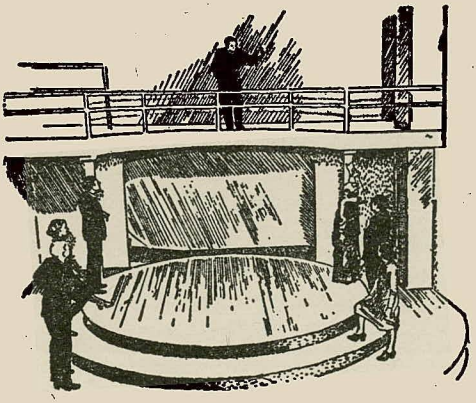
# GROUP PSYCHOTHERAPY

*A Quarterly*



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# GROUP PSYCHOTHERAPY

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## CONTENTS



FOUNDED BY J. L. MORENO, 1947

# INTRODUCTORY PAPERS

## PREFACE

It is immaterial to the group and action (psychodrama) theorists which method of interpretation one prefers, the psychoanalytic, the behavioristic or any other school. The point is that at the moment the individuals enter the group and action parameters, they are on a *new* plane and a different set of phenomena begins to emerge from their interactions. There should then be no quarrel in the study of group structure between the adherents of the different individual psychological schools. Rather, they can share in the development of new instruments and in the methods of analyzing the findings.

*—Moreno*

Once a year the society holds this educational Annual Conference to present current skills and techniques and conceptual framework to groups of professionals and laymen, in order to develop teaching and communicative skills as well as present new ideas. The members of the Society not only attempt to maintain mastery in their own profession, but also to acquire knowledge concerning other professions.

We invite your interest in these papers and we hope you will be stimulated by them. In presenting selected papers, digests and reports of the meetings and workshops of the 26th Annual Conference of the ASGPP, we are endeavoring to communicate to our readers the current state of the psychodrama and group psychotherapy movement and some of the issues which face us.

The ASGPP has been founded by Moreno in 1942. It has been developed and directed by professional men and women of energy, wisdom and vision. We have grown from a small few and have become a complex worldwide network.

In this field we are constantly reminded of the fact that the services of the psychodramatist and group therapist, along with other mental health workers, are in great demand, not only in the case of the ill, but increasingly in the case of the healthy, in schools, courts, community and industry, prisons, hospitals and day treatment centers.

Our membership continues to expand to include professional workers in the areas of education, the mass media, nursing, sociology, anthropology, music and dance, as well as medicine, social work and psychiatry. Our base is broad enough to include *all* aspects of daily living.

The demonstration programs of the meetings pointed out the innovations in religion, industry, training and therapy.

The research and preventive programs point out the continued challenge to our skills and applications.

The workshops enlightened and instructed on an individual and group level.

Invited addresses awakened our interest in dedication to the ideals of our whole society.

The Society was founded on the belief that individuals with deep convictions could, with professional collaboration, develop and sanction community action and provide essential leadership and impetus. Our membership is open to all those who work with groups and who have an interest in creating a better world, and on a local and national level to all professionals in the fields of human behavior, education and government who are interested in developing human potential and personal growth. It is not limited to the fields of psychology, psychiatry and social work but seeks to include all individuals working with and influencing groups geared to persuasion. It is an exchange bureau for community and professional responsibility.

J. L. MORENO, *editor-in-chief*
HANNAH B. WEINER, *associate editor of this issue*

# PRESIDENTIAL ADDRESS
# THE PROBLEM OF RE-ENTRY

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Change itself has always been difficult. To change, one must abandon some of the things upon which our identity is based. We must leave the familiar and the comfortable and step out into the world, new and inexperienced. For at least a short time we must suffer the trials of ambivalence and anomie. Our present world is in a ferment of political, moral, sociological, religious, philosophical and scientific change. Perhaps because of this, the characteristics of our world seem to be alienation and search for meaning—the identity crisis. We have changed, and we are changing, which is to our credit, but thus far we have not been overly successful in integrating the changes into our life patterns. It is the process of re-integration following change that I term re-entry.

I was first struck by the idea that change and re-entry are separate problems in 1954 when clinical trials with Thorazine were being run on 3000 patients in St. Elizabeths Hospital in Washington, D.C. Some of the results were spectacular. Patients who had been sick for years rapidly lost their symptoms. And yet some of the patients who had benefited most from the drug were unhappy and frightened when they lost their hallucinations. The voices might have been unpleasent, calling them vile names, accusing them of crimes, or threatening them. But they had lived with their voices and, while they may have complained about them, at least the voices were familiar. Without their voices, the world became strange. Eventually the patients got used to their world without voices and were content to have it that way. However, difficult as the change was to accept, the change itself was not enough. Some of them were lost. There was nowhere for them to go. Even though they were no longer psychotic, they could not re-enter the normal world and they had to be content living in the protected environment of the hospital. A more recent example are a portion of the Peace Corps workers who return to the United States with their value system modified by their experience and who flounder as they attempt to adjust themselves again in our society.

Accelerated attempts to find meaning are taking on the appearance of a national problem. With the use of marijuana, amphetamines, LSD and like

substances, too many people are catching glimpses of creativity, beauty, love and truth in themselves during their trips (when the trip goes well, of course) but are not managing re-entry. A few unfortunates stay in psychotic orbit. Many others come back with yearnings for the things they found in themselves in the drugged state but without the ability to take their change and to make it real in their lives. Some return again and again to the drug state and waste its potential by preferring to exist there. Even after an apparrently successful therapeutically oriented LSD session, sometimes the change that the individual has experienced is left behind after a short honeymoon. There is much work to be done after an individual has experienced a change if the change is to be useful and enduring. Re-entry requires learning a new way of life.

As I indicated earlier, this is especially true for those who recover from a mental illness. It seems somewhat fashionable these days to talk of mental illness as a way of life, or to say that mental illness is a myth. One even hears that the schizophrenic chooses to have his symptoms and that, when he decides to give up his symptoms, he will. He can decide to give up the game of being crazy at any time, and then he will be essentially normal. I think that this is a very cruel judgement placed upon the 2,000,000 schizophrenics in the United States and Canada and on the millions of schizophrenics in other parts of the world who have a recognizable illness no matter how different one culture is from the other. Schizophrenia is a disease or a closely allied group of diseases with definite signs and symptoms just as tuberculosis, diabetes and syphilis are diseases. These latter three illnesses also were called ways of life at one time before their causes were established. They too used to bring up the idea that the patient chose to have symptoms or that he had a weak character or a lack of moral fiber. Where records have been kept, the incidence of schizophrenia has been about the same over the past 100 years. It effects 1% of the population.

For anyone who looks at the accumulated evidence, there is little doubt that schizophrenia is a biochemical disorder. Utilization of the biochemical approach in addition to the usual psychotherapy, tranquilizers, shock treatments etc., has produced extremely encouraging results. Dr. Abram Hoffer studied two comparable groups of schizophrenics each of which received the usual treatment and one of which received benefit of the biochemical approach in addition. At the end of 10 years, 75% of the biochemically treated group had not been re-admitted to the hospital whereas only 35% of the control group had avoided rehospitalization. These long term results are significantly better than the expected recovery rates for schizophrenia ie.: ⅓rd spon-

taneous remission, ⅓rd relapsing course and ⅓rd permanently ill. The biochemical approach to the illness is evolving. Undoubtedly it will become much more efficient as new discoveries are made and new techniques developed. Hopefully we can look forward to successful treatment of many schizophrenics.

However, the recovered schizophrenic's problem with re-entry is severe. Often he becomes ill in the latter part of adolescence and is unable to negotiate the difficult shift from adolescence to adulthood because of his illness. When he becomes well he finds that he has lost years of development and has much to learn. Intellectual insight does not help much. He needs skills that he doesn't have. And he needs experience by which to validate his newly learned skills. Conventional analytically oriented psychotherapy has little to offer to him, as it has little to offer to the culturally deprived individual, to the adolescent, to the delinquent or, for that matter, to almost anyone else who is struggling with re-entry. However, group approaches, psychodrama, and other action methods firmly based on the importance of learning and experiencing how to live now are effective and fortunately are being utilized by a steadily growing number of workers in various fields. Many who use these methods do not realize that J. L. Moreno is the prime source of the ideas that they are enthusiastically putting into practice.

Dr. Moreno gave a prophetic title to his book—"Who Shall Survive" long before we had readily available tools and techniques to destroy ourselves. The basic ideas are there in the book as well as the basic techniques for survival, for change and re-entry. Moreno's system of thought is not dogma. There is no set collection of rules and presuppositions to be applied to every case. The method rests instead on the insistance that man can change and that man's spontaneity can be freed enough so that he can grow in his own unique way. As we become increasingly skilled in producing changes in our worlds, the problem of re-entry will become more acute and techniques for aiding re-entry will become even more vital.

# THE IDENTITY OF THE PSYCHODRAMATIST AND THE UNDERGROUND OF PSYCHODRAMA

HANNAH B. WEINER, M.A.

*Moreno Institute, New York City*

I am aware that the task I have set myself in trying to identify the psychodramatist as a professional person makes excessive demands upon me. It may be impossible to portray in words the functioning of such a person in terms of education, training and experience, since at this stage of the movement, every individual is related to each other and has a causal influence.

Specifically, the certified psychodramatist is identified by his function as a psychodramatist, sociometrist and group psychotherapist. He is a specially trained person who utilizes specific techniques and methods in the education and treatment of people with emotional problems; people who are training for overseas work; community people; and individuals in intergroup relations. He is far more than an exhibitionistic, theater-interested or skilled technician. His interest and work with the relationship and interaction of human suffering, human progress and social justice of mankind brings him into contact with psychiatry, sociology, medicine, biology, anthropology, education, public relations and with the study and development of family, institutions, society and group process. He has a very special role in relation to the changing and expanding field of community mental health and has the unique responsibility of establishing a method that synthesizes previous means of persuasion in that the psychodrama method can explore and treat immediate behavior in all of its dimensions.

The certified psychodramatist has received his psychodrama training at the Moreno Institute, (1940-1967) an accredited school approved by the State University of New York, Department of Education, New York City; the Moreno Academy, World Center of Psychodrama, Sociometry, and Group Psychotherapy, Beacon, New York.

Other places have been added in the course of years: St. Elizabeths Hospital, Washington, D.C. and St. Louis State Hospital, St. Louis Missouri.

There were three Institutes designed to teach psychodrama from 1958 to 1960: Detroit Michigan—Robert S. Drews, M.D.; California—Eya Fechin Branham; New York City—Hannah B. Weiner and in the current year the following activities were sponsored by the Moreno Institute

February, 1967—St. Mary's University, San Antonio, Texas and at Corpus Christi, Texas. Lecture-demonstrations.—J. L. Moreno and Zerka T.

Moreno with the assistance of Neville Murray, M.D.

March, 1967—Beverly Hills, California. Two day training institute, J. L. Moreno, M.D., Zerka T. Moreno and Lewis Yablonsky, Ph.D.

Long Beach and Berkeley, California. Lecture demonstrations. Martin Haskell, Ph.D. and Richard Korn, Ph.D.

April, 1967—Harlingen, Texas. Three-day training institute, J. L. Moreno, M.D. and Zerka T. Moreno.

The psychodramatist needs training and experience that he can bank on. They must be prepared with the expected and the unexpected to meet the challenges that they must face.

### Career Opportunities

Psychodrama specialists are working on the University level teaching psychodrama, role playing and sociometry in addition to other classes in either sociology or psychology; are consultants to community groups, police academies, industry, and public agencies; are physicians and therapists in private practice or in mental hospitals, day treatment centers, rehabilitation centers and residences. There are staff psychodramatists positions at St. Elizabeths Hospital established at GS 9 and above. Psychodrama trainers have been invited to teach the method overseas as well as prepare trainees for overseas work in the peace corps and missionary work.

### The Underground in Psychodrama

Our modern society is already at a point of development where one-to-one relationships between the individual and his environment is no longer adequate. The environment changes so quickly and is so unpredictable that previous methods of judgment are either too slow or cannot keep up. The techniques of the psychodrama lend themselves to expanding one's mind and experiences to the point where vicarious living adjustments are acquired. There is hardly a foundation that does not include among its workshops some form of the psychodrama. The Castalia Foundation, the League of Spiritual Discovery, the Psychedelic Theater, the Aureon Institute, the Esalen Institute —all use psychodrama to explore meaning for individuals in the range of their physical body, their mind expansiveness and their non-verbal behavior. The Theater of the Mind, the Atelier East as well as various others offer philosophical discussions followed by or incorporating psychodrama—as one illustration the "Chakras and Serpent Fire." The range of fees for these non-professional sessions is $1 to $150.

In comparing psychedelic psychodrama to actual psychodrama one theme is consistent—the psychedelic psychodramas are "canned," they are presented viewpoints of inescapable experiences of daily living. They explode the mind by bombarding it with every mechanical, audia and visual technique available. Perception is forced and not natural. Even in the presentation of the Magic Theater, human association is irreverent and obsolete. Feelings are *imposed* and re-created. In psychodramatic and sociodramatic productions, people feel the drama of life and social justice through empathetic identification and in a true creative and spontaneous encounter. Being "turned on" is not confined to the reality of illusion, but to the reality of the moment. Even when music is added in a psychedelic experience, the viewer feels engulfed by "rehearsed" improvisations. Again, in natural psychodrama the creative moment and the human feeling is real. In the natural psychodrama, creative thinking is revitalized because people interact with each other and are guided into presenting life experiences with each other. The ability of a Director to keep things happening goes beyond the fringes of perception to the embracing of human experience. None of these psychodramas are run by trained persons. The Annual Summer Laboratories in human relationships, presented by the National Training Laboratory and Cornell University, State School of Industrial and Labor Relations, also hold workshops in psychodrama and role playing for industrial educational, community and mental health workers. Some of these workshops are run by invited trained psychodrama directors—others are not.

There is the Creative Arts Development—a new approach to stimulating and showcasing production in the arts; AFTLI (Association for Feeling Truth and Living It)—a self help group; as well as several "interest groups" who use psychodrama as a means of stirring up emotional and individual involvement. There is also a very interesting concept of psychodrama—called "My Drama"—wherein the Director uses the psychodrama method but does not call it such in order to stay away from the tensions and fears of the psyche of the psychological. In essence, these productions can be dangerous in that merely the techniques are used and not the method or trained directors.

The Congress of Racial Equality (CORE), Leroi Jones and the Black Muslims, have used role playing as a teaching device and as a selection device. There is the Denes School of Psychodrama—another imitation of professional techniques.

The danger of these variations of psychodrama is that they can go out of hand and the field of psychodrama can be threatened before it advances as it should. The whole field of psychodrama and group psychotherapy is under-

going a rapid change—an indication of progress. But, during this time we must be adamant in articulating our roles and carefully delineating our position. We must take care that we do not make ourselves impotent by doing so much in this pioneering field that we do not do what we should do. It is interesting to note that after this Annual Conference Dr. John Mann and Dr. Lewis Yablonsky returned after an absence of almost a decade. In being reunited with them, I felt an even stronger grasp of, and loyalty to, the reality of improving our professional relationships. Their return indicated a re-organization in this movement which is easier to describe as progress.

We have a powerful method developed by a really humble man, which may not be evident to many at first glance, who discovered ways in which groups of people can be helped to produce enlightenment and changes not only in themselves, but, in their environment. The "tele" factor of interpersonal relations is everpresent in those of us who have become psychodramatists. But we must be careful not to become prematurely obsolete, for no one can become a psychodramatist in a vacuum. There are times when our relations to new therapeutic methods becomes almost irretrievably lost in the morass of dissention, discussion and counter-discussion surrounding the use of such a method, much like transference and counter-transference. Some earthbound scholarly mind must develop means of measuring the effectiveness of this very human art and science of treatment. We must be able to present the psychodramatist as a qualified and skilled professional. In order to do this we must not let the professional happenings which pose as psychodrama become the essence of psychodrama. These professional happenings lack the spontaneity, sincerity and originality of shared interactions. They merely break the games of life by providing another game of high speed action.

# PSYCHODRAMA, THE WARM-UP

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## REPORT

The purpose of the session was to help psychodramatists communicate with each other regarding ways and means of solving the "difficult" early phase of sessions and in establishing the proper emotional atmosphere favoring psychodramatic expression.

The following techniques were demonstrated by Dr. Sacks and other directors who were members of the learning group.

I. The Personal Warm-Up. This method, frequently used in practice by J. L. Moreno, depends on the available warmth of the director himself. By his outgoing personality and ready warmth the director implies, "See how freely I can express myself without fear. By example, this is the tone of the relationship I expect to establish within the group. Since I, the director, am open and honest, openness and honesty are officially approved qualities in this context rather than something to be ridiculed as in other social settings."

At the same time the director must also imply, "While I am free to express myself, I am not essentially self-concerned but invite you to come and join me, whereupon you will have all my attention."

This latter caveat is important since, if the audience senses that the director is expressing himself for narcissistic gratification, they will feel his lack of capacity to receive from them; they will resent it and they will become more inhibited and try to get the director to do everything.

Another point mentioned in the use of this method was the caution against copying the style of other psychodramatists. The personality expressed must be the authentic personality of the director himself rather than that of his mentor or teacher. This style is often used by Yablonsky and Weiner.

II. Another method described was the "cluster warm-up" in which the psychodramatist remains passive for some period before the initiation of the session observing the spontaneous behavior of the group. The director then picks up this fragmentary material and bases the warm-up on it. The method was demonstrated, using members of the meeting present to take the role of schizophrenic patients wandering aimlessly around the

room. The psychodramatist then suggested that they were all wandering through the park. One of the patients made a passing remark about being cold whereupon the psychodramatist immediately suggested that they huddle together for warmth. Since this suggestion was still on the non-verbal level, it was acceptable to the "patients" and brought the participants into relationship with each other. This style is often used by Enneis.

III. Another suggested warm-up technique was the use of a prepared scenario in which a farmer and his son try to convince a second farmer to permit them to release their pet canary from his newly tarred roof. The situation having conflict built into it tended to warm up the participants within the confines of the dramatic conserve presented.

IV. The empty-chair techniques was described in which the group is asked to imagine someone sitting in a chair placed on the stage. The point was made that the director must set the tone to favor creative productivity. For example, he might say . . . "I will now give you a few moments to try to imagine someone sitting in the chair. Try to picture the person's position, expression, clothes, etc." Then, after a pause, "Some people have difficulty in exercising their imagination in this way. Was there anyone who found themselves unable to do this?" Usually, after such an introduction there are few hands raised. Then, the other people find themselves willing to describe who they saw in the chair, to sit in the chair and to take the person's role. If, on the other hand, the director asks, "Is there anyone who can imagine someone sitting in the chair?" There are usually very few volunteers. If someone does speak up freely, he is often laughed at or considered too forward. This style is often used by Zerka Moreno and Sacks.

V. Still another warm-up technique suggested was a type of regulated conversation. In this technique two people are placed on the stage and asked to converse with each other . . . subject to three rules:

(1) No person can speak continuously while the other listens—each person must speak one sentence.

(2) Neither person must fall into a questioning mode but both persons must speak in declarative sentences.

(3) No person may change the subject but all of the sentences must be about only one of the two people on the stage. After a lapse of half the time devoted to this experiment the participants change the object of their conversation to the second person of the pair.

When this experiment was demonstrated, the participants discovered that much of their expression was of a hostile nature, probably projected onto the other person, having been generated by the strict regulation of the rules of the conversation and the blocking of their defenses. This style is often used by Sacks.

# PSYCHODRAMA IN THE PUERTO RICAN SETTING

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Limited experience in Puerto Rico[1] suggests that psychodrama is uniquely suited to the Spanish setting. Successful application of this approach is enhanced by the spontaneous style of living of the people as well as their keen awareness of and sensitivity to indicators of social setting and role.

The Puerto Rican is greatly influenced by his perception of his social setting. He tends to see the social environment in which he exists as having one of two bi-polar characteristics: either it is "safe" or "threatening." When his definition of his setting is one of safety, he is free and spontaneous in his talk and action and is generally exuberant in manner. He expresses emotion easily and is free to share the more intimate details of his life while feeling a deep concern for the feelings of others. Such a reaction is characteristic of informal settings like the home and gatherings of friends, neighbors and countrymen who can be thought of as peers because they share his position in life. When he finds himself in a situation which he defines as "hostile" (which is generally the case in formal situations or settings in which the people present are strangers or persons of different status) his manner is remarkably different. Instead of spontaneous exuberance, one observes inhibited awkwardness. The individual is quiet, repressed, fearful, insecure and apparently unable to respond.

The challenge to the psychodramatist in the Spanish setting is clear: he must either create for his protagonist a "safe" psychological frame of reference or he must work *in situ* where the protagonist feels safe. If he can do this, he can be assured of a performance of remarkable quality. When functioning in a setting which is generally defined as "formal" and "hostile," it is necessary to establish via psychodramatic "setting of the scene" an informal, "safe" environment. When this was accomplished, formally inhibited individuals became spontaneous and alert. Talk and action took on a quality of animation, the speech shifted from English to Spanish and the drama took on a life of its own. Indeed, it was frequent that the drama moved ahead so rapidly that it threatened to leave the director behind. However, whenever a scene was cut, the spell was broken and an awareness of a hostile environ-

[1] This paper is based on the author's experience while in residence as Visiting Professor in the Department of Psychology, College of Social Sciences, University of Puerto Rico, Rio Piedras, Puerto Rico, 1964-1965.

ment returned instantaneously. It was only after many weeks in which a "long-term warm-up"[2] emerged, that the discussions following the action achieved anything of the dynamic quality of the dramas themselves. And even then, it was the students who had had experience in the continental setting who were the most active participants.[3]

The problem of producing action in a "hostile" environment could be reduced by moving the drama into a "safe," informal setting. Howard Stanton and his co-workers have reported resounding success in survey research employing role playing *in situ,* that is, going into people's homes and interviewing them "on location."[4] These researchers found that the response to the challenge to assume roles was immediate and report that in one study "with residents of slums and housing projects in Puerto Rico" of some 412 interviews consisting of 2,939 role played scenes, "only 12 were not carried out. In each case, refusal appeared caused by the content of the scene rather than by the idea of role-playing itself; in most cases it meant 'I don't know what to do' more than I won't do it.' " (Stanton *et al.* p. 173)

Because of the ease with which the Puerto Rican generally moved into psychodramatic action this medium was found to provide a rich yield of insights into the Puerto Rican milieu. Success was achieved in employing such devices as the group dream, the magic shop technique and in enacting various facets of cultural conflict. A most interesting finding related to the dilemma of cross-sex role reversal. Women were able to assume male roles with ease, whereas men were inhibited and generally refused to play female roles. It may be true as Moreno has recently suggested[5] that there is no sex in the psychodrama of the cosmos, but at least in this setting, the threat to *machismo* which cross-sex role reversal meant to male students prevented them from pursuing the drama.

Such observations as these tend to suggest that the Latin lands provide a promising setting for further psychodramatic efforts.

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[2] See, Fink, Abel K., "Some Implications of Moreno's Concept of Warm-Up For Education," *Group Psychotherapy,* 15: 69-73, 1962.

[3] See, Fink, Abel K., "Group Dynamics at the University of Puerto Rico: A Study of Student Reactions to Classroom Group Experiences," Rio Piedras, P.R., 1965.

[4] Stanton, Howard, Kurt W. Back and Eugene Litwak, "Role-Playing in Survey Research," *The American Journal of Sociology,* 62:172-176, 1956.

