TIM: Lord.

MORENO: Lord.

TIM: Please help me . . . .
MORENO: Please help me.
TIM: . . . to be strong.
MORENO: . . . to be strong.
TIM: . . . and to understand other people.
MORENO: . . . and to understand other people.
TIM: . . . and not to . . . .
MORENO: . . . and not to . . . .
TIM: . . . be angry at sick people.
MORENO: and not to be angry at sick people.
TIM: . . . at sick people; and . . . .
MORENO: . . . and . . . .
TIM: Forever bring your love to me.
MORENO: Forever . . . .
TIM: So I may love my fellow men . . . .
MORENO: Love my fellow men . . . .
TIM: . . . forever.
MORENO: . . . forever.
TIM: Amen. (His entire body relaxes, he looks more at ease. His eyes are still closed.)
MORENO: Amen. That's good for you Tim, hmm?
TIM: Mmm. (Nods his head affirmatively, opens his eyes, looks up at Moreno.)
MORENO: Do you feel better now that you prayed?
TIM: Yes.
MORENO: Do you feel your prayers are answered?
TIM: Yes.
MORENO: Did you get results?
TIM: Yes, I feel much better.
MORENO: Do you pray very frequently?
TIM: Yes, but sometimes I don't pray at all and that's when I start being on the wrong road.
MORENO: Tell me Tim, at night, do you dream?
TIM: I don't remember my dreams.
MORENO: Didn't you have a dream recently?
TIM: Yes, but they're value. I only have frightened dreams.
MORENO: Frightened dreams. Do you remember a dream that is clear in your mind?
TIM: A long time ago, I had a dream.

MORENO: Well now, was it at night? Where did you have the dream, here in the hospital?

TIM: No, at home.

MORENO: At home. Let's go back into your bed. And go to bed and let's see how it is. Go to bed. What kind of a bed do you have? Do you have a room of your own?

TIM: Yes.

MORENO: All right, then go to bed, and stretch out on the floor.

TIM: On the floor?

MORENO: Yes, that's a good bed.

TIM: (Lies down on the floor.) Well, anyhow.

MORENO: Just a moment now. Do you sleep in your own bed?

TIM: Yes.

MORENO: In your own room?

TIM: Yes.

MORENO: Close your eyes. Try to concentrate now on that dream. Just a moment, don't tell me the dream. (Strokes Tim's head, tries to get him to relax.)

TIM: No.

MORENO: You have to act it out. Do you remember now the dream? Do you see the dream?

TIM: You mean the kind I dreamt?

MORENO: Yeah.

TIM: I woke up from it.

MORENO: I understand, but, begin with the dream when it starts, right? Do you see yourself?

TIM: That's the problem. I don't remember the dream, but I remember when I woke up and found the image before me.

MORENO: Well then, try hard Tim, try hard.

TIM: (Rather excitedly). No, no, there was no dream. That's the problem!

MORENO: No dream.

TIM: I woke up and tried. . . .

MORENO: Then wake up out the dream. Get up.

TIM: No, I got up like this. (Sits up, is quite well warmed up to the process now.)

MORENO: Alright, then let us see how you are when you get up—like that, what do you see? What happens?

TIM: I see this vague, vague, vague, vague image before me. It's all white.

MORENO: What do you see?

TIM: I thought it was a lady.

MORENO: A lady?

TIM: Yes.

MORENO: Let's see a lady. Here she is. Here she is. Here's a lady. (Points to a young girl, a group member who comes up.) What is she doing, the lady? Is she dressed?

TIM: She was just . . . yes, she was dressed in white.

MORENO: In white. Let's see her, she's dressed in white. And what is she doing?

TIM: She was just standing there before my bed.

MORENO: Come on, stand before Tim's bed. And what is she doing before it?

TIM: She was standing there and I said to her . . .

MORENO: You say to her?

TIM: I say, hello!

MORENO: Hello, what does she say back?

TIM: She said nothing.

MORENO: Nothing.

TIM: And I said, what's your name?

MORENO: What's your name?

TIM: And she said nothing.

MORENO: Nothing.

TIM: And then I talked to myself. What would a woman be doing in my bedroom? And she disappeared.

MORENO: She disappeared. (To auxiliary ego) Disappear. (She does so.) Nice lady, isn't she? Pretty. Does she look like Monica?