[5] Moreno, J. L. "Psychiatry of the Twentieth Century: Function of the Universalia: Time, Space, Reality, and Cosmos," *Group Psychotherapy,* 19: 146-158, 1966.

# PSYCHODRAMA IN A THERAPEUTIC COMMUNITY

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The essence of any psychodrama is spontaneity. For this spontaneity to emerge freely, an atmosphere of warmth and security must be created. The psychodramatic warm up is designed for this purpose. In a milieu such as the List Therapeutic Community[1] this atmosphere is created by the day to day interaction of its members. The development of these inter-relationships constitutes a continuous "warming up" which makes possible a more spontaneous use of psychodrama.

The people who make up this non-residential community live in the large metropolitan area surrounding New York City, and come from all walks of life. They might be a client's next door neighbor, friend, or someone in his family—any individual who is already able to function in society. However, these individuals usually feel that they are not realizing their potential and they have, to greater or lesser degrees, generalized feelings of insecurity, of anxiety, of a lack of fulfillment. While some clients within the community are undoubtedly neurotic, (perhaps Moreno's term "normotic" is more accurate) and some are frequently unemployed, the bulk of the population are normal people with normal problems. Furthermore, these individuals do not perceive themselves to be in a clinical setting, but rather in an ultra progressive school for their emotional, vocational and spiritual development. The accent on a group life and a family-like setting as a context for socialization is an integral component of the community Philosophy. The setting for this community is a suite of offices in mid-town New York. The therapists' offices enter into a common waiting room which serves as a meeting place for the entire community.

In the List Community, psychodrama is used both in private sessions and in group psychotherapy. The setting for the private session is the therapist's office, which generally contains a desk, and several comfortable chairs. The only special equipment is a small set of theatrical lights controlled by the therapist at his desk. The lights are designed to provide different color tones for the entire room rather than for lighting specific areas of the office.

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[1] List, Jacob S. Education For Living, Institute of Applied Psychology Publishing; 1959.

## A Deux

Many times, during a "first session," the therapist will use the empty chair technique to discover how the client relates to the significant people in his life. (Parents, siblings, etc.) Any one of these people might be placed in the empty chair and the client is asked to talk to him. The therapist may double for the client, or act as an auxiliary ego (speak for the person in the chair). If the client finds it difficult to relate to the empty chair, the therapist may sit in the chair himself or ask someone in the waiting room to come in and act as an auxiliary ego. This is the client's introduction to psychodrama. In subsequent sessions, psychodrama may be requested by the therapist and/or the client or may arise spontaneously. The surplus reality available on the psychodramatic stage is augmented in the private session. Here, the therapist's knowledge of the client enables him to more accurately portray the client's inner world psychodramatically. In the middle of a conversation between therapist and client, the therapist will suddenly begin to double for the client. This spontaneous doubling may only consist of one sentence after which he will return to his role in the conversation. Throughout the session the therapist will spontaneously double, act as an auxiliary ego, and make use of anything and everything that occurs in the session, including telephone calls and knocks at the door, to enhance the psychodramatic to reality.

Also within the private session, many standard psychodramatic techniques are employed, but without the formal structure of a complete psychodrama. For example, the use of the soliloquy. The client is talking about an incident from his past. Suddenly the therapist directs him to become the age at which the incident occurred; to talk as if it had just happened. As the client talks, he relives his feelings psychodramatically, perhaps with the help of the therapist acting as an auxiliary ego or double.

Role reversal may be used to show the client how he is relating to the therapist. If a therapist points out to a client that he is hostile, the client may or may not see this. But when he reverses roles with the therapist, sits in the therapist's chair and hears his own words repeated back to him he can feel his own hostility. The therapist also uses role reversal to see how the client perceives other people in his life, including the therapist. The client sits in the "empty chair" playing his father or mother and has a conversation with himself. "Himself" may be the therapist or the empty chair. Obviously other techniques such as standing on a chair, future projection and magic shop can also be used in the individual session.

### Pair Therapy

With the addition of a second therapist in the private session, the entire range of psychodramatic techniques is possible. However, pair therapy lends itself to certain psychodramatic situations more than others especially when the therapists are of opposite sexes. For example, if the client has established a relationship with one therapist, when the second therapist is introduced, the client may react as the child with both his parents. When this happens, psychodrama has begun spontaneously. The therapists will become the parents, or the parent and sibling acting as they know these people would act. They may deliberately ignore the child, talk about the child or follow the client's lead. With the presence of male and female therapist, the psychodramatic family situation can arise at any time.

Another psychodramatic technique that can be utilized effectively in pair therapy is the use of two doubles for one protagonist. One double takes the super-ego or restraining role, and the other takes the id or impulsive role. This is especially useful when an attempt is being made to show a client the ambivalence of his feelings as in an approach-avoidance situation.

### Group Therapy

In the List Therapeutic Community, Group Therapy is used extensively. As he develops a rapport with the client the therapist introduces him to the experience of group therapy. The therapist is usually the group leader, and the group members are usually his clients. There is a group meeting room equipped with a full set of lights and a portable multi-level stage. This room, however, may or may not be available and psychodrama may take place in the middle of a circle of chairs in the therapist's office. If no theatrical lights are available, room lighting is adjusted to fit the scene. The group is composed of from 7 to 20 people. The session starts with general announcements, informing different group members of anything from a personal growth or achievement to a party. There is no formal warm-up. The exchange of announcements is followed immediately by the statement—okay, let's go to work. The clients are ready to work. They have met each other outside in the waiting room for the second or third time that day. Several of them have probably had dinner together, others may work at the same job or attend the same school.

One member in the group brings up a problem, and the other members in the group attempt to help the person solve the problem working on the basis that each person is an intelligent human being. The problem itself often

has a relatively simple answer. However, the individual who has brought up the problem might not see the answer because various emotions are in the way. Therefore, the group itself tries to break down, highlight and examine the feelings of the person involved. The technique often used in this process is psychodrama. The psychodrama can be initiated by the client, by one of the group members spontaneously doubling or acting as an auxiliary ego. As a part of the group process the group members are trained in the techniques of psychodrama. This training is informal—if there is any explanation of the techniques used, it is after the group in an informal discussion. Except for these occasional explanations, the training is integrated with the individual's personal therapy. The group leader chooses auxiliary egos more often than does the protagonist. His choice is specific: based on his knowledge of the group members and of the role to be played. He selects an individual who can play the role effectively, (and thus help the protagonist) and learn something about his own behavior patterns at the same time. The leader may choose as a double a group member who is living through the same feelings as the protagonist. This person may be able to express feelings as a double or auxiliary which he could not express if he were the protagonist. In these situations we often ask the question—Who is the protagonist?

Many of the standard psychodramatic techniques are used in the group session, but rarely are scenes formally structured. There is no room description, or background information given, the characters involved just begin talking. It is possible to get into a depth psychodrama without the usual preliminaries because of the knowledge the leader has of the group, the knowledge the group has of the protagonist, and the trust the protagonist and group have in the leader. At many and various points in the psychodrama the leader will stop and ask for feedback from the individual group members. Often this will lead right into a continuation of the psychodrama or may lead into a second protagonist. Seldom in the group does the leader involve himself as an auxiliary and ego, but frequently he will double spontaneously from his chair for anyone, protagonist, auxiliary ego, or a commenting group member. This is representative of the sense of freedom which is present in the group. Any member can and does double spontaneously from his seat or from the stage and may enter the psychodrama as an auxiliary ego in the same way.

From this brief exploration, one can see the many possibilities for the use of psychodramatic techniques in private practice. It is the author's hope that others will share their experiences with psychodrama in private therapeutic practice, to expose, improve, and expand the use of these techniques.

# EXCERPTS FROM LUNCHEON ADDRESS

MERRIMAN SMITH

*White House reporter for United Press International, Washington, D.C.*

When first invited to speak to your society, after some self-examination, I *did* feel a certain qualification to speak here today. I was referring to my own life, my own way of making a living. My world—professional and personal, too—is a world of pressure and tension. As a reporter for United Press International assigned to the White House for more than 25 years, and along with the men and women similarly assigned—we lead lives that would be contra-indicated by almost any standard of mental and physical health. Work days that vary from seven or eight hours to 15 to 20 hours; work weeks that sometimes disappear into months without a day off; long road trips and always conscious of the fact that the next story you handle may involve anything from war to assassination.

There are at times, the doldrums in which one may take a couple of hours for lunch with no worries; when one may get home for dinner before eight or nine o'clock. But the situation is such that we begin to worry if these placid periods last too long—a feeling of guilt and apprehension creeps in—and you begin to wonder whether something big is being hidden. Almost never do you think positively in such a period and say to yourself, Isn't it wonderful—things must be going along awfully well for it to be this quiet.

Covering the White House as a regular assignment for something like 6,000 newspapers and broadcasting stations in this country and around the world, I must be constantly aware of incoming news, as well as what we originate at 1600 Pennsylvania Avenue or the L.B.J. ranch in Texas. More and more, the White House has become just about the most important source of news in the world—a development in a country 10,000 miles away calls for instant White House public reaction.

Despite the trouble spots at home and abroad, each year we *do* seem to be living more intelligently and more fruitfully in a number of ways. Our children certainly are healthier than they were several decades ago—and although we are in a continuing period of inflation, more Americans have more available cash today than they did ten or twenty years ago.

The problem is how to continue our rate of growth—how to keep on improving year after year? A great deal of credit must go to the people and professions represented in this audience as we search for new answers, new solutions.

A therapist speaks of a patient's inability to face or cope with reality. Another way of saying this is learning to live with crisis, for as the 20th Century approaches the 21st, our lives will not become less complex. A hundred or two hundred years from now, happiness, contentment and security will be—as they are today—entirely relative terms, all matters of degree.

You, the skilled and trained of an important part of our socio-medical framework, have ahead of you unlimited opportunities and unending challenge. I wish you well.

# SHORT PAPERS

## PSYCHODRAMATIC AND ACTION LEVEL TREATMENT WITH THE BRAIN DAMAGED—INTRODUCTION

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The following series of papers deals with some exciting applications of psychodramatic and other types of action level treatment for those afflicted with intracranial organicity. In order to contribute to your enjoyment of the many original and creative contributions that follow, I would like to make some general observations.

The diagnosis "brain damage" may conceal more than it reveals. Due to the non-protective environment we share, everybody has some degree of brain damage due to carbon monoxide poisoning, blows, falls, umbilical strangulation, high fevers allowed to rage unchecked, or strokes. At a clinical level patients may appear mentally retarded, schizophrenic, aphasic, or even normal. In the latter instance, close observation will probably reveal lacunae in judgement, perceptual ability, empathy, emotional response, planning ability, memory, or organizational ability. In sum, a diagnostic entity presupposes the existence of a clinical entity with specific predetermined demonstrable features arising from an etiology developing along a prescribed course. Nothing is further from the truth for those with damaged brains. In terms of etiology it is unimportant how they came by it. The sole criterion is that some area of their brain be damaged. Furthermore, the symptomatology is predicated upon the area and extent of neural tissue destroyed.

The absence of interstitial cells in the brain rule out the possibility of regenerating the dead or non-developed tissue. The focus of successful treatment then lies in helping the brain damaged person effiectively use what is left to him.

In practice, treatment should start with a careful stock taking of available inventory. If there is yet some function remaining in damaged areas, then, in a manner not unlike the physical therapy for a polio victim, careful development might serve to strengthen the sub-minimally functioning area to the point of helping it become operational.

Failing in this, or if the area has been completely devastated, the objective becomes one in which surrounding, or collateral areas can be trained to assume the function of the non-operational areas.

In practice this is very rarely the case with brain damage. Evaluative techniques are seldom that precise. Furthermore, the increasingly large identifiable brain damaged population coupled to the intensive individualized measures requisite precludes application of textbook treatments.

If the problem is organizational, a lucky strike can sometimes do the job. An example of each will serve to illustrate:

(1) In going to his assigned place in the workshop, Harry was unable to get to his table. Visual cues did not suffice. His conception of spatial relationships was confusing and inappropriate. Many times he would have a 'catastrophic reaction' when this resulted in a complete disorientation. Finally he learned to rely on kinesthesis and not on vision in order to find his way to his table in the workshop. When he experienced the varying pressure on his extended hand from passing three rows of tables, he knew it was time to turn and then after passing two tables, he had arrived at his right place. Once at work, ways had to be contrived to help him use intact abilities in the place of the unreliable visual cue particularly where spatial relationships were involved.

One of the important teachers of the brain damaged with visual organizational distrubance once told me of her own difficulties in that area. Due to her own inability to focus her attention on one subject at one time resulting in wildly randomized behavior, she was adjudged 'non-trainable' by several agencies around town. One day while being fitted for glasses, her optician had placed opaque lenses on her with a minute hole in the centers. Immediately her field of vision was restricted for her and her conduct became more precise. It became possible for her to develop her own qualities and eventually led to her helping scores of others.

The following papers are concerned with group techniques and programming for those with damaged brains. By using action level methods the range of communication and operation is tremendously enlarged over the classically narrowed ambit of many of the older methods. As many of the behavioral anomalies become obvious within a social context, it appears paradoxical to attempt their treatment in isolation. For these reasons, as well as the relative facility with which professional personnel can be trained, action level methods appear entirely appropriate for the treatment of many people who have experienced damage to their brains.

# AFFECTING RESPONSE AND WARMTH IN THE SEVERELY BRAIN-DAMAGED CHILD

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The retarded child is able to distinguish his tastes. His guide is the same one the normal person uses. He enjoys that which is pleasing to him. It is the responsibility of the teacher to try to instill in the child a desire to explore new possibilities. The task of the teacher as a creative individual, is to first establish contact with the child, then to develop a method of working with him through which he can respond. With this idea in mind, the teacher has at his disposal possibilities consisting of tried techniques and his own imagination. It is important for the teacher to explore novelty. The extent to which the child accepts novelty is based primarily upon two factors. The first is consistency of approach affording the child a feeling of stability and security, and the second is the teacher's creative ability. He must be willing to seek out the unknown. He must possess the ability to respond to the child as a creative individual. He must relate to the child's reaction, such as a giggle that might occur from the striking of a disonant chord on the piano. By incorporating the chord into a rhythmic pattern, we increase the stimulus which produced the original giggle, encouraging further awareness and response. This interaction unifies an experience. The teacher must grow with the child through these experiences. In this union, the possibility of developing the child's participation is greatly enhanced.

Music is movement. We call these movements pulsations. The pulsations impressing the ear create what we know as sound. We react in a positive or negative fashion to sound, perceiving it as either pleasurable or unpleasurable. With this in mind, all sound is music at our disposal for the child to experience. The laugh, footsteps coming up the stairs, the meow of a cat, an automobile as it accelerates, the spoon dropping from the kitchen table and sounding as it hits the floor, all are music. The sound of the spoon will frighten some children, and they will cry. Some will burst out into laughter. This like most sounds, can be re-called by the teacher to be embellished upon, leading to greater awareness. For example, if the child appears to acknowledge having heard the sound of footsteps, we can hum to the rhythm of the footsteps, perhaps clap our hands, and start a dance. We can go then to different kinds of footsteps, fast ones, slow ones, those on wood, those on linoleum, or those that make a different sound like a woman in high heels walking across a

marble floor. It is in this way that we can learn the frequency range to which the child is most responsive.

With those children who seem to be least aware, we can get many different responses to the same sound. Hitting two medium size wooden blocks together produces a loud piercing sound. Barry will react consistently by stretching his hand high in the air, standing on his toes, and grinning. Paul will turn around slowly to the same sound. Blowing across the top of a gallon jug, produces a lower pitch than the wooden blocks, and will elicit laughing response from Paul and a pleasant smile from Barry. If Paul watches the teacher blowing across the top of the bottle and hitting the blocks together at the same time, his reaction changes. He will come over and try to take away the blocks and gallon jug from the teacher with a very happy smile on his face. Barry's reaction, on the other hand, remains the same.

A jazz recording by Joe Henderson, an avant-garde saxophone player and composer, was played for the children. The recording is dynamic. It has sporadic rhythm and an extended use of the bass fiddle. The volume and bass control of the phonograph were turned up to maximum. The vibration could be felt by Barry by putting his hands on the phonograph. Because of the erratic loudness of the recording, his reaction to specific sounds could be observed. Paul was then placed on his stomach across the top of the phonograph. He tried hitting it, then found the speaker and put his hands and ear to it. Prior to this musical experience Paul responded to loud sounds with inappropriate laughter. The sounds obviously caused pain. Through exposure to rhythmical patterns, however, his reception seemed to become less scattered and more directed. Pain decreased, and on occasion, disappeared entirely. Now Paul not only tolerates sound, but sometimes enjoys it. He reacted to the high notes of the trumpet with real laughter.

One of the most useful ways of reaching the brain damaged child is through rhythm and the human voice. When the mother speaks or sings to her infant, the child, though he cannot comprehend the organized meaning can respond to the feeling imparted by the mother. He may fall asleep secure in his mother's arms as she sings to him, or cry with fright when she speaks harshly to him. A great many of our children must be approached as infants.

At the begining of this present school year, Larry, a child of five who was brain damaged and apparently autistic, made no sound other than crying. He apparently was not responsive to music. He loved being close to the teachers, holding their hands. One day the boy slipped and fell, hitting his head hard on the floor. While he was crying, the teacher sat Larry on his lap and began to mime his wailing sounds. His crying sound like, "da,da,da." When

he had ceased crying and was walking around, the teacher continued to imitate the cry, "da,da,da." Larry was attentive, and after five minutes, responded by issuing a single "da," not in the form of a cry, but in seeming annoyance. In the two months that followed, any sound that Larry made was mimed. During this time, he became increasingly vocal. He not only showed annoyance by saying "da," but also showed playfulness as well. He would come to a teacher, tap him saying "da," walk away, and return again repeating the same sound with a broad smile. His vocal range also increased. Before, he had been limited to a major third, now, he became capable of vocalizing more than an octave. As he began to express himself vocally, he also began to relate to the other children by tapping them and saying "da."

There is positive response to imitation on a higher level. For example, when we sing "Old McDonald Had a Farm," the teacher imitates the sound of the different animals. Most of the children respond with either repeating the sound of the animal along with the teacher, or by laughing and clapping their hands. The teacher sometimes substitutes for the animal sound, the name and sound usually associated with a particular child. For example, "and on that farm they had a Larry, ey eye ey eye oh, with a "da" here, and a "da" there, here a "da" there a "da," etc., or "the y had a Gary, ey eye ey eye oh, with a "a-ja" here and a "a-ja" there, here a "a-ja," etc. Both Larry and Gary responded positively. Larry smiled, and sometimes joined in with his own "da," and Gary by clapping his hands together, extending his feet from the chair and laughing. In other words, they showed recognition of themselves.

Most brain damaged children respond to the primitive and opposite sounds of laughter and crying. For this reason, the teacher made up a happy "ha, ha" song, and a sad, "aw" song. The happy song was a bouncy $\frac{3}{4}$ waltz meter, and the sad "aw" song a somber $\frac{4}{4}$ time. (Demonstrate.) The "ha ha" song began with a single "ha ha," building up to all different types of laughter. The "aw" song started off with the question, "Aw, I don't want to cry, do you want to cry?" "Aw, I don't want to cry." Then the teacher said, "Let's laugh, and we repeated the "ha ha" song. By going back and forth from laughing to crying, the child had the opportunity to experience not only the contrasting emotions, but the change as an entity in itself.

This work is being done at the AHRC Bronx Habilitation Center. It is part of a program based on activating brain damaged children, and music is a part of their daily lives.

# ROLE PLAYING AS A THERAPEUTIC TEACHING TOOL FOR SEVERELY BRAIN DAMAGED AND EMOTIONALLY DISTURBED CHILDREN

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This Center, which functions under the aegis of the Association for Help of Retarded Children, uses role playing in both individual and group settings with a population of severely brain damaged and emotionally disturbed children and adolescents. The various techniques proved to be helpful in assisting non-verbal and verbal communication, in encouraging self-help, to break perseverative patterns and establish self-confidence.

In an individual setting, the therapist worked with a seventeen year old schizophrenic girl who did not use speech and was withdrawn from her environment. Contact was made initially through singing. Throughout all sessions, the therapist spoke freely to the girl about whatever activity she was proposing for the period. She appeared, to the child, to assume her understanding although she made no demand for a spoken response. Each session ended with a few simple songs. Noting the girl's increasing attention to the songs, the therapist made comments about a song being "happy" or "sad." She then demonstrated emotionally how it made her feel. Finally, she presented to her client a small xylophone and asked if she could play a "happy" song. The girl took the mallet, tapped out a number of quick notes, and smiled broadly. Praise from the therapist produced more tapping and more smiles. The girl, after three months, was able to sing, in a monotone, the first bar of "I've Been Working on the Railroad."

The same technique was used with a schizoid boy of thirteen whose only means of expression was through coloring with crayons. After some weeks of observing without intrusion, the therapist began to mention "happy," "sad," and "frightening" pictures. She demonstrated how they made her feel. The boy apparently concluded that his feelings were being shared. Gradually he began to speak, first echolalically, then initiating bursts of speech. Through these his fears became identifiable, and work was started to cope with them.

Role playing on the part of the therapist was used also to help a twelve year old girl to identify the aura of her seizures and take steps to prevent their actual onset. The therapist studied the seizure pattern of the child, who was having both grand and petit mal types at the rate of up to twenty per day. By assuming a strongly dominant role, and using both voice and a grasp on the

girl's arm as aids to focus her attention, she demanded that the child raise her head, turn it and look at the therapist, and finally, make a verbal response to a question. The seizure so treated generally failed to come to completion.

After several months of this, at the first apparent sign of the onset of a seizure, the girl was asked if she felt "funny." She was told she could help herself, then she was led through the above pattern by the insistence of the therapist. Afterwards they discussed how she had felt. In a six month period the seizures were reduced in number to an average of four per week with the exception of two periods of about a week each when the average was higher.

Role playing was used more traditionally as a technique through which perseverative behavior patterns were focused upon and used as a basis for pantomimes and play. By acquiring a meaningful place within a complete action setting, they ceased, in general, to be perseverative and disappeared. It should be noted that, in this type of role playing, the therapist found it necessary to maintain always her own identity. Adoption of another "character" served only to confuse.

Although interpersonal relationships have come into being among the persons treated, there is no knowledge of long-range effects. The clients of the Center are learning to relate well to each other. This comes from their participation in an entire program of which individual work is only one aspect, and role playing one technique. However, it seems to be a useful technique and helps to encourage the child to respond to the group.

# THE ROLE OF THE PROGRAM DESIGNER IN A HABILITATION PROGRAM FOR BRAIN INJURED CHILDREN AND YOUNG ADULTS

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The Program Designer in a Habilitation program *is responsible* for the planning, development, and carrying out of programs designed to affect improvement and positive changes in the actions, attitudes, abilities, and behavior of the severely and multipally handicapped brain injured child and young adult. Our goal and hope is that after their participation in our programs, these clients will eventually be accepted into other and more advanced educational and vocational training facilities in public schools and sheltered work shops. With this additional training some may attain productive capacities and abilities for selective competitive employment. We have already had some success in this area and hope for more as our program continues. We must also bear in mind, that the Habilitation Program accepts many clients who have been rejected from schools and other formal programs and who have had little, if any participation in programs designed to meet their needs. We make persevering attempts to improve their physical, social, and emotional functioning, accepting these clients as they are and working to bring about improvement in *all* areas.

With the Assistant Director, the Program Designer has the responsibility to evaluate and interpret to staff the medical, social, psychiatric, and psychological data obtained from referring facilities, clinics, schools, parents and clients, discussing the areas of difficulty and planning their remedy.

In order to thoroughly evaluate new clients, we make use of situational diagnostic techniques. By observing the client's functional abilities and his reactions in our actual work and group situations, a truly functional picture is obtained. Planned and intelligent use of this information can benefit the client by manipulating the environment to aid his growth and meet his needs.

When Richard, a young brain injured adult came into the program; he was carefully observed and found to be impulsive, easily distracted, and generally disruptive. It was, however, noted that he responded to one staff member who role played the part of an authoritarian supervisor and was able to get Richard to do simple tasks. We also found that Richard was able to work when his environment was limited. Working with this information with

the staff member continuing in his role and adjusting the client's environment, gradual changes became apparent in Richard. He is beginning to perform well in the regular work area, he is less impulsive, and there is good carryover to other areas of his life. He now responds well to other staff members and his behavior toward others has improved. This *holistic* approach to the client, his needs, abilities, attitudes, and problems, and designing programs providing a suitable milieu for these needs, brings improvement not only to the client, but to his parents and siblings. The Habilitation Program understands this and also provides services for them in application of the holistic approach to these clients and their families.

The staff members are trained, not only in role playing but also in situational counseling. They spend little time in offices, separated from life, but work with clients in the various programs, interacting with them, giving guidance, helping them to change attitudes and to improve their abilities on the spot. By being there when the events which call for counseling arise, effectiveness and understanding are greatly enhanced and the results can be impressive. When Jan, for no apparent reason, reaches out and strikes Ann, the counselor's intervention at that point has positive and immediate results. Because there can be no denying the action, he is able to elicit some understanding on the client's part for her actions, have her take some responsibility for them, and perhaps redress a wrong. Ann can also benefit from this interchange and may be ready to receive an apology and may even become friends with her coworker, both having benefited from the incident and later exchange.

Staff is also instructed and supervised in the application of passive-assistive techniques in order to improve coordination, physical functions and learning leading to improved and productive habits. Simple repetitive work tasks are utilized as the basis for this training. This work is supplied by the regular A.H.R.C. sheltered workshop. Motivation is enhanced by giving clients cash payments for work and tasks performed. It is used effectively as a means to an end, increasing interest, motivation, and attempts to make improvements in performance.

We know that recreational activities can be and are a learning process in which physical and mental processes and abilities can be greatly stimulated by actually doing and experiencing. There are many fringe benefits to recreation, mostly noted in improved coordination, balance, sitting and work tolerance, stronger and more supple muscles, and a greater resistance to fatigue, colds, and petty distractions. Our recreational program not only includes swimming under the supervision of Dr. Jack Gootzeit and certified water

safety instructors, especially trained in working with the handicapped with situational techniques, but also field trips and outings. On these trips the client has an opportunity to interact with the community with the situational therapist present. His role is to aid clients at the opportune moments to react and grow with these experiences. We must also remember that recreation provides the client with opportunities for creative expression and development of new and important relationships with his peers. Few of our clients have ever been exposed to these opportunities. I might also add that these have been very effective in bringing parents, siblings, and clients into closer relationships, bringing new understanding gained from these contacts and informal discussions, in group and individual counseling concerning their problems. This is a change from the usual avoidance, feelings of isolation, guilt and shame one initially meets. Parents and siblings, in fact, receive scheduled services which consist of counseling and group educational programs where problems can be aired, discussed, and worked upon.

Our program has a Boy's Club consisting of clients who started together in group counseling last year. They maintain our cafeteria and surroundings, cleaning it before and after lunch and are learning to work under minimal supervision. They have elected their own club officers, run regular club meetings, purchased distinctive sweat shirts and have developed some "esprit de corps." Similarly, a girls counseling group is now beginning to form a club. They have undertaken homemaking chores; going out on trips to food stores, selecting and purchasing food staples, cooking and serving lunch, and cleaning up. They are also starting to iron and we hope will later be able to undertake sewing. These groups give opportunities for success experiences from which ego strengths can be reinforced. Staff is able to give ongoing acceptance and approval for improved work and rewards also come from approval from client's peer group. New members are gradually worked into these groups, which give them status, orient them into its expectations, and aid them to develop. Here, staff role playing brings understanding of realistic life situations for their exposure and development. Again, with the holistic approach in mind, staff has undertaken a program of counseling and working closely with the parents in seeing that there is a carry-over of progress from the program to the home and school. Parents are encouraged to accept their children as being *less* dependent and very capable of doing many simple and useful tasks in and around the home, such as general cleaning, shopping, cooking, etc. They are surprised and encouraged at the results and are some of our strongest backers for programs in this area.

Our programs require trained staff in their assignments as supervisors, aides, and volunteers; orientation, training and ongoing supervision is necessary. Many of our staff come from our volunteer pool and because of the training and work experience, and our feeling that they must also receive something for their service, remain with us in paid staff positions. Other duties include the maintaining of personnel records, replying to correspondence, making referrals, attending meetings, and planning with administration for future services, staff, and needs. The same tedious amount of clerical and paper work we abhor in our regular professional occupations is also with us. Yet, somehow, it is done. Mr. Walter Oldham and I have often expressed in our conversations, our feelings of frustration and disappointment in the time spent on administrative duties which take us away from our contacts with our clients. The program is similar to a three ring circus where so much that is exciting and informational is taking place that it is impossible to see and understand it all. Our rewards are great and come from seeing our clients grow and advance from severely regressed, impulsive, and intractable youngsters, to productive, more social and happy human beings. Some move on to actual competitive employment and others are now able to partake of advanced educational and sheltered work shop programs. The voices and faces of parents who tell you of the changes that have carried over to the home and community, the improved, more adjusted and independent youngster, the tremendous and selfless devotion of staff and parents, these are all so difficult to evaluate in terms of numbers and statistics, but benefits of great satisfaction come to us all.

Designing programs is not a static, fixed function. It must continue to meet the client's needs, change, explore, chance, and remain flexible and open to suggestions and modification. Understanding this, we look forward to improved and fuller programs for our clients, their parents and siblings, in order to aid their development of the skills and understanding so necessary for participation in lifes' activities.

# PSYCHODRAMA AS A TREATMENT OF CHOICE

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Psychodrama was selected as a treatment of choice for the benefit of a 65 year old dramatic actress in severe reactive depressions, in response to retirement from the stage due to waning energies. It was expected that the dimensions of the psychodramatic technique, calling for definition of problems, background setting and roles as well as role practice, role experimentation and role playing would free her for expression of her feelings and ensuing catharsis, since these dramatic modes were similar to her real life modalities of expression. It was also expected that her self esteem would be raised by discovering that she could adapt her fine professional skills to new goals, therapeutic rather than entertainment, and in a setting that did not make excessive demands upon her physical energies.

Furthermore, by presenting the psychodrama sessions as a learning situation rather than a therapy situation (with intent to prepare her for the role of assistant to the director of the psychodrama) her self esteem would be restored, at least in the hospital where the patients refused to believe that she was a former successful actress. They accused her of grandiose fantasy.

In short, by redirecting her highly differentiated professional ego skills into productive channels and according her the dignity of professional status on the hospital hall, she was expected to recover her "joie de vivre."

After two diadic sessions, Mrs. G. asked, with great enthusiasm, for expansion of the group to permit her greater experimentation and practice and to give other patients the benefit of these techniques. Accordingly the sessions were opened to patients with permission of their therapists. Patients were not obligated to continue attendance but could come and go at will. In spite of the permissiveness of these limits, the sessions were well attended with never less than 20 and often as many as 35. The sessions were held in the afternoon, once or twice a week for two hours each session.

To evaluate the benefits of these sessions and to provide the therapists with progress notes on their patients, records were kept of the patients attending each session, the number and type of problems raised, the roles played by each patient, and the insights verbalized by each patient. These data were tabulated each day on specially prepared charts which provided at a glance the movement of each patient during psychodrama. Examination of the progress charts suggests that patients who participated wholeheartedly in the psychodramatic activities were moved to more open halls at the end of the four week period.

The therapists reported that the psychodrama opened the patients for individual therapy, facilitating their movement toward health. They were soon ready for volunteer work and some were sent home during the period. It was also noted that once they became more responsive to individual therapy, they came less often and many stopped coming altogether to psychodrama, making room for ever new patients who needed and wanted psychodrama.

In view of the fact that the patients were all in psychotic states, it seemed wise to introduce certain ground rules—to reinforce the very tenuous inner controls of these patients which could give way under the impact of an action technique. Ground rules were essential to protect each patient from the push of inner turmoil which might be triggered by deliberate action-interaction and from traumatic aggression projected by one patient onto another. Ground rules included:

1. Problems were defined in concrete terms—time, place, etc.
2. No patient was forced to play a role, though friendly coaxing was permitted.
3. No one was permitted to analyze, interpret or confront others about their feelings, actions, motives; only the patient himself was permitted to express his own feelings, urges, motives and reactions.

Over a period of 3 months, 16 sessions (for a total of 32 hours), 54 patients attended the psychodrama sessions. 61 problems were presented and dramatized and 32 patients directly participated in role playing. All patients talked and expressed feelings or insights at one time or another. Of the 32 patients who participated in role playing, 29 were moved during this period to halls with greater degrees of freedom. Fifteen of these were placed on volunteer work and three were released.

Some of the problems presented and insights derived are exemplified below:

| *Problems* | *Insights* |
|---|---|
| 1. Cannot accept fact of illness and sees no need for hospitalization. | Intolerant of limits, demanding controlling, needs to grow up, this is illness. |
| 2. Flowering from seed | Painful process |
| 3. Four year old hates mother and her women friends. | Child wants to be listened to, not talked at or to, all the time. |
| 4. Therapist is not good, does not understand patient's needs. | Patient discovers she projects blame onto others when she is close to realizing that she is responsible for her actions. |
| 5. Patient blamed every boss she worked for, for loss of jobs. | Discovered she expected to keep jobs on basis of her beauty and sought support and protection from work on her jobs. |

In summary, psychodrama was the treatment of choice for psychotic patients in a hospital setting who resisted other forms of psychotherapy, passively or actively. It served to open them up for response to other forms of therapy. Patients who were not forced to play roles, chose to do so. Psychodrama taps three levels of responsiveness at once—the intellectual, emotional and actional so that it can reach everyone through one avenue or another and at the same time sensitize the other avenues of receptivity. The method is safe for it allows for action in make believe situations which are devoid of the threats of reality situations. It allows patients to reveal themselves overtly or covertly through direct verbal commitment or through non-verbal communication and does not commit the patient to any admission if he is not yet ready to be committed. Finally, the audience also derives benefits of catharsis by identifications with roleplayers.

# SOME CONDITIONS FOR PERSONAL CHANGE IN SENSITIVITY TRAINING GROUPS AND PSYCHOTHERAPY GROUPS

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It has become progressively more difficult to distinguish between the apparent effects of sensitivity training, human relations or basic encounter groups, and those of conventional group psychotherapy.* At first this bald statement seems to fly in the face of our common sense and professional experience. How can it be that people who experience short-term experiences which are not labeled therapeutic, react in ways similar to those of patient groups where the intention is to deal with neurotic problems of relatively long standing?[1]

We would expect that the time limitations of the former experiences (anywhere from several days to several weeks) as contrasted with the far more extensive psychotherapeutic experience should make some difference in internalization, working through, or consolidation of gain. Also, as clinicians, we are mindful of the differential composition of the groups ("normals" in the former; "patients" in the latter) and we would expect consequences which flow from differential expectancies and "definitions of the situation" by the two populations. While one might expect differences to emerge on the basis of such considerations, they do not—if one engages in a bit of translation of the languages used by the respective groups. Of course, patients will naturally emphasize symptom relief while former participants in training groups rarely acknowledge disabling psychological impairment. Successfully terminated therapy patients and satisfied consumers of training experiences reflect upon their gains in such terms as "greater self-acceptance," "increased understanding for others," and in general, "a better understanding of myself."

We do not, in this paper, wish to compare the processes in terms of their relative effectiveness. Like psychotherapy, sensitivity training has its share of indifferent, even negative, results. But the successfully terminated partici-

* Acknowledgement is made of the stimulating exchanges between the authors and Dr. M. A. Lieberman of the University of Chicago and Dr. Dorothy Stock Whitaker of the University of Leeds, England. Many of these ideas are products of our joint consideration of the issues. Paul Seder of Duke University has also been most helpful in these exchanges and formulations.

[1] The members of ASGPP will find in *Sociometry* vol. I-XVIII, 1937-1955, numerous references which deal with the problems raised in this excellent article (ed. note).

pant reflects on *his* gains as many psychotherapists would hope the successfully terminated patient would reflect on *his*. For example, in a recent follow-up of a summer laboratory sample, we found that participants judged to have actively involved themselves and to have maximally learned from the experience (as reliably assessed by external observers) were able, one year later, to specify on-the-job and in-the-family changes that any psychotherapist would have been pleased to acknowledge as evidence of positive therapeutic effects (Lakin, Ganung, and Thompson, 1967).[2] We postulate that, given an adequate level of involvement, the patient and the participant take away from their respective experiences certain kinds of learnings which are perhaps best termed attitudinal changes towards themselves and toward others. In the cases of the patients, a significant gain would be reported in terms such as "I don't feel so bad," "I see I am not so badly off when I compare myself with others," "People can like me when I thought they couldn't." For the participants, it is more frequently the langauge of an enhanced interpersonal effectiveness in functioning, "I can work better," "I listen more attentively and hear more," "I can express my feelings—positive and negative—more easily." While one is the language of patients and the other the language of "normals," both groups are testifying to attitudinal changes about the self in interaction. It is just such changes that constitute desirable therapy end products.

### Changes in Both Groups Are Attributable to Social Influence Processes

We considered that since effects were similar, perhaps processes were similar as well. Group therapy and sensitivity training have had a curious history of "non-relationship" with each other, characterized until relatively recently by mutual inattention or periodic excoriation (largely by group therapists apparently sensitive to the threat implied to professional jurisdiction). Both processes and cultures have had little attention from social psychology.[3] Such parochialism is unfortunate from a number of points of view. The losers are all three parties and their respective consumer groups. This is not to suggest that the current state of knowledge in any of these three cultures provides the answers for the puzzles of the other two. Experimentally constituted transitory groups whose conditions are induced by

[2] Unpublished manuscript.

[3] The reader should be advised that sociometry and small group research has been the tie between group psychotherapy and sensitivity training. see telic sensitivity, "Statistics of Social Configurations," *Sociometry,* vol. I, 1937 (ed. note).

instruction would appear at first to be a distant, if relevant, learning model for group therapy or group sensitivity training. Nevertheless, the repeated findings of the experimental laboratory, when compared with the experiences of the training and therapeutic groups, begin to draw in firmer lines what a number of us as trainers or therapists have come to realize from our clinical experiences—namely that the changes that occur as a result of training and therapy group experiences are attributable to social influence processes.

### Social Influence Processes at Work in the Training Group

In group sensitivity training, the group facilitates attitude change in at least three ways: (1) indirectly by removal of support for a particular pre-existing attitude about the self and about others; (2) the group generates discussion that leads to somewhat different attitudes than had previously been held by group members about themselves and about others; and (3) through individual "prescriptions for behavior" arrived at through group decision processes and through practice designed to consolidate group-induced changes.

In emphasizing the forces which operate upon the person in groups, we are probably raising for many trainers and therapists a kind of "red flag" with connotations of manipulation and the loss of personal freedom. To view personal change as a product of "pushes and pulls" upon the individual goes against the value orientations of many helping professionals. For the most part, trainers and therapists like to view themselves as "facilitators" of growth and as purveyors of individual freedom, not as manipulators or influencers of group forces. Perhaps it is for this reason that sensitivity training theorists seem to overlook some of the basic group mechanisms involved in the work that they do.[4] In fact, there has been a trend in the most recent past to de-emphasize the group experience and influence factors in favor of some more highly intimate and unique aspects of individual experience in the group arena. We would hold that the latter, no less than other change processes which occur in groups, are contingent upon the very same influence processes. The wish to "actualize" or to "self-realize" is very strong; however, it is necessary to confront the fact that these value orientations and what actually goes on in the groups are often orthogonal to one another. The intermingling of fact and value plays havoc with our attempts

[4] See tele and group cohesion, "Statistics of Social Configurations," *Sociometry,* vol. I, 1937, p. 363-368.

to understand the processes at work in these groups; manipulations and influences are at work and we should be able to face the dilemmas posed by these rather than pretending that they do not exist.

The conditions for unfreezing, changing, and re-freezing are related to the reciprocal interaction of person and group. The group can exert its force upon the individual in any of a number of dimensions, *provided* the individual is in an emotional way connected with and involved in the group. We may now begin to consider some of the processes which sensitivity training groups and therapeutic groups have in common.

### The Group can Satisfy the Universal Need for Belongingness

Both types of groups depend upon some effective levels of cohesiveness. The personal correlate of cohesiveness is a feeling of belonging, being a part of the collectivity. Without this feeling, little influence can be exerted nor can significant interdependent activity be undertaken. Unfortunately, laboratory studies have not comprehended the kinds and ranges of cohesiveness that we see in training and therapeutic groups. For example, attraction to others may not be the major determinant of cohesiveness in such groups. Factors such as mutual expectancies, shared fears, anxieties, or even shared animosities toward a trainer or therapist may foster the cohesiveness of the group. For example, "charismatic" focus on the person of the trainer or therapist is often the initial basis for adherence to the group. However, all these various reasons for belonging may be secondary in importance to the experiential satisfaction of the need to belong. Have we fully appreciated the strength of this need as a factor in the appeal of such groups to broad segments of the population? In this connection, sensitivity training is reputed to be eagerly sought as a palliative to the sense of alienation and distance from others. When one is anxious, one seeks out the company of others. Affiliation tendencies are increased by the anxieties of the novel situation in the training group. One important fact flows from this for our consideration of social influence processes. If the individual achieves a certain measure of success in belongingness, he is reluctant to displease fellow members; this renders him—by this very fact—more influenceable.

### The Self-Disclosure Norm in Training Groups and Therapeutic Groups

Cohesiveness at a certain level—neither too great nor too little and its personal correlate, the feeling of belongingness, provide the foundation for the development of a self-disclosure norm in the group. Remaining in the

group, as most participants do, implies that it begins to be used as a reference group; exclusion from it is painful; inclusion in it is confirming and reassuring. In the training group, as in the therapy group, a conflict is generated between self-disclosure tendencies with advantages of confession, relief, and expiation on the one hand, and the fear of disapproval and punishment for one's confessed weaknesses and inadequacies on the other. The group norms typically favor self-disclosure. The member who is inhibited and draws back from frank revealing of his feelings is subjected to pressure from other members. This pressure-sometimes gentle, sometimes not—combined with the individual's natural desire for approval from his peers in the group, usually results in some "supported" experimentation with self-disclosure with consequent interpersonal rewards. The participant usually does not experience these norms as coercive since he has ostensibly had some share in their formulation. The individual, having had the opportunity for participating in the construction of rules—has some feelings of fate control. Deviance, to a degree which may lead to expulsion, is rare in such groups, but individuals who adopt unpopular positions are vigorously responded to with efforts to reconcile or to convince. Thus, group pressures operate to limit the member somewhat in his choice of expression once he is involved.

The question arises whether the participant can reduce the social influence of his peers or effectively avoid it. In the training group, we could say that if he remained passive and in an observer role, he could limit the influence of others upon himself. However, this is what training groups in common with therapy groups do not tolerate. Participation and exposure are crucial in both these experiences. Hence there exists a continuous pressure upon members to participate in accordance with group norms, receiving periodic inputs or feedbacks about their own performances in the light of these norms. The total effect is to block many habitual forms of impression management.

### The Group Elicits Interpersonal Sample Behaviors

What is the content of sensitivity training groups? With what matters do they deal? A shift has been noted over the recent years from pre-occupation with group processes and group skills to a concern that can only be termed personality-centered. In the training group, as in the therapy group, customary roles, status shields, agendas, and other paraphernalia of a well ordered and conventional group meetings are done away with. The trainer deliberately severely limits his own structuring activities. The tension of an interpersonal void is quickly filled by rivalrous attempts to produce an

alternative to the vacuum; one which will relieve anxiety by reducing the terror of unknown potentials in encounters with other members. Each member responds to this new and threatening situation in a personal and characteristic way. His mode or style is quickly apparent, perhaps initially in terms of such factors as activity and passivity; later in more dramatic and impactful ways as expressive or suppressive; supportive or combative; hostile or affectionate. Each person reduces his personal anxiety through some kind of observable participative behavior. The style and quality of this behavior is thereafter defined as that person. In the absence of confirming evidence, this judgment persists until behavior changes take place.

### How Emotionality in the Group Affects Participants

The image of the credulous, suggestable, uncritical, and highly inflammable crowd remains for many the image of group emotional experience. Group moods are infectious. Feelings appear to spread rapidly. As one observer has noted, ". . . excitation of one part of the group can affect the whole, as a fever seizes upon all parts of the organism" (Neuman, 1954). Emotional expression in one individual serves as a stimulus to emotional expression in another. There are many examples in each of our experiences of spontaneous laughter and excitability. Students of group behavior have called attention to the fact that the individual, feeling relatively anonymous in the crowd, can perform acts which ordinarily he would be afraid to perform. The group seems to lessen the cost of performing these acts; inhibitions are diminished. The group does not make the individual more "primitive," it merely allows him to be more primitive without fear of repercussions. Affectional and hostile feelings are regularly evoked and expressed with greater frequency than in most types of interpersonal experience. The norms and the cohesiveness of the group support it and even grant the members a kind of apparent anonymity. The temporary emotional regression permits and encourages the expression of feelings the individual might find unthinkable in himself, much less expressable in public, under the protective association within the group. The greater propensity for risk-taking in groups on the basis of assumed responsibility diffusion implies that one can really let oneself go! (That is—up to a point—for while accountability appears to be lessened, it is, as many participants find to their subsequent dismay—actually heightened over time, but that is a matter beyond our present discussion). For the present, suffice it to say that the person feels encouraged to feel, and to express, feelings freely. The group seems to encourage it; the group even appears to demand it.

What is the therapeutic relevance of heightened emotional expressiveness in the training group? The implications for the repressed individual seem fairly obvious; the group tries to unfreeze him. There are, however, subtler aspects to the emotional atmospheres in group experience. Sensitivity training group members do not really abjure thought and planfulness. The individual does not really lose self-consciousness or self-awareness in a diffusion of identity to the extent that he loses track of his own emotionality and that of others. The member, while participating in group emotionality, is often able to pose to himself self-relevant kinds of problems or issues. Examples of these are: "How do I deal with my feelings anyway?" "How do I manage my agressive and affectional expressions toward other people?" Therapists would probably agree that these are therapy relevant questions.

### Social Comparison and Attitude Change

People appear driven to compare themselves with others. The need to compare oneself with others, coupled with the wish for approval from others, becomes a more or less explicit standard for the group. An individual locates himself in relation to other members of the group by means of such comparisons (Festinger, 1954). One does not seem to have to ask or teach patients to engage in this kind of comparison; they do it spontaneously. Such comparisons reduce feelings of isolation and uniqueness by providing plentiful evidence that others experience similar problems with parents, husbands, wives, and children, or similar feelings of anxiety and anger or guilt. A follow-up study on group therapy patients several years ago indicated that one of the major therapeutically potent factors for the patients was their mutual social comparison (Dickoff and Lakin, 1962).