TIM: Well, in a way.

MORENO: In a way. All the ladies look like Monica.

TIM: (Laughs).

MORENO: Well Tim, I'm glad that you have acted out your dream. Come on, get up for a moment. Well, and so Tim, here we are. I want to thank you. And now we will see what the other people think of you and your performance. Now we have seen you in action. We have seen you going home. We have seen you when you're looking for a job. We have seen you with your girlfriend, and we have seen you dreaming, right? And now you would be interested just like I, what they think of you. Is his behavior good enough that he can stay home and live again without getting drunk, without hurting his girlfriend, finding a way of life? Or is he to stay longer in the hospital? That's what you want to know, right?

TIM: Yes.

MORENO: Are you ready to live again like everybody else?

TIM: Yes.

MORENO: That is what we want to know. And I think here we have so many people who can help you, to tell you their sincere opinion, because you have been a bearer of truth, right? Everything you did was true.

TIM: Yes, sir.

MORENO: You didn't lie.

TIM: No. I didn't.

MORENO: Everything was just as it is.

TIM: Yes, sir.

MORENO: And we trust you.

TIM: Yes.

MORENO: And because we trust you, we will be as honest with you as you have been with us. Now you go back to your chair. Now I'll talk to you people. Now what do you think of Tim, do you think he's ready to go home? (Audience applauses).

MISS T: I think he's ready.

MORENO: What do you think of it?

MISS T: I think he's ready to go this afternoon.

MORENO: You think so? How do you think he acted with his parents?

MISS T: Well, he acted naturally. He wanted to defend them and they were not too harsh.

MORENO: How do you feel about a man who gets home and has no job?

MISS T: Well, he seems to be interested in looking for work.

MORENO: That's good enough, you think.

MISS T: It's his problem; he'll have to face it.

MORENO: And what do you think about his girlfriend?

MISS T: She must be a very sweet young lady.

MORENO: Yeah, and you, what do you think of him?

MR. U: Well, I think he's . . . .

MORENO: Do you think he's ready to go home?

MR. U: No.

MORENO: No. Why? Give us reasons.

MR. U: I think he's still emotionally immature.

MORENO: He's still emotionally immature. In what way does he act emotionally immature?

MR. U: Well, towards his parents.

MORENO: Towards his parents.

MR. U: And remembering so vividly his fit at the bar.

MORENO: You have a feeling that he might go back to that bar and drink again?

MR. U: Yes, I do.

MORENO: In other words you think he's drived towards finding some replacement for his love, in the form of alcohol?

MR. U: Yes, I think so.

MORENO: You think so. And how do you feel about a man who has no job and looks for it and is unable to get it?

MR. U: Well.

MORENO: What do you think?

MR. U: I'm confusing it with my own case.

MORENO: (To Tim) And you?

TIM: (Thinking it over.) I am not ready.

BOOK REVIEW

THE TUNNEL BACK: SYNANON, By Lewis Yablonsky, The Macmillan Company, New York, 1965.

Dr. Lewis Yablonsky, a sociologist, author of "The Violent Gang," and a former president of the American Society of Group Psychotherapy and Psychodrama, studied Synanon for three years. "The Tunnel Back" is his description and analysis of this community of former drug addicts and criminals, which has become a social movement of national significance. Dr. Yablonsky writes as biographer, historian, observer, analyst of the therapeutic methods, and social critic dealing with a social problem. Primarily, however, he deals with the solution rather than the problem. As this review is written for "Group Psychotherapy" a journal concerned with treatment, attention will be focused on this area.

Synanon was founded by Charles Dederich, a former business executive who had obtained symptomatic relief from alcoholism through participation in Alcoholics Anonymous. Dederich began a weekly free association discussion group with some friends from Alcoholics Anonymous in January 1958. By August 1958 the group was meeting three times a week, had become incorporated, and admitted its first "incorrigible addict." In August 1959, the group, then known as Synanon House, moved to a former National Guard armory in the midst of the stylish Pacific Ocean Beaches in Santa Monica, California. There were over fifty residents of Synanon at that time, white and black, male and female, young and middle aged, all narcotics addicts trying to rid themselves of their habit. At the time the "Tunnel Back" was written there were over 400 addicts in residence in the Synanon Houses in Santa Monica, San Diego, San Francisco, all in California, and Westport, Connecticut. The efforts of local authorities to evict Synanon for "Zoning" Violations are recounted in detail. So are the decisions of the state authorities to prevent parolees and probationers from living in or visiting Synanon. Despite all of its difficulties Synanon has survived and, according to Yablonsky, has been effective with 150 individuals who encountered clear failures with other methods of treatment. When we compare these results with those achieved at Lexington, Kentucky, Riverside Hospital, New York, or any of our correctional institutions we tend to agree with Yablonsky that this indicates an important "breakthrough" in treatment.