Social comparison in sensitivity training groups, as in therapy groups, occurs on both covert and overt levels. Sometimes the participant is confronted with new possibilities in feeling, perceiving, and behaving which are different from the ones they have been habitually bound by. In the overt form of social comparison called "feedback," members provide other members with information about their reactions to their behaviors. In the sensitivity training group, these are typically restricted to the contemporary situation and do not include personal histories or symptoms. Such information allows the recipient of the feedback to understand better the impact of his behavior on others while forcing some consideration of the function of the behavior for himself. Feedback contributes directly to a therapeutic goal of helping each person to recognize and accept responsibility for the interpersonal consequences of his behavior. In the sensitivity training group, when one

begins to feel warmly towards other participants, one often changes one's judgment in the direction of those others. Zimbardo showed that awareness of the fact that one's judgment is discrepant from one's friend instigates processes to change judgment in the direction of that friend. In the sensitivity training group and in the therapy group, if one perceives that other members' judgments are different from one's own, one experiences some pressures to move toward the judgments of the others—provided that the atmosphere favorable to affiliation has already been generated. This can have a particularly dramatic effect if the content of the discrepancy is judgment concerning one's view of one's self or of one's own behavior.

### "Therapeutic" Rewards for the Participant in Training Groups

Participating in a social system which legitimatizes attention upon one's self has demonstrated effects upon morale. The "Hawthorne effect" is not limited to factory girls. Another factor is a "moratorium" on the usual demands of living and a change from the social amenities characteristic of daily interpersonal life. But, beyond these, we would argue that each of the group processes we have described has a personal correlate and that the individual is responsive to these general processes in terms of his specific needs for them. We have already indicated that the group answers a fundamental need to belong. It also provides opportunity for mergence or fusion with the whole and separateness or distinctiveness—the first through participating in the group cohesiveness; the second through participating in the feedback process. Because the individual has the feeling of sharing in building the group norms, and thus abides by rules which he himself has shared in constructing, the pushes and pulls of the group are not all experienced as unpleasant, even though personal freedoms may be curtailed. There is a kind of exchange process involving an apparent diminution of personal options in exchange for group endorsed security and approval. Awareness of incongruity, imbalance, or dissonance in cognitions and feelings is experienced as unpleasant. Subjective feelings of this kind are characteristic of patients and of participants in training groups (Bugental and Tannenbaum, 1963). The effort after meaning in such experiences is an attempt to bring affects, cognitions, and personal behaviors into some balance. The nature of the experience, making salient as it does, states of imbalance or incongruence, motivates change. The social comparison and feedback processes on the basis of the affective arousal and the enhanced significance of group membership, backed by powerful inducements to behave in new ways, having destroyed old balances and accommodations among the person's affects, cognitions, and

behaviors generate pressures to construct new ones along consensually validated lines.

Change can occur at any of three levels: (1) compliance; (2) identification; and (3) internalization. The behavioral correlates for these three levels are as follows: For the first (compliance), new actions at the group's direction; for the second (identification), adoption of the group's stand-point for viewing the self and interpersonal relations; and for the third (internalization), generalization of therapeutic changes to specific real-life situations. While we are used to thinking of compliance as related to coercive change (an extreme example of which would be so-called brain-washing) and internalization as associated with the desirable effects of long-term education and psychotherapeutic work, the fact is that social influence processes and the individual participants' responses to them are involved at all three levels.

### Patient and Participant "Understanding" of Processes in Sensitivity Training and in Therapeutic Groups

In the light of the above discussion, the current de-valuation of insight by many therapists is important to consider. It would seem, if we follow the logic of social influence processes as the effective factors in inducing change, that insight is unnecessary for relief of psychological discomfort in patients and for changes in attitudes toward the self and others in sensitivity training groups. Our concern with insight stems not from its significance as a necessary mechanism of change, but from a valueing orientation. If, notwithstanding individual variation, relatively standard experiences involving cohesiveness, affiliation, conformity, and social comparison processes are decisive factors for participants in a therapeutic experience, the consequences of ignoring individual understanding of these processes seem to us to be potentially grave. Unless the individual can come to understand processes which can alter his behavior, there is the danger that he can become something of an automaton, responsive simply and directly to the pressures of the group and the prestige of the trainer or therapist.

### Trainer and Therapist as "Influencers"

The change process is influenced and managed to a degree by the trainer or therapist. Many aspects of the over-all atmosphere and the general acceptability of the training or therapy are related to perceptions of him by group members. A series of studies has dealt with the problems of high and low creditability of influencing persons. From this series of studies, the fact emerges that apparent "fairness," "trustworthiness," and "honesty" of

the trainer as influence agent determines whether many communications in the group will be accepted or rejected.

While it is important—perhaps even crucial—how the trainer or therapist is perceived as a person in terms of these characterological dimensions, it is equally important how he manages his own interventions in relationship to the felt anxiety among group members. Certain levels of fear and anxiety are more effective than others in producing salutary behavior change. Excessive fear arouses defensiveness with resultant extrusion of the experience. There appears to be some optimal level of fear arousal for inducing behavior change. The timing of informational input is also critical in training and therapeutic experiences. If the trainer or therapist presents information (we call it interpretation) only after having aroused needs relating to this information, the information will be more readily accepted than in the reverse case. Of course, in a typical sensitivity training group, as in the typical therapy group, cognitive restructuring (i.e., interpretation) typically does not occur until group processes have been well developed, by which time rather high levels of need tension will have been generated among members.

### "Monitoring" the Social Influence Process

Such factors as the kind of person he is perceived to be and the timing of his interventions or the appropriate management of group anxiety level touch on only a few of the myriad "management" functions of the trainer and therapist. The "pushes and pulls" of the social influence process often miscarry. In the dyadic therapeutic situation, the therapist is the arbiter of reality. In training groups and in therapeutic groups, the leader must contend with group consensus. There is no objective criterion of accuracy or reality in the training or therapeutic group. "Consensus" is king! As a recent observer of training groups has noted, misunderstandings may become pyramided upon misunderstandings and, without the active intervention of the trainer, the possibilities for destructive effects could easily be realized. Earlier we called attention to conformist and social comparison pressures which pushed upon one to change his attitude so as to conform to the group's position. Laboratory studies have repeatedly confirmed this effect. Some implications for the trainer and therapist from this line of research and clinical experience are very important. They suggest that a group can sometimes be over-determining of an individual's attitudes and responses. Results of a therapy can be anti-therapeutic in the case of the overly compliant person who strongly desires membership but feels himself a weak member. This individual is more likely than others to "go along" with a group norm

or value. The possibility of very superficial change is dramatically portrayed in the "band wagon" effect where changes in points of view or opinions or attitudes can be facilitated by simply conveying information that other group members have changed their opinions (Kelley and Woodruff, 1956). In brief, we suggest that the trainer, like the therapist, acts as a kind of "corrective" to the excesses of the group in any given direction.

### The Effects of Sensitivity Training and of Group Psychotherapy—Refreezing

As in psychotherapy, it must be acknowledged that satisfactory categories of change and the criteria of demonstrated change have yet to be established for sensitivity training experiences. Follow-up work in psychotherapy demonstrates the "cafeteria nature" of the effects of psychotherapeutic experiences—even the most involved, intensive, and presumably "deep." The highly idiosyncratic responses to therapy and/or training and the inherent difficulty of establishing comprehensive and standard criteria for behavior change have plagued attempts to evaluate the long-term effects of these experiences. We do not yet know the overt behavior correlates of the attitudinal changes induced in the training groups. One current danger is that in discouragement over attempts to specify the generalized behavior correlates of such experiences, trainers and participants alike fixate on the uniqueness of the experience itself and exhalt it to the level of an esoteric and mystical experience which has little translation to the work-a-day world. Such a resolution would be tragic inasmuch as it would separate the group training from its relationship with the everyday world of interpersonal experience. In this relationship lies its ultimate utility and significance if not its power.

# CONCEPTS OF DANCE THERAPY

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Whoever danceth not, knoweth not the way of life.
CHRIST in a Gnostic Hymn of the 2nd Century.

Dance therapy is a mode of non-verbal communication basic to any treatment program. Its power is in the use of the instrument; one gives expression to inner experiences through the use of one's own body. The rhythms of life, the sense of space, the world as experienced and imagined are all translated through the language of movement. It is a technique which concerns itself with basic emotions and permits their expression in a supportive and non-threatening atmosphere.

Each person has a vocabulary of movement basic to himself. He moves with his own particular style and feels more comfortable with one set of postures than with another. His gesture and posture are frequently a more honest expression of his feelings than his words. What if feelings are so intense that words are no longer adequate to the task? Suppose language is more of a barrier than a communication? How do we adequately allow expression of intense feelings in acceptable ways—particularly within the framework of an institutional setting? Dance, used as a therapeutic tool, involved with basic movement rather than any particular style, becomes a language to express and explore our feelings in relation to others and to ourselves.

All life is made up of rhythms. We breathe with our own rhythm; our blood courses through our body rhythmically; life is made of rhythmic cycles of sleep, work and relaxation, and nature around us offers many varieties in cycles and sounds. People respond to rhythmic beating—music—and through it relate to each other. Used as therapy, dance is most often conceived of as a group process. Since earliest primitive man, communities have used the rhythms of dance as a means of socialization, to celebrate the rites of life, power, abundance, and health. Strength and unity is developed through unison and group dancing. In like manner, as they share the experience of moving together, treatment groups feel the support and understanding necessary to break through the isolation of illness. Everyone works together, and in so doing can achieve, within individual limitations.

Man always uses movement in his daily life. His body posture with its tensions indicate his emotional state while his gestures emphasize his words. Particular physical activities may carry with them particular feelings, such

as the rocking of a baby or the shaking of a stopped up catsup bottle. In similar manner, movement can be used as an acceptable means of venting feelings along with the release of muscular tension. There is so close an interrelation between the psychic attitude and the muscular state that when we move a certain way, we begin to feel that certain way. In a march, one has to stand in a "proud" attitude and it is difficult to feel worthless when strutting. When one starts stamping one's feet and punching the air with tight fists, hostility and agressiveness begin to flow *because of the movement itself* and they then reinforce each other. It proves to be a cathartic release strengthened by the bond of sharing the same emotions with others, acknowledging that we all do feel such emotions. Feelings of tenderness and happiness as well as the more negative ones are found through movement.

Movement leads to a better orientation in relation to our own body. We do not know much about our body unless we explore movement. A self-image and a feeling of comfort with the physical self is something which must be built and created. The sense of self is the first discovery. People then can correctly perceive others and more comfortably relate to them. While we want to understand the thoughts and gestures of others, we also want our own thoughts and gestures to be understood. Experiencing strong emotions simultaneously with others builds mutual bonds that no intellectual probing can achieve. Over a period of time we hope to establish a meaningful relationship between the participant and the therapist and between this same person and others within the group. Physical contact with others through dance becomes a meaningful experience in the process of socialization. The tender feelings that people can have and receive are discovered again, or found for the first time, by holding hands, by being rocked or by rocking someone else.

Although we are working on a non-verbal level, there is a constant attempt to develop verbalization on an expressive level so that a person can make use of other forms of treatment. We are concerned with building the ego, with instilling a sense of love and an ability to achieve.

Dance therapy has been used successfully in mental hospitals with patients of all ages and diagnoses, in out-patient clinics, with children suffering from speech and hearing difficulties, neurotics, the retarded, delinquents, culturally deprived and autistic children. As an adjunctive therapy it is a growing profession. The unique emphasis on the meaning of movement can provide aspects which can and should lead to fruitful cooperation with other disciplines. It goes back to the basic core of what is human, acknowledging our fundamental nature without suffering the pitfalls of environmental or cultural barriers.

# PROFESSIONAL RESISTANCE TO PSYCHODRAMATIC INVOLVEMENT

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Does the psychodramatist demonstrating before professional audiences face any special kinds of resistance, which in turn affect the nature and quality of the psychodrama? To what extent are these resistances within the members of the audience? Why? How do they affect the psychodrama? How is the problem complicated by the presence of lay persons or students? What, if anything, can be done about the problems?

Our concern with this question of resistance to psychodramatic involvement is not an easy one to explore. We must investigate the warm-up of the director; the position of the audience and place of the psychodrama as a therapeutic instrument and method in terms of the spontaneity of the audience who participate. We are responsible to assist something to happen, and in doing so, encourage freedom of self expression and to put aside even the idea of disapproval. We must be careful not to permit the politics of self expansion and privacy control, or to limit the director and his staff in their approach to action.

The March 17th session on the professional resistances to psychodrama involvement was faced almost immediately with a manifestation of professional resistance. The members of the professional audience appeared reluctant to participate in an "open" psychodrama. Was it the nature of the topic which provided built-in resistances, or were there other elements unique to the evening's experience which explained the resistances?

Earlier references in the psychodramatic literature suggest that experienced psychodramatists and sociodramatists have been unable, in certain settings, to involve professional persons in psychodrama. To some extent, this may be explained by the expectations of the members of a professional audience—that they will "observe" rather than "participate" in a psychodramatic session. Questions of prestige and of personal exposure to fellow professionals may well account for such resistance in some cases.

In our experience, many professionals in the fields of individual and group therapy and in community sociodramatic situations, in identifying with

the director's role, or with the therapist's role, may contribute to the difficulty by his inability to place himself in the role of the client.

At the March 17th session there was a failure on the part of the professional audience to recognize the fact that it was living through the very kind of experience that the evenings' panelists had been discussing. This failure heightened the degree of suspicion with which members of the audience regarded the motives of the directors. On several occasions members of the audience demanded to know if they were being deliberately placed in a situation of heightened frustration, whether they were being deliberately kept from moving into psychodrama. On the other hand, the pressure of so many members of the audience to move into psychodrama was illustrative of the very point which the title of the session was intended to point out. Finally, the suggestion by Dr. Joseph Meiers that the evenings' session was essentially concerned with the axiological aspects of psychodrama and not the actual drama itself, may be a point well worth considering. The members of the panel had started out with the assumption that they were to be involved primarily in a discussion of the nature and sources of resistance by professional persons to involvement in psychodrama, rather than to an actual demonstration of psychodrama. It was probably a source of confusion. The appearance at the bottom of the program of the work "demonstration" apparently built up the expectations of the audience while the members of the panel had come to the meeting with the intent to discuss the theoretical aspects of the topic.

Whether by intent or by accident, the evening's experience was itself an example of the fact that resistances or blocks to the participation by professional persons in a psychodrama before a large audience do occur.

In essence, the psychodrama was the action in the audience. The audience members themselves were the protagonists, with various directors and auxiliary egos acting as a chorus for individual audience members, supplying immediate repair for some of the instant brutality that passed for closure. There were attempts to break down "stylized" techniques through spontaneous action. Most of these attempts were met with reproach. There was a real fear of actual involvement and the invisible man was much present.

Three questions were raised:

(1) Does the Director have the right to "refuse to direct," even when the audience claims need and love?
(2) Can auxiliary egos over-stimulate?
(3) Where is reality and who is real?

# PSYCHODRAMA OF ADDICTEDNESS

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My experience in psychotherapy of the addicted at the House of Detention for Women in New York City was a psychodrama performed spontaneously by the inmates who acted out the roles of the pusher and the addict trading heroine on the street.

After this they staged a family gathering presumably in the home of one of the addicted women, parents, brothers and sisters, neighbors and one mysterious being "the criminologist," all waiting to hear the story of addiction of one of their own.

The family members, supposedly ignorant of what had happened displayed the misunderstandings, derogations and rivalries within the family life that had taken place, were part of the background and part of the loneliness and despair that may have caused the addiction of one of the members of the group who felt cheated and left out. In the beginning of the performance it was the role of the criminologist to announce that there was a cure and a place where addicts could be cured when submitting to treatment. In later performances one of the family members brought up the question of cure.

In evaluating the psychodramatic acts it was important to spot some motivation towards changes e.g., the addict who in the street scene opposed the offers of the pusher and rejected to buy "the stuff." Another element of testing motivation for change was the role of the mother, sometimes suggested to the therapist by the inmates.

In this performance the mother took a naive approach, in wanting to share the problems of the addicted child she resolved to become an addict. At this point the performance took a turn toward vehement expressions, and a presentation of the insight into the dangers of being an addict, the isolation within society, and the disability of establishing a normal life.

There were other psychodramatic elements in the actual life of a detained person, one of them at the time of departure-an inmate leaving, going free again. These were some of the largest group therapy meetings with everyone wanting to be present at least as part of the audience of the scenes that developed. At one of the last meetings a young, intelligent woman, who felt strongly that she had rid herself of the desire for drugs at this stage, presented to the group her new-found philosophy of defiance, She planned to go right back to the same environment and "show them" right there where her

failures had occurred, demonstrating her new convictions. She ended up with the statement "We used to think that the others outside of the life of the addict were the squares. The truth is that we are the squares because we were the ones who repeated our failures again and again without learning anything from our defeat."

When it comes to actual proof in statistic figures of improvement, this would be hard to achieve in a population so prone to asocial problems. Control groups would have to be set up. Then more planned experiments may fulfill these conditions for evaluation. However, forms of psychodrama as described here may present part of such a process of reeducation.

# MUSIC, THE EMPATHIC BRIDGE TO COMMUNICATION

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Van De Wall states that Music is essentially a harmonizer and it tends to make more harmonious the conflicting forces within the mentally ill and even helps to adjust to the laws and customs of society.

In order to get a deeper appreciation for Music Therapy let us turn back the "Pages of Time" and investigate how Music was used as a form of therapy thousands of years ago. It has been established that four thousand years ago the priest-doctors of Egypt had a favorite incantation in Music purported to have a favorable influence on the fertility of women. The Hebrews used Music in several cases of physical and mental illness, the most famous being that of King Saul who at the time had been in a black depression. David was called to the palace to play lively music on his harp which in turn dispelled the depression. Plato also regarded music very highly. In his Republic he stated that health in mind and body could be obtained through Music.

The first use of Music as a regular therapeutic agent is attributed to Zenocrates, an ancient Greek who used harp instrumentation to quiet the wild outbursts of the severely mentally disturbed and it was then learned that soft music had a soothing effect and that lively music had a stimulating effect.

A few centuries later in the United States, an enslaved people made great use of music in group psychotherapy. During this time the negroes composed songs to express their moods and everyone in the group contributed to the lyrics or/and the music which in turn enhanced catharsis in the musical therapeutic sessions. It may be noted that the effect of spirituals and work songs of the southern negroes made life endurable under very difficult circumstances. It can be hypothecated that an individual, whether actively or passively participating in a music session, seems to respond from his own emotions and an empathic bond is established among those who are exposed to these sessions.

Further, music with its ability to stimulate individual emotions penetrates the barriers of illness and the response to the music is elicited by the needs of the individual regardless of his particular handicap.

As a music therapist one would not expect a regressed catatonic schizophenic to relate immediately to a group as an active participant, but with the help of the "empathic bridge" of music to which he responds as a

person and to which others may respond similarly, he may share his experiences. After a period of time this bridge may be widened to include others without too much fear and he may feel at least temporarily that he can accept and be accepted by the group. It is important to note that he will respond when ill, to the same or similar forms of music that he did when well.

In conclusion music therapy is used to strenghten the individual's respect for himself through the use of a nonverbal form of communication and so enables him to relate to others to the degree that he feels rapport with the music therapist or the group and to that degree he will be able to lay aside momentarily the behavior patterns which isolate him.

In retrospect, music has its place in the total picture of rehabilitation when the individual, in spite of his difficulties can use it through the help of music therapy as a means of communication or emotional expression.

# EXPERIENCES IN GROUP PSYCHOTHERAPY

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This is the first group meeting after a four-week vacation.

No patient arrives on time. The first, Jack, is 10 minutes late. He has the same Austrian background as I, and we engage in superficial conversation.

Helen comes in a few minutes later. Standing, she looks at Jack and me and says: "I don't want to interfere in this private conversation; I'd better leave." I answer: "Sit down, Helen, and help us to start the group."

Helen mentioned before our vacation the possibility of being pregnant. Now in answer to Jack's question, she says she is sure and is happy about her pregnancy. Both state that they had a good summer: Jack is satisfied with his work, Helen with her marriage, and there is nothing to talk about.

Abe appears and asks critically, "That's the whole group?" Now all three patients ask me how *my* vacation was. I smile and say, "Thank you, fine." Now, 20 minutes late, Dorothy comes in and apologizes for being late; she had to finish cleaning her apartment. These four members constitute the group for this session. Dorothy asks whether I heard from Saul, a patient who had left the group two weeks before the summer interruption. The other three also want to know about Saul, and what happened to him.

This topic brings up several themes. Why did the therapist not prevent Saul's dropping out? What will he do without therapy? Was it not the therapist's anger or irresponsibility which caused his leaving? Or were there other mistakes in handling it? Abe had met Saul socially during the summer and tried to convince him unsuccessfully to continue therapy. Jack feels guilty, because though concerned about Saul, he disliked him and prefers a group without this patient. Dorothy defends the therapist; she is glad that Saul is out. Helene has no opinion. The therapist openly admits defeat; she could not help Saul, whether he had remained or left. The members know that Saul had over 20 therapists in the last 10 years.

After a few minutes of silence, Dorothy brings up doubts about her individual treatment. She is in conjoint therapy with two therapists and asks whether she should continue her individual sessions which are not helpful to her. On the other hand, the thought of giving them up makes her sad and tearful. The group becomes lively and interested. The discussion shifts toward an evaluation of Dorothy's therapeutic progress or standstill during the summer; her involvement with a rejecting boyfriend and an irresponsible

father are taken up. Intepretations and advice to leave her father and how to relate to her boyfriend make a lively interchange, which continues between patients even after the official 90-minute session ends.

That is approximately what happened between the 4 members present in the first session after a summer interruption. Now let me tell you what I thought and felt about it.

After the initial stalling and floundering discomfort, the group found a topic around which their doubts about therapy could crystallize: Where is Saul? This surprised the therapist because Saul, a rigid paranoid personality, had talked at length about his dissatisfaction with the group and the therapist, and had been absent the last two sessions before the summer interruption. But here it was, the emotional interchange; "who is responsible, am I my brother's keeper, or should only the therapist be responsible how far does responsibility go?" etc. Nobody said to the therapist: "Do you care for me? Will you want to, will you be able to help me?" But this indirectness did not matter to me. The interaction became genuine and everybody, therapist included, became more aware of inner feelings and motivations, and the individual differences of these in each of us.

*Jack* especially, the fellow of Austrian background, a homosexual of great intelligence and talents, and a life style of successful intellectual defenses who, until this session, had felt superior to all group members, expressed for the first time, together with his guilt feelings, genuine anxiety: "What will happen to me if I, like Saul, cannot change? How terrible that Saul's life is hopeless. But why should I be so upset about his leaving, though I dislike and despise him?" Jack's sudden identification with Saul and his confusion was a novel experience for him and for all of us. In contrast to Jack, *Abe* has a life style of masochistic savior, caring for the helpless with whom he identifies and who have to appreciate him so that he can accept himself; he had made many futile attempts to convince Saul to continue group treatment. Now Abe had tried and failed to be the "super therapist." The therapist made only an internal note of Abe's savior complex. The neurotic need to strive for self acceptance through others caused severe conflicts petween him and his wife. Any interpretation of this connection, at this point, would have only disturbed the emotional interaction occurring in the group.

Each patient was preoccupied with anxiety concerning therapy and the therapist's integrity. Each coped with his anxiety in his own idiosyncratic way: Abe expressed his life goal: "I'll be able to do better for Saul and help him;" Jack desperately asked for reassurance that he is different from

and better than Saul; Helen quietly withdrew because she felt unable to cope with the problems floating around her; Dorothy supported the therapist ("Saul's absence is o.k.") and expected to be supported.

All these emotions and thoughts were expressed indirectly and certainly not recognized clearly by anybody. When a short silence occurred, I experienced it as a breathing spell, a period of recovery in which the tension in the group ebbed away; the tension which had been verbalized mainly by the two male members, but which seemed to have gripped everybody, even though Helen remained silent and Dorothy had said only a few words. A new topic emerged when Dorothy introduced her confusion concerning her two therapies. Her basic conflict between overwhelming dependency needs (satisfied in her accepting, warm relation to her individual therapist) and her fear of closeness because of a compensatory need for rebellious self-assertion (frequently shown to me in the group) poisons her love relations and prolongs an ambivalent attachment to a widowed father whom she despises. Does she have to renounce one close relation to win another? The "leitmotif" of this session, doubts about therapy, continues, but a new tune emerges: insecurity in all relations; the more needed, the more feared. Helen, the newly and happily married one gives advice to Dorothy because she has just gotten over some of these fears. Dorothy wants the group's sympathy, which she gets. But she does not see any way out of her present conflict.

Using the group session with the 4 members (they were later to be joined by 4 others still on vacation) as an illustration, I would like to present to you one more point: All right, if the therapist is so smart and has so much more understanding of the meaning of the group process than the patients themselves while they are interacting, why, then, were not some of the therapist's insights communicated to the patients? Why did the therapist choose not to intervene and interpret? Did the group move without interpretation in a therapeutic direction by 1) re-creating an atmosphere of trust, of open communication and mutual involvement; 2) promoting the patients' self-understanding and awareness of others; 3) activating them toward growth and healthy behaviorial changes? Was all this achieved in the session just described without the therapist offering any interpretation?

In my retrospective evaluation the group's initial reluctance to get involved was dispelled by the single phrase: Let's work together to start the group. The anxiety aroused by Saul's leaving was neutralized by an open and realistic admission of the therapist's limitations.

Dorothy then, anxious and unhappy, focused on her basic conflict between dependency and self-respect. The group members contributed, each in

his or her own way, emotionally and constructively, I thought, to clarify and find a solution. Perhaps specific interpretations would have been meaningful at this point. The patient's dependency on each therapist, on the father, on the boyfriend, neurotic demands, destructive doubts about her ability to be a person in her own rights, masochistic rebelliousness, etc., etc. could be pointed out. It is essential that the therapist understands this patient's basic conflict. The therapist's insight becomes a blueprint for therapeutic strategy, so that all transactions in the group can be evaluated within the movement toward healthy growth. Even if the members' contributions are fragmentary, contradictory and sometimes mutually exclusive, Dorothy feels that her behavior and feelings make sense for them, that they accept her. This is reassuring and strengthening for Dorothy. Within the framework of her central conflict, fear of and need for an authority figure, any interpretation from my side may have increased her difficulties and resistance. In earlier sessions she had shown an attitude of "help-me-but-only-my-way." At present she wants 'answers' but what she accepts is reassurance. She is not ready for clarification suggesting a real change of cognitive awareness that she could gain independence from her parents' influence by an attitude different from the one which so far had been most helpful to her. She is afraid of losing her identity and is committed to self assertion. In growing up she has to learn the next step: to discriminate between destructive and constructive influence. Psychological growth occurs through integration of new experiences and ideas offered constructively by a knowledgeable person.

This paper has dealt with timing of interpretations in the group setting. During the emotional heat of manifold interactions the therapist rarely has time for a thinking choice. He has to use his intuition based on experience and on his healthy attitude toward people in general.

In conclusion, convince the patient that you understand and respect his need for continuity, for remaining "a person." Don't get angry and frustrated if a patient doesn't change as quickly as you would like him to, but consider it a challenge to help him be less anxious about his integrity and to learn new modes of perceiving and coping. Prove to him that change will pay, even if at the beginning it may be uncomfortable and frightening. You will be able to make him see the possibility and the reward of changing if you start to look at the world through his eyes, if you understand thoroughly his fears and his needs.

# AN ADAPTION OF A SOCIOMETRIC TECHNIQUE IN COLLEGE TEACHING

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## THEORETICAL BASIS AND RATIONALE

With its theoretical basis in the legion of literature pertaining to the motivational importance of personal involvement in purposeful behavior, the present researcher has assumed that college student participation in planning socialized research has definite educational advantages as well as specific positive outcome in human relations development and resource development. Atkinson (1966), Atkinson and Walker (1956), and Murphy (1944), have reported research which bring the position of social affiliation into focus. Similarly, Grosbeck (1958) has, in research pertaining to social description and configuration of motives, given emphasis to the function of these variables in achievement.

It was hypothesized as a result of cursory observation of experiences in teaching introductory (general) psychology courses during the past five years, in both small suburban and large metropolitan college settings, that sociometrically determined participation in group research planning, design and execution leads to increased learning, small group participation, general class performance and learning.

It is contended by Moreno (1965) and others that consideration of the social interactional relationships, as "not just a collection of individual differences," but as the "motive of the embryonic matrix, the underlying sociometric or group matrix," that is markedly important in exploring group structure with a view towards facilitating learning. Moreno (1934 and 1959) has further emphasized the value of exploiting social relations among task-oriented groups through consideration of sociometric parameters.

## POPULATION AND PROCEDURES

Eight unselected, co-educational classes of undergraduate college students, practically all of whom were under 21 years of age, comprised the population which totalled 188. The median student age was 20.4 years. The mean class size was 20.3.

In the instructional context of a series of 15 weeks of lectures by the present instructor, in which at the second class meeting a socialized research

plan was described and set into action, small groups were defined differentially according to a reflected model of sociometric determinancy as defined by Moreno, et al. (1950) or, in an arbitrarily determined way by the instructor, under instrumental motivational conditions. The age and sex distribution of these groups is presented in Table I. Here the operant instrument consisted

TABLE I
AGE AND SEX DISTRIBUTION OF SOCIALIZED RESEARCH GROUPS

| Groups | No. of Males | No. of Females | Mean Age |
|---|---|---|---|
| | Sociometrically-Structured Groups | | |
| I | 14 | 4 | 19.50 |
| II | 14 | 6 | 21.07 |
| III | 17 | 4 | 22.00 |
| IV | 15 | 5 | 20.10 |
| V | 11 | 4 | 19.56 |
| | Arbitrarily-Structured Groups | | |
| I | 15 | 4 | 19.21 |
| II | 14 | 7 | 20.10 |
| III | 18 | 2 | 23.02 |
| IV | 14 | 5 | 20.17 |
| V | 11 | 4 | 19.08 |
| | 143 | 45 | |

specifically of the traditional college ones—"positive" marks (Sx or S) provided group responses were satisfactory and "negative" marks (S— or U) if, on the other hand the group response proved to be inadequate, as evaluated by the course instructor.

The socialized research program under the sociometric design consisted of (1) describing to the entire group the values of such learning procedures for them and for more effective and meaningful research in a broader sense, (2) defining several socialized topics in psychological research areas for class pursuit; (3) defining and setting into action a sociometric plan consisting of each person forming with others into small groups based upon a common interest or needs to pursue in pursuing one of the areas or upon his subjective interest to be associated with the other members of the group for any reasons growing out of general class association or participation; (4) and promoting group structure—defining its purpose in relation to a selected research topic, electing a group leader to provide over-all leadership within the group and provide coordination or liaison with the total class research program, and electing a recorder to keep progress notes and collate the general

overall group research report. Under the arbitrary structure, the design was different from the sociometric design in that the instructor assigned each of the students to a group with four other students, one of whom he designated leader and the other recorder, based upon his subjective judgment of their relative capacities for leadership as reflected in their class participation.

Each group met separately during the beginning 20 minutes of each subsequent six classes to evolve independently with minimal instructor direction to discuss their research areas and evolve objectives, goals, procedures or plans, and to collate their findings. Groups held additional group meetings as optionally decided upon by the group, based upon requirements for progress. Divisions of labor and individual roles of preparation were determined and carried out. Finally, at the two sessions immediately prior to the final class meeting each group presented an oral and a written report of the group research to the class. Oral presentations were either by the group leader, by individual member presentations, or by group panel or seminar. Written summaries of the research reports were in the form of coordinated group written reports. An instructor's combined evaluation of each group's socialized research report was made, and using the following instructor subjective scoring system, a letter grade was assigned to each: 1) outstanding reports were rated "Sx"; 2) satisfactory reports were rated "S"; 3) slightly below satisfactory reports were rated "S—"; and 4) unsatisfactory reports were rated "U." Finally, member rankings on a five-point continuum of the degree of participation of each group member were also obtained.

The continuum points are as follows: 1-excellent participation 2-good participation, 3-average participation, 4-fair participation, and 5-poor participation.

## Results

It evolved rather sharply that the socialized research groups in which sociometrically-designated models were adhered to achieved considerably more educationally than those students of the groups which were arbitrarily-designated by the instructor. These results hold with regard to the specific goal-directed activity—the socialized research—as well as in regard to the general achievement in the class. It appears that the former group surpassed the latter in motivational activity, from insight-seeking discussions, because the sociometric selection model reduced the risk-taking aspect of their learning situation, thereby permitting educational growth to occur more readily.

Atkinson, et al. (1960) conducted studies which provide evidence of the theoretical basis of risk-taking model in achievement motivation. Such was

indeed the consideration of the instructor-researcher in designing this learning experience for the college students.

Besides the superiority in overall class achievement which is not analyzed in the present study, as indicated by the instructor's assignment of the traditional letter grades, superiority in both instructor grade assignments to the quality of a combined oral and written report of the socialized researcher clearly favored in general the sociometrically-designed groups—those with a built-in risk-taking gradient. A similar picture obtains when the member-ranking factor is analyzed. Analysis reveals a preponderance of "excellent" and "good" participation by the groups with sociometrically-designed structure.

The results pertaining to the combined instructor's evaluation of the socialized group reports are presented in Table II. They show that 78% of

TABLE II

COMBINED INSTRUCTOR'S EVALUATION OF SOCIALIZED RESEARCH GROUP REPORTS

| Groups | Sociometrically-Structured Groups Evaluations | | | |
|---|---|---|---|---|
| | *SX* | *S* | *S—* | *U* |
| I | 8 | 0 | 0 | 0 |
| II | 7 | 1 | 0 | 0 |
| III | 8 | 0 | 0 | 0 |
| IV | 5 | 3 | 0 | 0 |
| V | 3 | 4 | 1 | 0 |
| | 31 | 8 | 1 | 0 |
| | Arbitrarily-Structured Groups | | | |
| I | 1 | 4 | 3 | 0 |
| II | 2 | 5 | 1 | 0 |
| III | 1 | 5 | 2 | 0 |
| IV | 4 | 3 | 1 | 0 |
| V | 0 | 8 | 0 | 0 |
| | 8 | 25 | 7 | 0 |
| | 39 | 33 | 8 | 0 |

the sociometrically-structured group evaluations were assigned the instructor's rating of "outstanding," while only 20% of the arbitrarily-structured groups were assigned the "outstanding" rating by the instructor. Twenty percent of the sociometrically-structured groups achieved "satisfactory" ratings by the instructor. Combined with the "outstanding ratings," this comprised 98% of

all the reports assigned "positive" ratings by the instructor. Therefore, only 2% of these groups presented reports which were evaluated below "satisfactory" and "unsatisfactory," or "negative," by the instructor. The arbitrarily-structured groups, on the other hand, while showing a total of 82% "positive ratings," achieved a large preponderance of these at the "satisfactory" level. Table II shows that sixty-three percent of these ratings were "satisfactory," accounting to a major extent for the 82% total "positive" ratings for these groups. Twenty percent of the reports of these arbitrarily-structured groups were assigned slightly below satisfactory ratings, comprising the total percentage of "negative" ratings.

Table III presents the results pertaining to the member rankings of the

TABLE III

MEMBER RANKINGS OF PARTICIPATION IN SOCIALIZED RESEARCH

| | Sociometrically-Structured Groups | | | | |
|---|---|---|---|---|---|
| | Rankings | | | | |
| Groups | 1-Excellent | 2-Good | 3-Average | 4-Fair | 5-Poor |
| I | 16 | 1 | 0 | 0 | 1 |
| II | 3 | 7 | 8 | 2 | 0 |
| III | 15 | 2 | 0 | 1 | 3 |
| IV | 14 | 4 | 0 | 2 | 0 |
| V | 12 | 0 | 0 | 3 | 0 |
| | 60 | 14 | 8 | 8 | 4 |
| | Arbitrarily-Structured Groups | | | | |
| I | 10 | 7 | 2 | 0 | 0 |
| II | 2 | 6 | 10 | 1 | 2 |
| III | 4 | 2 | 4 | 8 | 2 |
| IV | 2 | 4 | 8 | 4 | 1 |
| V | 1 | 13 | 0 | 1 | 0 |
| | 19 | 32 | 24 | 14 | 5 |
| | 79 | 46 | 32 | 22 | 9 |

extent of their individual participation in the socialized research projects. Among the sociometrically-structured groups, 63% of the members were ranked by the members as "excellent" in their performances in the accomplishment of the group research goals, while only 20% of the arbitrarily-structured group members were assigned the rank of "excellent." Thirty-four percent of the latter group, however, were assigned "good" rankings for participation, with only 15% of the former group being assigned this ranking.

Nine percent of the members of the sociometrically-structured group were assigned "average" rankings with an appreciably higher number, or

25%, of the arbitrarily-structured group assigned "average" rankings. Combinations of percentages of rankings show that 87% of the members of the sociometrically-structured groups were assigned ranks of "average" or better for participation in the socialized research projects. 80% of the arbitrarily-structured group members were assigned ranks of "average" or better.

Nine percent of the sociometrically-structured group members were assigned "fair" rankings, while 16% of the arbitrarily-structured group members were assigned a "fair" ranking.

Four percent of the sociometrically-structured group members were assigned "poor" ranks for participation by the group members themselves, while a slightly larger percentage, 5%, of the arbitrarily structured group members were assigned the lowest rank.

Combinations of percentages show that 13% of the students in the sociometrically-structured group were assigned "below average" rankings, while 21% of the members of arbitrarily structured groups were assigned ranks of "below average."

In the sociometrically-structured groups, numerous reciprocal member attractions were observed although not actually measured as to their intensity or extensity. It was obvious even on observation that the group members mutual fulfillment that roles were enhanced in the group interaction. While the specific bases for their reciprocal attraction were not statistically analyzed, it is obvious that an array of characteristics, mental, artistic, social, cultural, religious, and racial, which Moreno listed, (1950), were operative in the process.

In the initial meetings of the sociometrically-structured groups, which were announced to be "open," there was considerable motility as members searched to find the group into which they fitted. Some persons quickly identified themselves with a group; a few individuals were unsettled or "isolated" even at the class meetings at which their reports were presented. The sociometrically-structured groups held considerably more outside class meetings than the arbitrarily-structured groups. Their cohesiveness and esprit de corps were obvious. They prepared their reports generally in sufficient copies for each class member to have one—a feature totally absent among the arbitrarily structured groups.

## Conclusions and Implications

It is evident that the trends observed in this pilot research support the hypothesis that through a structural design of instruction, in which socialized research projects are conducted by sociometrically-determined, or structured groups—a model which is programmed to serve "a risk-reducing function,"

learning and participation towards achieving the learning goals are decidedly enhanced. This model may prove to have a motivational value in fostering numerous achievement activities of both an educational and industrial nature in which small group participation is involved. The application or replication of the design for utilitarian purposes used here remains, of course, contingent upon refinement and elaboration of the approach focused upon in the present research. It would be particularly cogent to the body of social interactional research to evolve analyses of the actual socigrams of the groups.

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# ROLE REVERSAL*

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Mr. Chairman, Dr. and Mrs. Moreno, Ladies and Gentlemen:

The genesis of role reversal is not only one of the most admirable but also the most paradoxical feature in the development of psychodrama. To paraphrase J. L. Moreno, role reversal was the third psychodramatic revolution.

When Moreno first stood up against literary drama and the theater of his time, he did so in the name and for the purpose of liberating stage creativity from the dead weight of literary achievements, from sterile ruminating on stored-up, canned, "conserved" theatrical staples, from second-hand recreations of some playwright's preformed, and vastly immutable, vision. To Moreno, the playing, not the play, was the thing. Moreno's drama was to emerge from the performance, not the other way round.

Thus came into being Moreno's Theater of Improvisations, his revolution number one.

Moreno's actor freely ad-libbed, on the spur of the moment, and in response to the extemporizations of his co-actors, the emotions, the speech, and the peripeties of the character created in the very process of the impromptu performance.

This deliverance from the corpse embrace of the written play could not for any length of time gratify Moreno's idiosyncratic craving for absolute creativity. Though the actor had been freed from the bonds of a prescribed text and plot, he was still restrained by the impersonation of historically coined characters. He still portrayed a soldier one night, a revolutionary the night after, and a dreaming poet the after afterevening.

Moreno's second revolution liberated the actor from the fetters of extraneous characters. The central notion of Moreno's new theatrical attempt—considerably more than the first one his original own—became SELF-ENACTMENT. The gist of Moreno's defying credo at that point in time was, Why should anyone enact anyone else? He shall and will enact, and through enactment create, himself!

Generously endowed with twenty-twenty hindsight, we see clearly now how sound, how logical, and how timely the transition to this second phase

* Presented, in slightly different version, at the Second International Congress of Psychodrama in Barcelona, Spain, August-September 1966.

had been. Enriched by the experience of the first revolutionary span, Moreno's actor had now the skill and the will, the freedom and the courage to enact himself, to master his groping, ambiguous, multiple self.

And what made him do such with increasing eagerness was the discovery that self-enactment, besides offering the fascinating innovation of the protagonist being his own dramaturgist and his own dramatic creation, yielded also the unexpected additional boon of catharto-therapeutic gain and psychal integration.

But at this ascending stretch of psychodrama's history psychodrama was still a long way from the startling—and crucial—concept of role reversal.

Indeed, at this point we were farther from it than ever before, because by definition and intent self-enactment strictly precluded the enactment of anyone else.

This being so, how come the antithetic emergence of role reversal? When and why did Moreno's actor begin to enact, of all alien things, his antagonist? Was self-enactment, like its predecessor, improvisation, incapable of dispensing the ultimate fecundity of self-actualisation? Was there in the old literodramatic model something else that continued to confine and to hold back creative self-revelation and revelatory self-creation?

For answers to these questions we must return to our—and Moreno's —point of departure, to literary drama. This retrogressive detour may be something of a nuisance, but if we bore you, bear with us. It was at a spiraling bend of psychodrama's progression, faintly reflected in our sketching of it, that role reversal had been born, a concept and tool surpassing in originality everything Moreno had achieved theretofore and destined to give sense and direction to his complete break with the theater and to his conscious ralization of psychodramatic therapy.

Now then, what last inimical principle was there in literary drama that Moreno had yet to overthrow to complete his revolutions?

As we have tried to formulate it in another context,[1] literary drama presents artistically structured human action. But it is not just any kind of action drama is interested in. Drama portrays the action of conflict and struggle. A dramatic utterance, unlike a genuine prose sentence or lyrical line, is, at least in principle, a tactical move, an "act" of aggression or defense. Every slice of true dramatic dialog is a skirmish. One of the basic nomenclatures for dramatic speech units is "riposte"—a fencing term.

[1] *International Journal of Sociometry and Sociatry,* Vol. III, No. 1-2, 1963, Beacon, N.Y.

And that is not all.

It is not just any kind of conflict that drama portrays. Commercial and doctrinal-propagandistic quasi-drama excepted, literary drama is built on the premise of ongoing, perpetual conflict.

Drama, to be sure, is always contaminated with ideology and non-dramatic literary components, with passages of an explanatory, philosophical, descriptive, or poetic character. Worse than that, for many internal and external reasons drama must and can portray only limited, episodal confrontations. Every play must have an end. And drama abounds in deus-ex-machinations to bring to a formal conclusion any given, time and structure bound, single dramatic work. But we entirely miss the point if we attach undue significance to the outcome of a play. The end ends only the play but not its message of unending conflict. The contest, not the score, is the thing.

The Greek tragedians, the unsurpassed masters of the art, were fully aware of the formal limitations of a single production. In fact, it was they who had imposed on the stage play the three restraining esthetic norms, the three unities of place, time, and action. In rational conformity with its inherent scope, the Greek play was a single dramatic episode taking place within one day at one spot.

At the same time, and in order to manifest that strife, unlike the play, was not transitory, the Greeks invented the device of trilogy. The very same protagonist who had somehow brought one lethal controversy to a conclusion in one play became the source of a yet fiercer, bloodier, conflict in the next tragic episode, thus adding personal guilt to the misery of anirenic impersonal destiny.

Whatever the merits or demerits of "Who Is Afraid of Virginia Woolf?", a play so far removed from the Greek tragedy in time, in form, in content, and in ethico-esthetical intent, its basic dramatic message is still perennial rage, exhausting but never exhausted dramomachy consuming the confronting parties, each one of them innocent victim and vicious nocent in unending virulent strife.

(To round up the survey, the most recent dramaturgic innovation has only replaced eternal interpersonal enmity with the just as perpetual existential collision between the rational and the absurd.)

This horrifying rigid, uncompromising, *tragic* aspect of literary drama, as we conjecturally assume, must have exerted a double effect on J. L. Moreno, who had in the meantime become Moreno, M.D.

Dr. Moreno could hardly have escaped noticing the amazing similarity between the patterns of the litero-dramatic and neurotic fabrics. And he

could hardly have failed seeing that it was precisely the relentless drive to absolute self-enactment that was inescapably leading all opposing dramatis personae into the dead-ends of everlasting confrontation and mutual sterilization, if not annihilation.

It must have been this final insight into the obsessional textures of literary drama, neurosis, and self-enactment that energized Moreno's complete break with the theater, his relinquishment of literary drama for psychodrama and of the theater for therapy, that triggered the creation by him of his most striking, and this time, *anti-dramatic* innovation aimed at complementing contest-generating self-enactment with collision-abating other-enactment, which is role reversal. A break that later, when he was judging a certain interpretation of psychodramatic techniques to be "from a theatrical rather than psychodramatic point of view," enabled him to say: "These two positions are diametrically opposed. Indeed, it is very unfortunate that we use the same terms for two operations that differ so strikingly."[2]

As the term implies, role reversal means an exchange of roles, an exchange of positions; conceptually, role reversal means transcendence of self or of self-component; in practice, role reversal is a gradual, cautious technique of outsight training.

Initially, the protagonist, upon assuming the character of his "opponent," may actually intend to act as the "devil's advocate"; he may try to 'prove' the legitimacy of his hostile position. Yet the effect of the mere consent to relinquish one's own self, be it ever so deceptively or superficially, the very attempt to desist from the stance of confrontation, the sheer movement to the "other side," is of unfailing value. And there is, potentially, an increasing momentum in the effect. Properly conducted, the ongoing process naturally compels the psychodramatic protagonist to deepen and to widen his empathic identification with the opponent, just as this same process compels him to see his own self-enactment through the eyes of the adversary or adversary substitute (auxiliary ego) who now portrays him.

It cannot be sufficiently stressed that the optimal outcome of role reversal is not merely a rational settling of arguments, although it obviously is partly that, too. Nor is it group-induced acceptance of an ethical precept, something like "Love Thine Enemy," though, quite naturally, it is that too. If anything, it's living one's enemy, in an atmosphere of freedom and supervision, of self-will and nonthreatening external control.