What is the treatment program? Yablonsky refers to it as a total therapeutic community and credits Moreno with this concept. It is a com-

munity in which everyone is therapist and at the same time a patient to everyone else. He describes it in detail, quoting liberally from case histories, therapy sessions and interviews with old and new residents. It may be summarized under the following headings:

1. *Milieu Therapy*—Ā protective environment is provided in which the drug addict finds fair play and sympathy for positive behavior and punishment for deviance. The punishment may take the form of a "haircut" (see 5 below), ridicule, and, in extreme cases public exposure. No alcohol, use of drugs, violent behavior, or dishonesty is tolerated.

2. *Role Models* are provided. The new arrival is viewed as a child. He is watched carefully. All of the higher status people, however, are former addicts. The newcomer sees evidence to support the indoctrination promise of "we can help you kick." All around him are people who have succeeded.

3. *Possibility of Upward Mobility.* The supervisors of every project, the directors of Synanon and all the holders of intermediary status positions are former addicts. The newcomer can see himself rising on the status ladder. Whereas as an inmate of a prison or patient in a hospital he remained in the lower caste position until he left, at Synanon he can rise in the hierarchy. The patient can, in time become the therapist. He has to learn and conform.

4. *"Synanons"* three times a week. These are group therapy sessions conducted by former addicts with experience. Exaggeration of negative behavior, caricature, and ridicule are techniques used.

5. *"Attack" therapy.* Some synanon sessions emphasize verbal attack on an individual by leaders and others in the group. Attacks may also come in the form of "Haircuts" in which a director ridicules or criticizes an individual or subgroup for immature behavior.

Phases of treatment and stages of growth are also described in detail. During Stage I the individual lives in the main building and is closely watched. After a year or two he usually passes to Stage II in which he lives in Synanon, but is free to work, go to school, and have other relationships in the community. After about 2½ years of residence the individual "graduates" to Stage III. He may, in this stage, live and work in the community or work for Synanon Foundation. In either case, he may go or come as he pleases. He is encouraged to maintain a "lifeline" to Synanon and attend meetings. It is rare for a Synanon "graduate" to revert to drugs.

Since the treatment program of Synanon has many facets it is impossible to attribute its success to any one of them. Yablonsky points out

that in combination they encourage a substantial number of addicts to stop using drugs and to engage in constructive activities. Certainly the therapeutic milieu must account in part for changes in behavior, particularly when combined with the presence of successful former addicts as Role Models and with the possibility of upward mobility. How much change can be attributed to the "synanon" form of group therapy is impossible to determine without further research. The same may be said for the "attack" therapy used. Yablonsky appears to reject the idea of such research at Synanon. He and Dederich feel that the pre-testing necessary for evaluation studies might prove traumatic to newcomers. Research into the effect of "synanon" type group therapy might be feasible, however, in other settings.

The philosophy underlying "synanon" group therapy is similar to that of other "here and now" forms of therapy. Psychodrama, for example, emphasizes the "here and now" and the exposure of fantasies. The treatment of the criminal, the drug addict, and other deviants presents the therapist with a dilemma. In dealing with persons who have had trouble with authority figures, he frequently finds it necessary to be nonjudgemental, sympathetic and supportive in order to establish a therapeutic relationship. He must also reject deviant behavior, deviant values, and fantasies. As Yablonsky points out, sympathy may reinforce the undesired behavior.

How is this dilemma resolved?

1. In "synanons," by verbal attack on deviant behavior, deviant values, and fantasies. Exposure may take the form of exaggeration, ridicule, and/or caricature. If support is deemed necessary the skilled Synanist may supply it. Yablonsky points out that the attack itself is positive in a sense because it demonstrates that others care.