It is therapeutic growth.

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[2] Personal communication.

The effect of role reversal is an approximation to a total reorientation of the three images of the self, the other, and the reality situation.

In the cumulation of successful attempts—they are, of course, not always, and never completely, felicitous—the psychodramatic protagonist-patient learns to step out of the boundaries of the self into the interiority of the real or presumed antagonist. He is increasingly the self and the non-self, the I and the He, attainably proximal to a state of We, in which sadistic triumph, masochistic submission, and obsessive stalemate lose their emotion-, goal-, and behavior-determining power.

It is because of role reversal's unique purpose and exclusive potential to transform confrontation into contact and beyond that into co-agency through means other than logico-persuasive or purely analytic but by means of life-like, experiential training for these goals, that we, in conclusion, deprecate the abuse and trivialization of this ingenious therapeutic technique and its amateurish perversion into a gimmick freely dissipated for its effect on the onlookers rather than for that on the patient and the serious task at hand.

This paper, like its serial predecessors, has consciously restricted itself to one subject. We have carefully avoided as much as an allusion to the specific operative force psychodrama counts on, that is, to Spontaneity, Moreno's other great therapeutic concept, or to such practical questions as the applicability and effectiveness of role reversal in the treatment of psychoses and the expendability of psychodrama to inter-group confrontations.

We hope to deal with these subjects and questions in future papers at subsequent psychodrama congresses a great many more of which we wish Dr. and Mrs. Moreno to attend and to inspire.

# ABSTRACTS AND SUMMARIES

## DIRECT NEUROPSYCHOLOGICAL TREATMENT, A NEW APPLICATION OF ELECTRO SHOCK THERAPY (ECT)

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Although ECT has been in use for over twenty-four years, studies establishing criteria for treatment and predictions of results are still lacking. Results of past studies may seem to be contradictory because of the failure to recognize the dependence of behavior on certain neurophysiological parameters. These parameters have never been elucidated because ECT has proceeded largely on an empirical basis, without a model which can predict the effects of treatment. The proposed model leads to the definition of parameters not previously considered by clinicians, a resulting hypothesis regarding the effects of the treatment, and directions for administering more effective treatment. Furthermore, the model reconciles the seemingly contradictory results of previous studies, suggests new applications of convulsive treatment, and, hopefully, will lead to the needed studies being carried out.

The proposed model considers attention to be the "selector" of the contents of consciousness. By directing the patient's attention strongly to his worst neurotic or psychotic symptoms (hallucinations, compulsions, etc.) the neural circuits correlated to these thoughts are "selected." Administering an electric current (ECT) at that instant produces a power surge through these "selected" circuits, rendering them refractory to further excitation, and *peri passu,* ablating the correlated psychopathological thought. The resulting hypothesis for treatment is as follows:

### HYPOTHESIS

If the patient's attention is directed strongly, by hypnosis if necessary, to his most disturbing feelings and imagery (e.g., actively hallucinating, not just imagining he is hallucinating; carrying out a perverse activity, not just imagining doing so) and if he is instanter given ECT (awake) there should result a significantly greater improvement than that obtained with ECT given in the normal way. Patients whose psychopathology was refractory to all previous treatment would thus become accessible to treatment.

In an experiment to test the null hypothesis (that there would be no significant difference between results of ECT given with anesthesia and given

according to this proposal) hospitalized patients whose obsessions, compulsions, hallucinations, and delusions had failed to respond to ECT given with anesthesia were treated in accordance with the hypothesis above. All recovered from their psychopathology immediately and were discharged from hospital within a few days.

## AN EXPERIMENT IN POETRY THERAPY

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### BACKGROUND

This study is an attempt to validate an earlier study at Slippery Rock State College which determined that seven of eight subjects improved emotionally by means of 26 hours of poetry therapy at the college clinic. In this study it was not possible to keep the control group intact since four of the seven asked for individual treatment during the period of the experiment—as was agreed upon designating them members of the control group.

### HYPOTHESIS

The symbolism in poetry provides an effective tool in group psychotherapy with emotionally handicapped college students.

### METHOD

Eight college students with a mean age of 19 and a mean IQ of 118 entered into group psychotherapy involving poetry as the tool to effect abreaction and insight. The students have been accepted by means of a diagnostic battery including the Rorschach, the TAT, MMPI, and DAP in addition to a psychiatric interview. They have been matched with a control group which is receiving no treatment.

The group meets for two hours at the Indiana County Guidance Clinic every Tuesday. Poems which are judged to symbolically express problems the patients are repressing are read and free association follows. Analysis of patient reactions to the symbols of the poems constitutes the major effort of the therapy.

# CHARACTERISTICS OF COMMUNITY MENTAL HEALTH PRACTICE

RICHARD BROTMAN, PH.D.

*New York Medical College, New York*

We define "the problem," and our definition sometimes does not match that of the presenting source. Likewise, we try to reject ritualistic solutions, which might be popular and keep us in the treatment business, but which are beside the point.

Our diagnostic procedures include careful attention to social as well as individual variables.

We are more concerned with risk populations than with individual cases.

Research techniques are used to obtain data upon which action can be based. Research is usually an integral part of intervention, with instrumentation serving both as the basis for analysis and as a vehicle for communication.

Our intervention goal is generally systematic change; the technique for entry is the use of concrete case examples.

In our activities we distinguish organizational levels and maintain an awareness of the social structure in which problems arise and intervention occurs. Thus, for example, we plan programs with the faculty and consult with the school board on matters of direction. Or, when working with a patient, we join with the Department of Welfare line worker in planning services while engaging supervisory and administrative personnel on matters of policy.

Our activities embody a philosophy of social control which stresses communication rather than fiat. We are convinced that sumptuary laws are self-defeating—social health problems are hardly amenable to solution through legislation. We would be the last to deny that alcohol or the "dangerous drugs" are in fact dangerous, but we insist that the way the problem is usually handled, via the dis-integrative measures of condemnation and punishment, only makes matters worse.

Our ultimate goal is to prevent individual and social breakdown. This accounts for our focus on dysfunctional aspects of the social milieu and our attention to risk populations. We want to prevent destructive colliding between individuals at risk and certain control mechanisms of the social system.

In our present practice we most often choose to intervene at the individual-community interface. This requires our association with both the individual and significant representatives of the particular institutional sphere

in which pressure or discord is occurring. The kind of change we want to bring about—that is, the elimination of dysfunctional adaptation patterns in both the individual and the social unit, and the substitution of more successful ones in their place—can most efficiently be brought about through this bilateral approach.

## PSYCHODRAMA IN AN ADULT EDUCATION PROGRAM

ISRAEL ELI STURM, PH.D.[1]

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A series of psychodramatic and sensitivity-training sessions took place in courses offered as part of a nominal-fee Adult Education Program (Huntington, N.Y.). These courses were conducted by the writer for ten weekly sessions each, from 2-3 hours each session. The purpose of this note is to describe this experience so that, from a viewpoint of either "community mental health" or (as the writer prefers) education, such courses could be introduced more readily in comparable settings.

The first course (Spring, 1965) was described in the Adult Education brochure as follows:

> PSYCHODRAMA: A workshop of psychodramatic sessions with voluntary audience participation. The goal is to enhance interpersonal effectiveness by practicing self-expression and by playing the roles of others in different enacted situations. Emphasis will be on "sensitivity training" as used in community and industrial settings rather than on "group psychotherapy" as used in psychiatric settings. One way of summarizing psychodrama's focus: "See yourself as others see you."

This course was not held because fewer than ten registered for it. Because the course description might have been unattractive, the second course (Fall, 1965) was described in greater positive detail, as follows:

> PSYCHODRAMA: A workshop of psychodramatic sessions based on voluntary audience participation. The goal is to enhance interpersonal effectiveness by practicing self-expression and by playing the roles of others and of oneself in new situations. Emphasis will be on improving

[1] The writer wishes to acknowledge the cooperation of the directors of the Adult Education program who made these courses possible: Frank W. DeGraff and E. Robert Paris.

old roles, learning new roles, living out fantasies, preparing for future situations, self-criticism, personality expansion and improvement, and desensitization of interpersonal and audience discomfort.

This course was held, but sessions focused typically on students discussing their reactions to each other and to the group, rather than on role-playing *per se*. The writer used the sessions to try out a behavioristically-oriented "cue-response-reward" theoretical framework in which he attempted to distinguish and identify overlapping and diffuse components of fleeting interpersonal interactions.[2] The students seemed to profit from apprehending their personal impact upon each other and expressing previously neglected observations and wishes. In that some of its stated goals were partially fulfilled, the course appeared to have a satisfactory outcome, although such judgment is subject to the same errors as are any clinical assessments of therapeutic progress.

The third course (Spring, 1966) was described identically as the second, and had a similar outcome. There were three noteworthy phenomena in these sessions: (a) The students again generally by-passed formal problem-centered role-playing to concentrate on issuing and labeling verbal, tonal, and motoric communications while remaining seated. (b) There was present an in-group clique of "sophisticates" who were holdovers from the previous psychodrama course and who were somewhat inhibitory on the others. (c) The large number of registrants (23) was unwieldy, generating inhibitions and, alternatingly, an unmanageable volume of interactions, despite the 50% attrition by the last session.[3] To accommodate these considerations, the fourth course (Fall, 1966) was divided into two sections which were described as follows:

SENSITIVITY TRAINING I: An experimental workshop in group process and psychodramatic techniques. The goal is to enhance interpersonal effectiveness by: practicing self-expression, improving the discrimination of subtly-communicated interpersonal cues, expanding social competence through role-playing, and more accurately assessing one's own social stimulus value. Limited to an enrollment of 15.
SENSITIVITY TRAINING II: An extension of Sensitivity Training I for those who have had any experience or training in psychodrama, sensitivity training, T-groups, "self-awareness" groups, or other settings involving "group dynamics" principles. Limited to an enrollment of 15.

[2] This attempt at a "learning theory" approach resulted in a milieu apparently closer to T-Group sessions than to the generally more subjective, noteworthy "self-confrontation experiments" of D. I. Malamud. The writer's most frequent queries were: "What happened?" "What did he do to you?" "What did you do to him?" "For what purpose?" rather than "How do you feel?" "What associations come to mind?"

[3] Such attrition is not uncommon in Adult Education courses.

Sensitivity Training II did not receive sufficient registration. Sensitivity Training I was held and had a satisfactory outcome in that, again, some of the course's goals were partially fulfilled. Thus, there were occasional expressions of previously withheld but socially useful behaviors, suggestions of more facile social stimulus discriminations, applications of more sophisticated social response differentiations, and indications of somewhat broadened behavioral repertoires, derived from both direct interaction and role-playing. Most of the students in this course, however, were college-trained, and the writer felt that Adult Education courses should be directed towards the more typical, noncollege adult. With the goal of attracting less educated students, the fifth course (Spring, 1967) omitted mention of its orientation with regard to psychodrama, role-playing, or sensitivity training, and was described as follows:

> PSYCHOLOGY DISCUSSION GROUP: A forum for adults wishing to raise and discuss questions relating to the broad area of psychology. It is the responsibility of the students to provide discussion material. The instructor's role is limited to that of moderator and commentator.

Registration for this latest course was insufficient and it was not held, perhaps because of the uninviting phraseology of its description. But the explanations offered to explain the insufficient registration do not contraindicate the merit of psychodramatically-oriented courses, in this program, or in general.

In summary, a series of courses employing psychodramatic and sensitivity-training principles was offered in an Adult Education program. These courses seemed to serve a useful educational or "mental health" function as well as provide opportunity for further theoretical development of psychodrama and its corollaries. The writer has described his experience for the purpose of presenting a point of departure for others who may be interested in conducting such courses in similar settings.

## POETRY THERAPY

JACK J. LEEDY, M.D.
*Cumberland Hospital, Brooklyn, New York*

Project Teen Aid is part of the Office of Economic Opportunity (OEO) of the United States Government. It is sponsored by the Willoughby House Settlement and the Visiting Nurses Association of Brooklyn. Meetings are held every Thursday morning at 149 Oxford Walk, Brooklyn, New York,

which is located in the Willoughby Housing Development. Techniques of poetry therapy were discussed along with experiences within the group and the group responses.

It is the aim of the director to have poetry therapy groups established as part of the total treatment plan in every Mental Hygiene Clinic; in hospitals and rehabilitation units; as part of the Social Rehabilitation Unit of the Post Graduate Center for Mental Health in Manhattan; in day care hospitals; Senior citizen groups; children's and adolescents groups; in centers for the rehabilitation of alcoholics and drug addicts.

## PSYCHOEDUCATIONAL SERVICES IN A COMMUNITY MENTAL HEALTH PROGRAM

LILLIE POPE

*Coney Island Hospital, New York*

Psychoeducational Services are an excellent medium through which a Department of Psychiatry may provide Community Mental Health Services that are preventive as well as therapeutic. Such has been the experience of the Psychoeducational Division of the Psychiatry Department of the Coney Island Hospital.

The typical Psychiatry Department in a city hospital, mandated to serve those of limited economic means in its geographical area, has in the past found itself unable to reach the children referred to them by the schools for psychiatric help. The most frequently encountered reason for this difficulty is the resentment of the family upon being referred to a Child Guidance Clinic; the parents mistakingly see such a clinic only as a preparation for the referral of the child to a state hospital for commitment. Through the Schools program and the Learning Disabilities Clinic, this hospital has been able to reach this ordinarily inaccessible and unreceptive population and to provide children with mental health services at an age when prevention is still possible.

The approach is three-pronged: first is the recognition that hospital staff and services must be made available in the heart of the community—outside of the hospital plant, if necessary. Thus, the clinic team, staffed mainly by special educators, goes into the school building to observe the children who are referred to them by the school staff. The clinic staff also

conducts weekly therapeutic groups at the school, with participants chosen from referrals by the principal, guidance counselor and teachers. To provide a closer bond with the community, a nonprofessional member of the psychiatry department staff, drawn from the local community, visits parents in their homes to interpret to them the function of the Department of Psychiatry and its Schools program. She enlists their cooperation; at first, this consists of their giving permission for their children to be involved in the program. In later stages, the parents often become more trusting as they see the work done with their children, and many of them come in for counseling and group therapy.

The second aspect of the program is provided by the Learning Disabilities Clinic which is situated at the hospital. Most of the children referred by the school have emotional disturbances, as demonstrated by their acting out and disruptive school behavior, and in addition, have reading disabilities. When appropriate, tutorial services are provided at the hospital twice weekly for some of these children. Their parents, despite an initial resistance to the Child Guidance Clinic, are receptive to the idea of having their children helped with school problems. The children are willing and eager to attend a "learning" clinic and the schools also welcome the assistance provided for them. When parents of the children who are in great need of tutoring are unmotivated, or unable to bring them for tutoring because of the many household and child-care responsibilities with which they are burdened, our program accepts the responsibility for escorting children who are too young to travel alone to the tutoring sessions. The children are provided with specific reading instruction, with an awareness of, and sensitivity to interpersonal relationships—a type of "hidden psychotherapy." The child is provided with technical assistance designed to overcome his reading difficulty, and is also helped to establish a more positive relationship with adults and other human beings.

Finally, we take an active role in consulting with school staff and all those who deal with the children we reach. This includes weekly consultation with school administrative staff and teachers, regular meetings with a Mother's Club, and the organization of ongoing seminars for school personnel.

On an over-all basis, our program is still modest in size, but the results are encouraging. A number of children have been retained in school who otherwise would have been suspended. Specific behavioral and academic gains have been demonstrated in many cases. Parents are showing greater interest and involvement in our program. Teachers and school personnel are requesting more consultations, more seminars and more workshops. Bridges

have thus been built between the Department of Psychiatry, the school, and the community, so that a more effective community mental health program can be carried out. We see encouraging signs that through such a program we may be helping people to help themselves.

## PSYCHODRAMA, SENSITIVITY TRAINING, AND GROUP PROCESS MONTHLY THREE DAY WORKSHOP

WILLIAM N. DEANE, PH.D.

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At Vermont State Hospital a monthly three day program in psychodrama, sensitivity training and group process has been offered since April, 1966. Psychodrama, sensitivity training and group process are melded together in a functional way, utilizing a six member staff ranging from limited to rather complete professional training, and is offered to a wide variety of mental health practioners throughout the State from the psychiatric aide to the psychiatrist. Appraisal and evaluation of the program are presented.

## GROUP PSYCHOTHERAPY WITH GERIATRIC PATIENTS

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According to my experience, anxiety decreases in group psychotherapy, transference to one or more members of the group is easy to achieve because of the variety of choices, and meaningful discussions are possible because a common goal or interest can be found with less effort. In a group of geriatric patients, the patient who tends to distort the therapist into a fear-inspiring figure, feels the presence of others to be protection for him. Acceptance by the group is, at times, very important to a patient. Furthermore, feelings of difference and isolation decrease because the patient's problems are shared by others. The group may also be stimulating for the patient who must compete for the interest of the therapist and struggle for status in the group where he is brought into contact among persons of different background and outlook. Furthermore, each member of the group is helped to grow toward a higher level of emotional maturity.

The problems of identification are also of great importance in geriatric group psychotherapy. If members of the group are able to identify with others in the group, this is beneficial, influencing the whole atmosphere of the group. Identification by the therapist with his group represents a great advantage. For this purpose, the therapist for a geriatric group should not be too old or too young and should be in good emotional equilibrium himself. The therapist should convey, most of all, empathy and hope to his patients.

During a period of 12 years, over 240 geriatric patients have been treated by group psychotherapy. After six months of treatment, 90% of all the patients treated in this way made a better adjustment on the ward, showed improvement of their table manners, dressed more carefully, took a more active interest in occupational and recreational activities, developed new hobbies and used ego functions to control their hostility (after verbalizing it). Some even lost their delusional ideas and showed a better apperception of reality. Furthermore, the mingling of patients of both sexes has been found to stimulate active participation in the group discussions to a greater degree and to further better socialization. This modification also contributes to better personal appearance of the group members. Follow-up studies have shown a reversal of shyness and isolation, and an increase in skills to meet and talk with others. About 40% of these patients, after one year of treatment, were able to adjust outside the hospital, in nursing homes, foster homes and in the circle of their own family. This is about the same percentage of results reported by M. Linden.* 2% relapsed and had to return for further hospitalization and treatment after one year of trial visit.

## TRAGEDY AND TRIUMPH OF PSYCHO-SOCIO-DRAMA

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Motif: Das grosse, gigantische Schicksal. . . .
Welches den Menschen erhebt
Wen es den Menschen zermalmt. . . .

Fate—the great giant
Who elevates the human being high,
While it crushes him. . . .
Friedrich Schiller: Shakespeares Schatten

* Kurt Wolff, "Geriatric Psychiatry," Charles C. Thomas, publisher, Springfield, Ill., 1963.

Why "Tragedy AND Triumph?" They are the only aspects in mankind's history that are relevant to the development of the triad of Moreno's work in the first decade of the Twentieth Century in Vienna and then in the United States—Psychodrama, Sociodrama and Sociometry. Since Moreno's arrival in 1925, these methods have been developing in this order: THE FUNDAMENTAL WORKS pointed the way, *Group Psychotherapy* (1931); *Who Shall Survive* (1934)—A New Approach to Human Inter-Relations, intertwining sociometry, psycho-socio-drama and group psychotherapy—the three pillars of the triad reflecting the intensive *action* in thought, research, training and therapy of the needs of the "American Scene."

Tragedy is not seen so much as the stony resistance which the Moreno-led movement endured at the hands of the "conservative Establishment," but rather the potentially far greater *future* tragedy which might arise when this triad will have to weather the increasingly turbulant onslaught of "world-wide revolutions"—wars, automation, economic-psycho-cultural crises, including the growing narco-epidemics (LSD, etc.) in and outside of the Americas.

It is postulated that the *triumph* of the triadic group movement can be expected *only* as and when (1) this movement keeps its momentum sustained by skilled and dedicated leadership, unified by the goal of SURVIVAL of mankind—with the ever-increasing base in the non-professional masses of youth, families, popular groupings on the national and international levels; and (2) care must be taken that theory and practice of this movement be constantly "watched" to be continuously adapted to the larger changes in society by sustained use and refinement of the methods of sociometry and micro-sociology, keeping in mind that the commonwealth is the goal (1942).

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# THE PHILOSOPHY OF CLIENT CENTERED GROUP COUNSELING

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## REPORT

Man, a product of man, is not born emotionally sick; through man, he becomes sick. The hope is that in the group process he can release himself; that he can become spontaneous, articulate feelings, learn how to communicate with his fellow human beings warmly, openly, honestly. In this kind of relationship, the person can come to understand himself and, hopefully, others.

In a competitive, highly judgmental, alienated culture, man lives alone, suffers alone and dies alone. Seldom does he have the opportunity of shedding his skin and sharing his closed private world with the closed, private world of another.

A therapist committed to the client-centered philosophy has faith in the client, the person; he has faith that each person knows better what is good for him than anyone else, including his therapist. Further, in a non-judgmental relationship where he is given warmth, understanding, acceptance, the client-centered therapist believes that the client will have the courage to articulate his feelings, confront his problems, and be better able to manage to cope with these problems than in an authoritative situation where he is told what he should and ought to do. The cure resides in the client, in the client's capacity to cope with whatever he has to endure. There is also the corollary belief that each human being seeks health and gravitates toward health. Client-centered counseling is based on a democratic philosophy, exemplifying the highest respect and faith in the human being.

In the group, it is hoped that each individual will learn how to listen to one another and how to give each other warmth, understanding, and sympathy in a non-judgmental way. In this kind of situation, there is the hope that therapeutic outcomes may ensue.

## THE HETEROGENEOUS GROUPS

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The heterogeneous groups described are composed of subjects who have come in conflict with the law from a variety of causes and diverse personality disorders. Within these groups are found sexual devients, drug addicts, embezzlers, and larcenists, to name a few of the "gentle types." On the more violent side we have knifers, stickup men, and perpetrators of physical assault. Their ages range roughly from 21 to 40.

The miscellaneous nature of the problems presented by this population makes it imperative to apply a therapeutic approach applicable to a wide variety of cases and simultaneously adaptable to group process. At the outset of our exploration it appeared that a non-directive, non-judgmental approach such as that proposed by Carl Rogers might be most in keeping with their authority problems. Most of these patients have spent some time in jail; some a great portion of their lives. They have been scolded and upbraided by teachers, parents, and probation officers, and have been chastised by jailers and police officers. All of this appears to have had little positive effect upon their antisocial behavior. The therapist's non-judgment reception of that behavior probably represents to them a new and favorable atmosphere for self-reappraisal. Hopefully, the result of this thinking will be a change toward more constructive behavior. The therapist stimulates this thought process by offering to the patient's consideration, aspects of his problems which, perhaps, have hitherto been neglected by him. This provides a setting for the therapeutic process; additionally, it provides the patient with a warm, accepting atmosphere in which he can bring all his mental capacities into play with a minimum of emotional interference. It is fundamental to this method that no one does his best thinking under emotional stress. The inability of these patients to activate constructive thought processes or control thinking and its behavioral consequence in real life stress situations is amply demonstrated by their criminal history.

The distinction between feeling and emotion should be clearly delineated. The warmth, acceptance and mutual interest between the group members and the therapist and between the members themselves can certainly be described as feeling and is encouraged. Emotion is exemplified in the explosive ventilation of hostile disapproval on the part of patient or therapist as in so-called "attack" therapy. Such emotional outbursts, since they are dis-

ruptive to the thinking process are not encouraged in this "cognitive" approach to therapy.

The success of the approach may be evaluated in terms of the behavior of the group members. The best available criterion is the rate of recidivism. Since there is an acknowledged tendency for multiple offenders to continue in their pattern, any diminution in the rate of recidivism can be construed as a positive effect of therapy. Judged by this standard, the cognitive approach has been remarkably effective because during the past two years only one patient of some 75 to 100 has been rearrested.

The patients have also shown a marked trend toward conformity in the domestic and social aspects of their lives. This latter criterion, however, does not lend itself to the precise evaluation that rate of recidivism provides. However, the two factors are probably related in the life style of the individual and are closely tied together in the cognitive therapeutic process.

## SITUATIONAL THERAPY

JACK M. GOOTZEIT, ED.D.

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Situational therapy is a technique in which role, social relationships and the physical environment are used to bring about a therepeutic effect.

According to Gootzeit (March, 1960), situational therapy is a process of instruction, training, counseling, and environmental manipulation in which an individual's pattern of activity is fitted to those minimal standards of behavior demanded by the community. A situational therapy program provides an activity setting (work, social, recreative, camp, etc.) in which an individual's pattern of activity is analyzed and guided by the intervention of activity therapists and their auxiliary workers, who attempt to modify problems of an emotional, physical or social nature in an activity setting.

Situational therapy utilizes real life situations. In the case of A.H.R.C. Habilitation Programs in New York City, the situations are the pre-vocational, recreational, social, and educational activities, their settings, and all the people in them. In essence, situational therapy is group therapy, in which the client participates without being labeled or being made conscious that he is being treated.

The Habilitation Programs' population consists of mentally retarded, brain injured, and emotionally disturbed individuals, whose ability to express their wants, desires, and needs are quite limited, especially if these needs must be expressed verbally.

For these reasons, situational therapy has proven extremely effective. In play therapy, children reveal tensions, anxieties and problems with a minimum of verbalization. Their primary method of communication to the therapist is through activity. Another form of activity group therapy is Psychodrama. Here the stage is the setting, with the therapist exchanging and playing various assigned roles with the clients. In both techniques, the therapeutic session is of short duration. The real life recreational, educational, or vocational situations offer many opportunities in which a client's reactions can be observed and affected by manipulation. For example, the manipulation of roles in life situations can affect behavioral changes.

"Role" is the type of behavior that one exhibits in terms of what others expect or demand of him. A person assumes a role whenever he interacts with others, and he assumes different roles in different situations (Moreno).*

The process of assuming roles develops first in the family, then in play groups, in school, and finally in work and recreative situations. As a person plays a role, he assumes a certain position or standing relative to others. This relative position is called "status."

A therapist, merely by being in an activity setting, assumes various roles. People react to him because of his position. When a therapist understands the role dynamics and assumes, assigns, or manipulates roles and status positions in the interest of affecting adaptive and adjustive changes in a client, he is utilizing the situation as a therapy.

Inasmuch as every therapist, auxiliary therapist, assistant, or client in a therapeutic situation assumes a role and affects the client, a therapist must be able to manipulate and control the situation in order to bring about therapeutic change.

To affect adjustive changes, some therapeutic worker in each activity setting must represent the demands of the community. Punitive or judgemental roles should not be assumed by the therapist because assumption of such roles could impair the counseling relationship between the therapist and client. The therapist mainly assumes such roles as friend, confidant, supporter, person who listens to one's troubles, and a person to whom to appeal. Assump-

* Biddle, Bruce J. and Thomas, Edwin J. *Role Theory: Concepts and Research,* John Wiley and Sons, 1967, New York.

tion of such roles by the therapist affords the client an opportunity for reflection of feelings to a person not in a position to express value judgement to the client.

The role of auxiliary therapists as judges, discipliners, reward givers, love and rejection givers provoke regression, anxiety and maladaptive behavior which afford the therapeutic team opportunity to assess social relational problems so that they may be treated appropriately, and ultimately, when the client meets similar situations in the community, he will be able to handle them adaptively.

Counseling, role playing, psychodrama, and specific therapeutic techniques are then introduced into the situations, or clients are taken into counseling, etc. as need arises from the life situations.

In order for the therapist to structure these role relationships, he must have the responsibility to assign specific roles to the auxiliary therapist and to make the role relationship clear to them (perhaps by short role playing training sessions, in which initial understanding can be demonstrated).

## PSYCHODRAMA WITH WITHDRAWN PATIENTS

JOSEPHINE PRICE, A.C.S.W.

*Mental Health Institute, Mt. Pleasant, Iowa*

IOWA

After a year of weekly sessions with recently admitted patients, I started a second group for patients who had been hospitalized ten to twenty year, and a third group for patients on two closed wards.

The goal was the same for all three groups—total group participation, which was obtained after four sessions.

The main approach was "Psychodrama for Fun," but as the groups progressed, some of the patients were able to volunteer personal problems dealing with their families and with the hospital.

I have come to the conclusion that psychodrama can help regressed and withdrawn patients in a mental hospital.

# PSYCHODRAMA AT THE CATHOLIC SOCIAL SERVICES

HENRY FEINBERG, M.A.

*Washtenaw County, Ann Arbor, Michigan*

MICHIGAN

There are three psychodrama groups at the Catholic Social Services of Washtenaw County. The first is a Mother's Therapy Group which I conduct with Margaret Oghlgreen. This group began with members who were mothers without husbands but has since been enlarged to include mothers with "ineffectual husbands." Since its inception in July, 1965, the group includes 10-12 active participants who discuss family difficulties. The topics of the evening are chosen around the expressed needs of the individuals in the group. The directors set an atmosphere which is permissive and group-centered. Some of the topics that have come up for discussion include:

1. Why do children steal money from parents (in this case purses).
2. Is there a difference between "stealing" and "taking."
3. What should be done if there is fighting among the children in one family.
4. What happens if a child is "caught" smoking.

The questions are not directly answered; all the mothers suggest answers and debate the efficacy of the suggestions. A description of one evening will suffice to give a general idea of the atmosphere. One mother told the group that her fifteen year old was suspended from high school because he was caught smoking in the hall. With a cigarette in her hand, the mother wanted to know what attitude parents should adopt when children smoke. The answers supplied were: "It is alright if it is not done in the home"; "It was more dangerous and damaging when smoking was done behind the back of the parents;" "It would lead to lung cancer—the children knew it—why do they smoke"; "Is it a status symbol?" "Is it such a status symbol that children cannot refrain from smoking when with their friends (peers)?"

The values and purposes of this group is to let each member realize that she is not alone with her problems as well as to discover the "common problems" in all families. Problems are discussed, anxieties are relieved, and the women gain personal support. Often the problems are worked through and disappear. Injuries, either to themselves or to their children are discussed openly, and the causes of low sense of self worth are investigated.

The other two groups consist of young boys. Each group is made up of eight to ten "acting-out" boys who have been considered "problem children" in school. The groups meet for 45 minutes weekly. They are permitted to do anything they wish, so long as they don't damage each other or property. They play darts, make plastic models, use the phonograph to listen to records. These activities enable the boys to establish interpersonal relationships and obtain approval among their peers where they have never had, or taken advantage of such opportunity heretofore. In many instances the group meeting is an added therapy situation; individual therapy time for the boy is available. This group is between the ages of nine and twelve. No specific problems are discussed. They will bring no problems to the group. These groups have been in attendance since July, 1965. The boys are quite unruly at the beginning, but they gradually cease to act out as much as they did previously. They learn to share, to help each other, and to develop friendships. There is little direction from the therapist. The groups are conducted in laissez-faire fashion.

### The Michigan State Chapter

This chapter meets on the first Monday of every month at Wayne State University. The meetings are open to anyone interested in the methods and techniques. Psychodrama, sociodrama and group therapy methodologies are demonstrated. A census is usually taken of opinions of the audience members to ensure the topic is of interest. The sessions are under the directorship of the members of the chapter who are Fellows in the National Organization. These are: Dr. Robert S. Drews, Marguerite M. Parish, M.S.W., Director of Catholic Social Services, Martha Steinmetz, Field Supervisor of Travelers' Aid, Inez Silk, Office of Economic Opportunity, Mrs. Josephine Drews and Henry Feinberg.

At the end of each session, Dr. Drews conducts an Axiodrama in which he summarizes the session, stressing the important psychological or psychiatric implications.

# COMMUNITY PARTICIPATION AND SHORT TERM TREATMENT NEEDS CITIZEN COOPERATION

JOHN D. CASE

*Bucks County Prison and Rehabilitation Center, Pennsylvania*

Correctional treatment is essential at the county jail level. The paternal warden who did small favors for the man who performed menial tasks to earn a few cents a day and to get out of a cramped cell is at least an anachronism, if not a thing of the past. Treatment time is short in the county prison, and treatment is intensive. To do a good job we need help from our citizens and with the help of our citizens and the staffs of the various community agencies such as Family Services, the State Vocational Rehabilitation and others, we should be able to provide short term treatment in the county institutions.

Before 24 hours have passed for any man committed to the Bucks County Prison and preferably at the time of his commitment when his wounds are fresh and he is psychologically open and bleeding, he will be seen by a counselor. Thus begins his treatment, at the most opportune moment. Before any program can be planned for this individual his immediate problems must be solved. It is the IMMEDIATE problem that we refer to, the one that needs "instant solving." Now also, is the ideal moment to call upon the many and varied agencies of the community that can assist this man in solving the problems that loom the largest at the moment, so that when they are solved, this agency and others like in the community can work at eliminating the long-standing, serious and more significant problems primarily responsible for establishing his criminal pattern.

We are fortunate at the Bucks County Prison and Rehabilitation Center to have copies of a voluminous, very useful loose-leaved directory published by the County Information Service, which lists the health, welfare, recreation and community resources available in Bucks County and the greater Philadelphia area.

If the new inmate has a family problem, which is very likely for while sending a man to prison may serve the laws ends, it also may leave his family in a distressed condition, a call to the County Family Service Association, which has been assisting area families for the past 14 years, will provide professional counseling for troubled individuals and family groups. Supported by the United Fund, this agency has been of invaluable assistance to us in helping to solve the immediate family problems besetting many of our newly committed inmates.

In our Work Release Program, there was at first, no clear cut plan for getting work for men who were placed on this program. Jobs were obtained by searching through the want ads, and the men were taken to the job interviews by an officer. This was a time-consuming procedure that led to the use of a more efficient method. We turned to the Hatboro Office of the Pennsylvania State Employment Service which offers job placement, counseling, testing and industrial services for individuals. Pamphlets, films and exhibits are also available through this service. Through the work of this facility an ever-increasing number of Work Release trainees have been guided into well paying jobs—jobs that have been good for them and the community.

We have found that many of the men who are in prison got there because they lacked the skills to get better than a manual-type job, and drifted into crime because of the idleness resulting from dropping out of school and being unable to get work. These men are in need of training or re-training that will make them eligible for better paying jobs—jobs with standing in the community. The State Bureau of Vocational Rehabilitation's representatives come here to see these men, test and counsel them and where applicable, give them the opportunity for more schooling especially in the trades and through training in the skilled occupations.

The basis of a man's urgent problems is not always a family or vocational matter, it may be physical or emotional. Persons who need eye-glasses, for instance, can be referred to the County Association for the Blind, which will make the necessary arrangements for eye care. Emotionally disturbed individuals can be referred to three non-profit organizations for required psychiatric or psychological treatment. We have an ever-present problem with alcoholics and the aged chronic alcoholic can only be treated, in most instances, by being "dried-out" in a special hospital. A list of such hospitals is kept for reference so that they may be contacted where hospitalization is indicated.

The local Veteran's representative is called in on veteran affairs and has been of definite service to the veterans in the prison population. Organizations for adult welfare, senior citizens welfare, child welfare and mental health are all available to the men in prison or to their families and the work of this group and the time and effort of the individual citizens, provide the prison with the help it cannot afford to do without, and this in turn, does much to build an effective bridge from the prison to the community.

# TOWARDS A SCIENTIFIC EVALUATION OF PSYCHODRAMATIC THEORY AND THERAPY

PAUL HUREWITZ, PH.D.

*Hunter College, New York City*

On of our present needs is to begin to clarify how theory can be translated into practice, so we may scientifically test the premises of different modes of therapeutic experience.

Psychodrama and other forms of therapy suffer from the same problem of lack of operational clarity. For example, is Role Playing and Psychodrama the same or different? One might further help to clarify the differences and/or similarities between Role Playing and Psychodrama by describing how each operationally defines a particular concept, i.e., how do Role Playing and Psychodrama utilize the following two concepts developed by Moreno: 1) the concept of the "Preverbal Matrix of Identity" (a biosocial-psychomotor substrate of personality) and 2) the concept of the "Megalomania Principle" (the child's feeling of being all powerful and immortal).

One can see the difficulty implicit in trying to operationally define these concepts in therapy. They reflect man's verbal attempt to categorize certain processes of development. These processes are perceived and interpreted by the theorist, who is also a product of the environment he is observing; and thus he may also have a bias in what he perceives.

The same problem would exist if we try to define Freud's concept of "Id" or Jung's concept of "Archetypes."

I believe there is a way out of the dilemma. The following are five suggested steps that may be taken to ameliorate this problem:

1) We must clarify our concepts more precisely in operational terms.
2) We should attempt to develop a common reference point (a dictionary of definitions) so we may try to compare the meaning of different concepts. (The use of the semantic differential may allow us to consensually describe a concept).
3) We can define how these concepts are used in a particular setting (defining the operational role of the therapist in using this concept in the setting).
4) We should try to note the effect that the therapeutic procedures have on the person who is being helped. This evaluation should be based upon the previously stated goals that have been translated into observable, measurable behaviors. The goals should have con-

sensual validation, so we may compare outcomes of different therapies. (Factor analysis and multiple observers should help us to acquire reliable data than can be analyzed to note the effect of different procedures and different therapists in helping others to achieve these goals.)

5) There should be a follow-up to note if these gains continue or if they are only a product of the particular setting and have limited transfer value.

This suggested model should help us to move ahead in advancing our knowledge and insights of the developing human organism; it will begin to take therapy out of the occult and place it into the realm of scientific inquiry.

## THE GROUP THERAPY PROGRAM AT THE CIVIC CENTER CLINIC

JULIUS RUBIN, M.D.
*Brooklyn, New York*

This presentation is being given by the Civic Center Clinic in Brooklyn, an agency that treats only offenders over 16. The Clinic was opened in 1952 by volunteers headed by Sol Tropp, a probation officer. In 1953, Dr. Ralph S. Banay, an internationally renowned forensic psychiatrist, became director of the Clinic and is still providing strong and progressive leadership. Very small at first, it has expanded until today it includes 11 part time professionals, one full time social worker, four full time clericals.

Group therapy was initiated early; by now we have been treating and experimenting with different group approaches for 12 years. At this time we have in operation three groups of sex deviates, one of heroin addicts, two of users of barbiturates, amphetamines, marijuana and LSD, two "heterogeneous," that is, all offenses except sex and drugs; i.e. robbery, prostitution, car theft, etc., one group to screen new clients and an "autonomous" group of "old-timers," patients who have been in treatment for three, four or five years and who still require group support; this last group meets every second time without a professional leader. All groups meet once a week for 1-½ to 2 hours in the evening.

Most of the patients, being over 16, can come only at night, therefore the bulk of treatment is one after 5 P.M. Individual therapy is utilized with

37% of our 225 patients, group therapy with 63%; about 5% of these are receiving medication. The therapy groups number from 6 to 15 people; we do not find 12 to 15 members excessive, but rather preferable. We have 8 or 9 male patients for every female; the sex deviates groups are completely male—female homosexuals do not come for treatment—the rest of the groups run to up to 20% females.

We are conducting our third one-year course of training in group counseling for suitable persons in the field who we expect will either conduct groups in probation or parole, or supervise other workers doing this mode of treatment. The barbiturate-amphetamine groups and the screening group are experimental and have been funded by other agencies.

## GROUP THERAPY WITH SEX DEVIANTS

SAMUEL BUCHHOLTZ, JUR. SC. D.
*Brooklyn, New York*

Two open-ended groups are conducted consisting exclusively of male sex deviants, each numbering approximately 12 members. At all times each group has at least one female staff member present who serves as an adjunct to the therapist and actively participates.

Treatment is based on Reality Therapy techniques. It is not claimed that this approach represents the only method by which the sex deviant can be successfully treated. However, it appears to be the most effective method for most patients on the basis of our experience here and thorough study of the literature.

In utilizing Reality Therapy several assumptions are made. A person's fundamental needs consist of feeling worthwhile to himself and to others and being involved in a meaningful relationship with at least one other person. If these needs are not met he cannot function effectively. Further, historical determinism has no validity for the therapeutic process. The past may very well influence present behavior but does not compel it. Life history may be significant for the clinical picture but is irrelevant in therapy. In the absence of organicity, the term, "mental illness" is essentially a social judgment about a person's behavior rather than a medical finding concerning some internal mechanism which irrevocably produces the behavior manifested. Feelings are inextricably entwined with, and the resultant of, behavior. There-

fore, if a person regularly engages in anti-social behavior he will feel worthless, depressed, isolated, etc.

There are a number of operative elements in the therapy process that are emphasized (the possible presence of other elements is not thereby excluded, viz, insight, reference to feelings, etc. They are considered, at most, ancillary to the essential nature of the therapy process). Firstly the therapist endeavors to be open and is not reluctant to reveal himself when appropriate. In other words, he is "humanized" in that he does not merely present himself as a technician who "does something to" the patient. The group members are not permitted to describe themselves as mentally ill and therefore not responsible for their deviant behavior. Since a person is not a prisoner of his past there is little concern with history and the focus is on the *here and now.* Group members are asked to evaluate their behavior ("Has your behavior done you any good?") and are expected to formulate plans as to their future behavior, i.e., they are encouraged to take steps that will initiate a constructive socialization process. Their deviant behavior is characterized as "corrupt," "irresponsible" or "immoral." A group member may be told that he has been "acting crazy." Group members are expected to seek better ways of fulfilling their needs, to acquire meaning and a sense of purpose and direction in their lives. Excuses for continuing deviant behavior are rejected. Moral judgments concerning behavior are made by the therapist and group members. Although most therapy procedures disclaim the presence of moral values, experience has shown that they are at least covertly present or implicit in all such procedures.

## THE NEED FOR RAPID AND EFFECTIVE PSYCHOTHERAPY IN A COMPREHENSIVE MENTAL HEALTH CENTER

LESTER A GELB, M.D.

*New York City*

The so-called psychoanalytic approach to cure patients by recreating the past, encouraging a transference neurosis and then "analyzing" it is not going to meet the present needs of the many mentally distressed people in our community; neither is a treatment model based on the private practice of medicine likely to be effective. What is needed is an actual affective, collaborative *interaction* with the distressed patient. There is no such thing as "therapeutic detachment"—there is only anti-therapeutic detachment.

Neurotic behavior is a learned way of living. Therapy must *be* change—a new life experience which produces *new* ideas, *new* feelings and *new* interactions. We learn from experience only. Therapy must produce and reproduce healthy experience.

We must enroll the patient in an activity program dedicated to his own salvation and that of his community. The mental health of a patient cannot be separated from the health of his community, since an unhealthy society produce unhealthy people. Therefore, the healthy individual must be involved not only in overcoming the destructive aspects of his own living, but also the destructive forces in the environment in which he lives.

Treatment along these lines are more to find a patient enthusiastically involved in change. The form of therapy—individual, group, psychodrama, or activity therapy can be chosen and changed in accordance with the needs of the individual.

# WORKSHOPS

## THE BANBAM GROUP

MEYER RANGELL

*Civic Center Clinic, Brooklyn, New York*

The BANBAM Group is illustrative of the open, inquiring, forward-looking approach of the Clinic in its efforts to experiment with and to explore new methods and new treatment approaches for old problems.

The choice of the name itself is purposeful and is related to the philosophy and the methodology of the treatment approach. "BAN-BAM" is a simple, short-hand device designed to keep the *purpose* of the group in terms of *a behavior goal* before each member at all times. It states simply that we are here to *BAN B* arbiturates, *A* mphetamines, and *M* arijuana.

In the field of the character disorders, and particularly in drug addiction, traditional, conventional psychotherapy has not produced the desired results. Our group is based on the principles of Reality Therapy, and the additional indigenous leadership of a trained, rehabilitated ex-addict, who attempts to change the tone and the direction of the therapeutic process.

To understand the reasons for the failure of conventional therapy, and the theoretical basis for our approach, we suggest first that the character of the addict in general, and particularly the extent to which he has learned to manipulate the people around him, tends to facilitate his manipulation of the therapeutic situation as well, with the result that the too-permissive character of traditional psychotherapy is deliberately twisted and manipulated by him to permit him to *continue his addictive behavior* and even to *discover a new rationale to justify it.*

Reality Therapy, on the other hand, counters this trend by emphasis on Commitment and Contract. Emphasis is placed upon a commitment to change behavior at the very outset of the patient's entry into the group and upon a contract to abstain from drugs. The contract and the commitment (repeated at the weekly sessions) are made with the entire group, as well as the therapist, and it is the group, and particularly the ex-addict leader as role-model and change-agent, who support and help and teach the patient new ways of behaving so that he can keep his contract and his commitment. We stress the *responsibility of the patient* for his current behavior and his future development, and refuse to permit excuses or the rationale of "sickness" to justify his slipping back into destructive, antisocial patterns. Through a

caring involvement with the therapist, the indigenous leader, and the entire group, and through his reciprocal involvement with the problems and planning of others, we hope to direct the addict into new gratifications and more responsible patterns of living.

The group focuses attention on the here and now, on current problems, on the formulation of concrete plans for improvement, and particularly on the question: "What are you doing to help yourself?"

The group makes every effort to strip away falsity and deceit, to prevent self-deception, self-pity, and emotional indulgence, and to build instead on the assumption that the individual possesses worth and capacity, that he can do something to help himself, that he does have the potential capacity for constructive behavior.

## THE CLERGY AND PSYCHOTHERAPY

*Chairman:* JAMES L. ZACHARIAS, B.D.

ACTIVE PARTICIPANTS: MARGARETTA K. BOWERS, M.D.
REV. JOHN GREEN
REV. CHESTER RABER
REV. ALAN ZACHER

*Commentator:* JACK WARD, M.D.

### REPORT

This workshop pertained to the technique of bibliodrama which Dr. Raber and Dr. G. Douglas Warner had experimented with in their seminars with clergymen, in teaching Sunday school, and with people who have religious orientations. Following are the steps which developed in the workshop.

1) The project was briefly described and an indication made that there might be someone in the group present who had led a Bible story which he had not been able to understand, or a biblical incident that seemed wrong to him, or some biblical story that seemed to have an addition or a portion added that was not there. Or some members of the group might simply have a favorite story which seemed to be related to them or some part of their life. Dr. Raber indicated that he would attempt to conduct a psychodrama with this story, having the person who selected the biblical event as protagonist and whatever auxiliaries necessary from the audience.

2) A woman volunteered the story of Abraham and Isaac at the time of the sacrifice and stated that it had always angered and puzzled her. She said she could not understand a God who would require a father to kill his son and that this whole concept of justice was revolting to her. She briefly stated her idea of the story and indicated the chief characters, at the same time selecting people who could fulfill these roles best. She chose a man to play God, another to play Abraham and she played Isaac.

3) With the usual psychodrama techniques of role reversal, soliloquy, etc., the story was enacted. There was a good deal of audience participation as different concepts of God were discussed by the female protagonist Isaac, a reluctant bearded God, and an Abraham who was female and who opposed biblical Abraham. Needless to say the protagonist gained insights into her relationship with her father.