2. In Psychodrama, fantasies and undesired behavior are attacked through the use of role reversal, double, mirror, and other techniques developed by Moreno. The director therapist may remain sympathetic, supportive, and nonjudgemental if, in his clinical judgment, these approaches are indicated.

3. In Group Therapy a skilled sociometrist can manipulate the group in such a way that members of the group attack fantasies while he is free to remain nonjudgemental and even sympathetic. The use of co-therapists may resolve the dilemma, with one being supportive and the other pressuring the individual to face realities.

Yablonsky described a project sponsored by the Nevada State Prison in which drug addicts, members of Synanon, were brought into the prison

as therapists. The problems encountered with staff members, inmates, and professionals are analyzed, and the implications of the program for professional therapists are discussed.

"The Tunnel Back" provides us with an excellent account of the Synanon program as seen by a highly qualified participant observer. He found that a large number of former criminals are not committing crimes and that a large number of former addicts are not using drugs. He considers this a success and attributes the behavior changes to the Synanon program. The book provides interesting reading. The discussion of "synanon" as a form of group therapy reveals the possibility of its application to non-addicts as well as addicts, non-criminals as well as criminals. It may also be applied to other therapeutic problems and this possibility makes the book *must* reading for practitioners in the field of psychotherapy.

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ANNOUNCEMENTS

Italian Publication: Scuola e Citta

The abovenamed monthly review in the field of education, directed by Ernesto Codignola and published by La Nuova Italia, Firenze, has just released an issue, dated November 1964, entitled: INTRODUZIONE A MORENO. The table of contents lists the following contributions: Jacob L. Moreno—Psicodramma e creativita nei bambini e negli adolescenti; Antonio Santo Rugiu—Lo psicodramma nel campo educativo; Benedetto Bartoleschi —Lo psicodramma nel quadro delle psicoterapie di gruppo; Jacob L. Moreno —Dialogo del "portatore di verita'; Luisa Mele—Valore educativo e terapeutico del gioco drammatico; Maria Corda Costa—La sociometria nella psicologia sociale contemporanea; Lydia Tornatore—Techniche sociometriche e educazione alla spontaneita; Leonardo Trisciuzzi—Elementi di sociometria; Notizie su Jacob L. Moreno e orientamenti bibliografici; Leonardo Trisciuzzi —Ricerca sulla dinamica dei rapporti interindividuali mediante il test sociometrico.

IInd International Congress of Psychodrama

This will take place in Barcelona, Spain, August 29–September 3, 1966. Honorary President: J. L. Moreno, M. D.; President: Ramon Sarro, M. D.; General Manager: Juan Obiols, M. D.; Assistant Manager: Zerka T. Moreno.

Registration Fee: U.S. and Canada, before September 30, 1965–$50.00; After September 30, 1965–$60.00; all other countries, before September 30, 1965–$35.00; after September 30, 1965–$40.00.

Registration and program information may be obtained from the Second International Congress of Psychodrama, P.O. Box 311, Beacon, N.Y. 12508

Anonymous Donation to the Moreno Academy, World Center of Psychodrama, Sociometry and Group Psychotherapy

An anonymous donation of ten thousand dollars has been made to the Moreno Academy. The members of the Committee of the Moreno Academy herewith express their profound thanks for the generous contribution made by this anonymous person, and even more for the highly original and ethical form of anonymity in which it has been made.

The benefit of this gift has already enabled the Academy to sponsor the Second International Congress of Psychodrama to take place in Barcelona in August, 1966, by a contribution of $1,000 to the Congress budget, and by extending a number of scholarships to students of the Academy.

French Psychodrama Film

A gift copy of an extraordinary motion picture made during the First International Congress of Psychodrama in Paris in August, 1964, under the sponsorship of the Services de la Recherche et de la Formation Professionelle, of the Office de Radiodiffusion-Television Francaise, and produced by Jean-Luc Leridon, has been received by the Moreno Academy. The film shows a psychodrama session directed by J. L. Moreno and presents two themes; Psychodrama of a Marriage, and Psychodrama of a Dream. The film runs two hours and is a 16 mm black and white sound motion picture. It is planned to show the film to students of the Moreno Academy.