The psychodrama submethod—"bibliodrama"—was found to be particularly amenable to clergy groups and the often unproductive religious education methods that are perpetuated on weekends throughout this country.

## RATIONAL-EMOTIVE PSYCHOTHERAPY

ALBERT ELLIS, PH.D.

*New York City*

### REPORT

A workshop in rational-emotive psychotherapy was given, mainly through the means of live demonstrations with individuals who volunteered to bring up personal problems in front of the audience. Dr. Ellis interviewed several individuals who brought up their problems of hostility. He attempted to show them that this hostility was not caused by the precipitating events—at point A—that occured to them, and that they believed brought on their angry feelings at point C. Instead, he tried to show them their own interpretations, or internalized philosophies, at point B, were the true cause of their feelings at point C.

Thus, in the case of one girl who was angry at the Program Committee of the Conference because some of the scheduled events had not taken place in the manner that she expected they would, he tried to show her that it was not the poor scheduling that upset her, but her own irrational demands that the program committee *should* have handled matters better, that *it was*

*awful* that it didn't do so, and that she *couldn't stand* this kind of supposedly poor performance on its part.

Similarly, in the case of one volunteer who presented a problem of anxiety, Dr. Ellis attempted to show her that it was not the situation in her life which was causing this anxiety, but her own convincing herself that she *had* to handle it better, that she *couldn't* do as well as she *should have* done, and that she was a relatively worthless individual for being so inept. In all cases, he attempted to show the individuals presenting their problems that *they,* and not the events of their lives, were creating their own hostility and anxiety; and that therefore *they,* by changing their internalized interpretations and attitudes, could quickly minimize these negative feelings.

In some of the cases, the volunteers immediately saw that they were responsible for creating their own feelings and that they could do something effective about changing them; and in other instances, they only partly agreed that this was true and seemed to believe that their feelings were independent of their thinking. There was lively participation by many members of the audience, some of whom went along with Dr. Ellis' thesis that we create our own negative emotions by convincing ourselves of an irrational idea and then stubbornly sticking with this idea, and some who insisted that emotions exist in themselves and are not necessarily related to human ideation.

## ABSTRACT OF WORKSHOP

SAUL PILNICK, PH.D.

*New Jersey*

### REPORT

The Essexfields Group Rehabilitation Program and the Collegefields Group Educational Program were discussed in some detail. Each program deals with twenty boys at a time, all of whom have been referred by the Essex County Juvenile Court in New Jersey. Both programs are non-residential in nature and operate during weekdays.

In the case of Essexfields, the boys are sixteen and seventeen years of age, work on specially designed work details during the day, and participate in guided group interaction sessions during the evenings.

The Collegefields program involves boys of fourteen and fifteen years of age who are technically on the Newark School System roles, but in reality are truanting and present severe delinquent and educational problems. Instead

of a work situation, the Collegefields boys participate in a specially designed school program, located on the grounds of Newark State College in Union, New Jersey. The educational experience occurs during the mornings, and in the afternoons they attend guided group interaction sessions.

Research has been conducted in the case of both programs and the results have been extremely encouraging. Essexfields and Collegefields boys have lower recidivism rates; tend to develop positive attitudes toward parents, school, and work; and generally show significantly greater personal and social growth patterns than do comparable groups of youngsters.

At the heart of both of these programs is the concept that the peer group constitutes the essential agent of change, and that direct involvement on the part of the youngsters themselves unleashes tremendous resources devoted toward rehabilitation goals. Youngsters from both programs remain involved in the operation of the programs long after they have been released and have been reintegrated into work and school situations. The talent these youngsters have developed in leading and conceptualizing group meetings has been utilized by Scientific Resources Incorporated, a private behavioral science organization in Union, New Jersey. Former Essexfields boys, acting as consultants to SRI, have assisted in the establishment of a number of delinquency programs throughout the United States and Puerto Rico. In addition, their skills have been utilized in research projects, survey work, interviewing, and the writing of programmed instructional materials for disadvantaged youngsters. The Essexfields-Collegefields programs are indeed the forerunners for the new careers movement, since they have demonstrated the validity of creating upwardly mobile careers for former delinquent youths.

## HYPNODRAMA

LEO WOLLMAN, M.D.

*Brooklyn, New York*

### REPORT

Dr. Wollman started with an attendance of about fifteen and ended, about an hour later, with approximately sixty people crowded into the small room.

The case of the depressed schizophrenic, presently in St. Elizabeth's Hospital, Washington, D.C. was taken for demonstration. The attending psychologists participated. One took the role of the patient and another

enacted the part of the therapist. Dr. Greenwald energetically played the role of a consulting psychiatrist. Other members of the Workshop took various roles in the Hypnodrama, such as another patient in the open ward and a member of the nursing staff. During the course of the demonstration, Dr. Wollman hypnotized three participants who enacted roles while in the hypnotic state. The response was overwhelming and the consensus of opinion was that the Hypnodrama demonstration successfully illustrated the techniques and skills involved in the treatment of a particular situation.

## DREAM WORKSHOP

RENEE NELL, ED.D. AND DAVID KIPPER, M.A.

*New York City and Tel Aviv, Israel*

### REPORT

This interpretation of dreams is based on the Jungian approach. It differs in many essential ways from that of Moreno or any other psychotherapeutic school. Jung sees the dream as a Gestalt, i.e. a total coherent configuration like a piece of music, a painting, or a story. The first sentence of the dream in general sets the theme which is developed in the ensuing content, and the end of the dream brings the conclusion. In the interpretation a field theoretical approach is used. All figures in the dream are seen in interaction with each other. The manifest content of the dream is taken at face value. There is no assumption as to a dream censorship. Jung thinks that the censor appears in the dream as a message that cannot be read, words that cannot be heard, a telephone connection that cannot be made. The dream is seen as an immediate response to the events of the previous day working as a corrective agent for these events. Jung believes the psyche and the unconscious to be a self-regulatory system working towards balance and normalcy just as the body does. In the dream, our unconscious finds many ways to show us how we could establish a homeostatic balance.

Jung's most useful contribution to the interpretation of dreams is his emphasis on interpretation on the subjective level. Although all dreams are interpreted objectively as well, the subjective level is considered more important, and is generally more interesting to the dreamer. Let's say someone dreams "I unexpectedly met Aunt Mary." The difference between the ob-

jective and the subjective interpretation is that, on the objective level, the dreamer would say "I never liked Aunt Mary. She was known as penny-pinching and suspicious." The dreamer might add that yesterday he was in the company of a woman who for some reason was repulsive and he could not see why. Following the dream, he suddenly feels that the woman he met resembles his Aunt Mary and now he understands why he disliked her. On the subjective level, however, the dream informs him of something much more important. Aunt Mary is seen as the dreamer's own tendency to be penny-pinching and suspicious, a quality he dislikes in himself and tries to rationalize away. The interpretation of the dream would show that the day before he was unexpectedly confronted with this trait through the woman he disliked and, repressing this awareness, he then dreamt about it. Where on the objective level the dreamer became aware only of why he took a dislike to a fleeting acquaintance, on the subjective level the dreamer became confronted with a negative characteristic of his own, which is a therapeutic gain.

In order to follow Jung's interpretation of dreams, it is important to have some knowledge of his symbolism. To name only two symbols here: the Animus and the Anima. All masculine and feminine figures are seen as psychological representations of the masculine or feminine principle. In order to separate these psychological functions from biological masculinity and femininity, he terms the feminine principle the Anima, a Latin word for psyche. It represents subject-relatedness, feeling, intuition, nurturing, receptivity and the like. The male principle, called Animus, symbolizes object-relatedness, logic, intellect, guidance, outward directed activity. To see these and other symbols in interaction in the dream is helpful for diagnostic purposes from the first session on as well as for evaluation of the developmental process during therapy. The goal of therapy is to further the process of individuation and the dream is considered the most important tool in guiding a person in that process.

## MOVING INTO ROLE PLAYING, METHODOLOGICAL AND THEORETICAL ASPECTS

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### REPORT

This was a "Know How" workshop, discussing the approaches, techniques, psychological and sociological considerations of role playing. A panel of experts from the University of Bridgeport discussed creating role playing situations, resistances to role playing and role assignment, face saving efforts, role taking vs. role playing, false starts, cutting, moving out or taking a break, timing aspects, didactic aspects, learning and converging, the function of auxiliaries and other aspects of role playing.

Teaching process and skill was the main framework for action. Discussion followed.

## METHODS AND TECHNIQUES IN ACTION

*Therapy*: SYLVIA ACKERMAN, M.A.

*Moreno Institute, New York City*

*Industry*: JAMES ENNEIS, M.A. AND NORMAN ZINGER

*St. Elizabeths Hospital, Washington, D.C.*

### REPORT

In an effort to assist Conference registrants in applying psychodramatic techniques to both the therapeutic and industrial utilization, the directors of these workshops had the following objectives in mind:

(1) Train future directors in techniques by using available methodology.
(2) Provide a working knowledge of the various psychodramatic approaches to personal utilization and therapeutic application.
(3) Explore, identify and seek solutions to the problems relating to the problems relating to the transition of newly acquired psychodramatic learning to on-the-job back home application.

The interesting parts of this workshop happened when the group members present asked questions. The questions were immediately put into action and stopped at crucial moments to see what was going on, to redefine the situation, and to reenact it. When a classical group psychotherapist expressed his distrust of the value of psychodrama, he was put into his typical situation and asked to act. The use of doubles to express hidden thoughts developed a swift acquisition of skills and broke down communication barriers. The "therapist" became aware of what was happening both in time and space. Some problem areas dealt with were:

The value of co-therapists
The difference between male and female roles
Non-verbal communication
On-the-spot learning

In all workshops, there was total participation.

# PSYCHODRAMATIC TECHNIQUES IN ACADEMIC SETTINGS

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The comments below are based upon the author's experience in applying psychodramatic techniques to a variety of academic situations where psychotherapy itself was not an explicit, prominent goal. The settings discussed are university courses, theological seminary "sharing groups," an ecumenical lay academy, a teacher training project, a criminological institute and a medical school. No special claim to originality in the specific techniques used is being made, but this summary may serve the orientation need of the psychodramatist considering the possibility of offering his services in the academic area, or of the professor already there, who wonders how psychodrama may help him in his work. Inasmuch as this presentation is necessarily brief, the reader is encouraged to call or write the author at the address above for details of further interest, including the specific identities of the institutions involved.

(1) THE UNIVERSITY. Although the curriculum of this large, urban university offers no course bearing the word "psychodrama" in its title, the author has included psychodrama demonstrations, sociometric methods and role training in his social psychology, personality development, and mental health courses, because they were felt to be appropriate to both the mode of course presentation and its subject matter. The students were predominantly mature adults, attending evening college on a part-time basis, and working toward their undergraduate degrees. An attempt was made to capitalize on group processes from the outset; for example, at the first class session the students were invited to arrange all the chairs in a circle. Then, with his own performance as model, the instructor gave his first name, and added some associations to that name ("Don—reminds me of a river in Europe"), encouraging students to volunteer their associations too. Nevertheless, the instructor was careful to insist that each one give his own spontaneous association first, that all might be afforded a glimpse of that person's self-concept before it was "corrupted" by the preoccupations of others (interesting in their own right, of course). When the instructor encountered an outgoing student he already knew, he suggested a pantomime of associations rather than a verbal statement, and threw out a challenge to the group to supply an "interpretation." When "going round" was completed, the teacher made some remarks about the remembering process and showed that he could call the names of all persons present, but more than that, he gave them the chance to discover that they

could too, despite the fact that several had seen themselves as not being able to remember names. A student arriving too late for the above, feeling guilty about her tardiness, was shocked to be introduced to everyone present, her amazement effectively displacing the guilt, and the group amused but identifying with her. That a sense of group unity was well on the way was evidenced in the entire class's spontaneously having coffee break together, rather than singly or in pairs or threes as happens typically on first nights without the warm-up. With such an atmosphere to build upon, it is easy to introduce psychodrama demonstrations, and also to provide standard life situations and spontaneity tests tailored to fit an evening's topic. In one demonstration we allowed a young woman to practice what she anticipated encountering in emancipating herself from her family, and in another demonstration we explored a policeman's ambivalence about giving a powerful political figure a speeding ticket. A group-centered situation producing considerable class involvement arose out of the textbook's allusion to "six Basques on a raft" (Roger Brown's *Social Psychology*). The vicissitudes of the six volunteers for the psychodramatic journey produced occasional hilarity, punctuated by some very sobering moments, all of which enhanced the impact of the text, while supplying elaborations a mere reading and discussion of the text never could have provided.

(2) Theological Seminaries. Typically a seminary aims to establish a sense of community that shall include the students' wives as an integral part of their program. The obstacles to doing this in regular class work are obvious, but an open psychodramatic group, available on a voluntary basis, consisting primarily of the students and their wives has been meeting continuously on a weekly basis for the past five academic seasons at one seminary. There the seminary subsidized the group, but in another seminary the couples themselves underwrote the cost, with the seminary supplying an assist later on. Therapy is not mentioned in connection with these groups; their stated purpose is to provide opportunity for sharing on more than an intellectual level. Frequently emerging problems have to do with interpersonal relationships with spouses, peers, parents, authorities, faculty, church dignitaries, children, employers, the sick and the public at large. Furthermore, on a sociodramatic and/or role training level educational and ethical issues may be readily explored. Graduating students found the group particularly useful in making the difficult transition to the "world outside." Thus they were enabled to successfully meet and impress employer boards and committees, not only obtaining positions, but also making a smooth, confident beginning in their life's work.

(3) Ecumenical Lay Academy. This was sponsored by a theological

seminary as an interdenominational effort to provide training for church school teachers and other volunteer, non-professional personnel; the word "lay" in this context means "non-clerical." The aim of this eight-week course was not to create psychodrama directors, but to facilitate their personal growth through the experience of being a participant in a psychodramatic group, and also to make available for their use the psychodramatic techniques which have become a part of sociodrama and role training. Furthermore, when competent directors become available to the individual church education programs, the students here constitute a pool from which auxiliaries may be drawn. The first meeting began in a way similar to the university course above, but then the director said, "Because our enrollment is so large, I would like you to divide the group into two smaller groups *in some meaningful way,*" the anxiety level of the group soared. The director assumed a passive role, and refused to provide any further help to the group in completing their assigned task, except to re-iterate the instructions, emphasizing the word "meaningful" when they were about to have recourse to some arbitrary technique, as counting off by two's. It usually takes such a group from a half hour to 45 minutes to complete the seemingly simple task by themselves. Then the director introduced the distinction between the content and process of group discussion, leading the group in a discussion of the process which had just taken place. A group can easily warm up to sharing their feelings about the "leaderless" situation, and how the group tried to draw back the old leader, and then the obstacles encountered when they sought to set up a new one. Such discussions provided the primary media for introducing didactic material, and the didactic material was selected to capitalize upon what had gone on in the psychodrama immediately before. Obviously the division in half affords a splendid opportunity to direct attention to the quest for a basis, which basis sociometry provides; one can even use some of the same language as the discussants, showing them how nearly they came to re-discovering sociometry for themselves. With two groups, each to be self-named (another discussion!) but here called A and B, the following format was used on subsequent evenings: Initially group A was set up as an inner circle, with group B as an outer circle beyond them, to observe and take notes. The warm up and action scenes were directed toward the inner circle, but persons from both group A and B were invited to participate in the sharing. Then groups A and B reversed roles, with B becoming the inner circle and A as the outer circle. The first task of group B was to discuss what had happened to group A, and it was at this time the director introduced any didactic material which seemed to be pertinent to what was being said in group B. This led to group B's warm-up and action scenes, with group A now

being invited to join in the sharing. Sometimes the session would end at this point; sometimes we were able to get group A back into the inner circle to discuss B before the time was up. Wherever we ended we would begin at the same point when the groups convened again. Occasionally we took time out to work on matters of special interest to the group, such as the "Living Bible," reminiscent of Dr. Moreno's Living Newspaper. Here a Biblical drama in modern form was spontaneously re-enacted and elaborated. Parables such as the Good Samaritan and Prodigal Son, or even ancient stories such as Adam and Eve's encounter with God in Eden, are shown in all their contemporaneity. The "Sunday School" we knew as children was never like this!

(4) TEACHER TRAINING PROJECT. This was a weekend workshop sponsored by a large midwestern state university for teaching teachers and principals how to do role training. Early in the sessions a standard life situation was introduced. The director called for someone in the group who had a car he was proud of to come and show it to us. The enthusiasm with which the particular volunteer did this made the word "proud" a gross understatement. We then had him take a girl friend for a "spin" and when he had been goaded (it didn't take much!) to excess speeds, we introduced the state trooper. Everyone was involved in the fun, as was evidenced in the discussion following. From then on the group was sufficiently spontaneous to work out, with only a little help from the director, standard life situations appropriate to their own students' needs. Likewise spontaneity tests mirroring the typical employment or placement interview were constructed; particularly fruitful was a sociodrama exploring labor grievances. This was a learning experience for the director too, who saw himself for the first time on video tape!

(5) CRIMINOLOGICAL INSTITUTE. This was an all day workshop sponsored by another midwestern state university offered in behalf of parole officers and graduate students in criminology. A psychodrama demonstration in which a marital problem was aired served to warm the group up. The director had the group select problem and protagonist as follows: He began with a chain warm up, introducing himself to an attractive outgoing woman from the group as himself a former resident of the state with previous interaction with notorious prisoners known by reputation at least to all. She then selected someone from the group to meet, learn something about, and yield to that person the opportunity to select another to meet . . . etc. Then the director called upon the group to count off by fives, and accordingly sent the five "buzz groups" formed thereby to the four corners and middle of the room with the assignment to choose a specific problem and someone involved with the problem to present the matter to the whole group. When the group had reassembled after 15

minutes, the five representatives reported. The director sent the representatives to the space in the room where their respective buzz groups had been, and then told the whole group to choose their protagonist by standing beside him. When sufficient space is available as was the case here, the required movement deepens the involvement and actually speeds up the democratic process. After the psychodrama we role-played a typical situation facing many of the participants, a parolee trying to "con" his parole officer. This led in two fruitful directions: first, the parole officer's supervisor was also present, and we were able to work with their interaction; and secondly, we were able to allow the persons from the group who would handle the parolee differently show how they would do it. The director allowed no comments upon their productions until the protagonist had had another opportunity in action incorporating whatever he wished from the alternative suggestions. Afterwards the director stressed the value of just such an approach to role training. Near the close of the workshop Corsini's article on the *Death of a Psychopath* was mentioned, leading to a dramatic re-enactment with spontaneous elaborations of the scenes Corsini had described. No one present would admit to being a psychopath, but the person who did play the role confessed to the group that he could readily understand how this approach had worked so well.

(6) MEDICAL SCHOOL. Unlike the previous situations mentioned, here the director was presented with a series of small working groups, each with its own relatively long history. Each eight person group came one time only to an unconventional psychodrama theater located at a state hospital to "see" a psychodrama demonstration. The director attended carefully to the group's spontaneity upon their entering the theater. Occasionally there was consternation concerning the absence of "patients," or the fact of being on the "wrong side" of a one way vision mirror; it was necessary to work through these concerns before moving on to other things. Then the director invited someone to explore the room, its lights, and its many levels with him, stressing the fact that this cannot be experienced while remaining seated in a chair. With the ice broken all the participants readily do the same, throwing out witticisms and generally carrying on in such a way as to give the director many clues for further use later. Next the director asks the group who can be counted on to be the most honest, straightforward and forthright; if they cannot decide between two candidates, he then asks which of these is better organized. The chosen person is then told to arrange the group throughout the room in positions and postures which will represent where each stands in relation to the others, on a dimension or dimensions to be announced later. Last of all the "organizer" himself takes a position in the room, and the director invites the

members of the group to speculate as to the rationale for their respective placement. (This is one version of an action sociogram, described elsewhere in this journal by Barbara Seaborne). On more than one occasion the discussion led directly to an exploration of interpersonal difficulties among the members of the team. In this way it was possible to work out the matter psychodramatically, restoring group unity, and enhancing both interpersonal and medical effectiveness.

The author has had experience with other sorts of groups in an academic setting, such as a campus YMCA-YWCA retreat featuring psychodramatic exploration, but the above should suffice to present what may have been done even in those which remain undiscussed. Dr. Doris Twitchell-Allen has reported elsewhere an undergraduate course devoted entirely to psychodrama. This author would welcome a discussion of the use of psychodrama with graduate students in clinical psychology or social work, in order to compare these with situations where the students appear apart from the academic setting for therapeutic purposes. One may suspect that the explicit acceptance of therapeutic goals may affect outcomes, but in what way?

# THE SEMINAL MIND OF J. L. MORENO AND HIS INFLUENCE UPON THE PRESENT GENERATION

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In the social sciences, more than in any other branch of the humanities, it is particularly difficult to assess, as a contemporary, the sources of inspiration and the channels they have travelled on their way to becoming absorbed by the culture. Indeed, history itself is written from a subjective and biased point of view and one of the most persistent problems, even in elementary education, is the frame of reference which determines it. Thus, religion, for instance, may at times "bend" the truth as seen by the scientist, if not to force outright distortion of fact. Thus no one, not even the scientist is above suspicion in staking claims or pointing out sources.

As a participant actor in one of the major revolutions in social science, therefore, the author is in a particularly vulnerable position, and the writing of its history, even when supported by objective evidence, dates of materials in print, and so forth, is often called into question. Nevertheless, it is profoundly satisfying to watch the spread and growth of ideas and to see them being carried forward by contemporaries, not merely as a confirmation of findings, but because of the assistance thus rendered in establishing the new frontiers of thought. In this manner we see these ideas moving from the private and personal to the general and universal. Many of Moreno's ideas have reached such a level of universality that they are becoming widely accepted, as if they had always been, a fact which may be of interest to the members of the ASGP&P and to the readers of this journal.

In my various roles as teacher, researcher, practitioner, editor, author, etc., I have tried to trace the development and influence of Moreno's ideas upon the group psychotherapy movement, on existentialism, behavioral techniques in psychotherapy, and psychodrama. The most recent of these efforts appeared in the *International Handbook of Group Psychotherapy* (Philosophical Library, 1966), in a chapter entitled "Evolution and Dynamics of the Group Psychotherapy Movement." To my satisfaction, this chapter provoked numerous discussions and inquiries, some of which I will try to answer in this paper and in subsequent instalments.

1. Who introduced the concept of "the encounter," as used by the existentialists today?

The best way to answer this is to quote from Professor Paul E. Johnson's

book *Psychology and Religion* (Abingdon Press, New York-Nashville, 1959): "In the spring of 1914 Moreno published in Vienna the first of a series of poetic writings entitled *Einladung zu einer Begegnung* (*Invitation to an Encounter*), which is evidently *the first literary definition of encounter*, the concept which has become central in the existentialist movement. . . . During the years 1918-20 Martin Buber was a contributing editor of *Daimon*,* and his articles appeared side by side with Moreno's, prophetic of the role each would have in the history of interpersonal theory."

It is clear, therefore, that Moreno should be credited with having first introduced the concept of the encounter, and not Martin Buber who was, however, a powerful force in spreading it.

2. What relationship is there between the concept of the encounter and "the encounter group," whose recent spread arouses curiosity?

In the past few years the National Training Laboratories for Group Development in Bethel, Maine, and many of its followers throughout the country, have increasingly discorded the terms "T-group" and "T-group training," and replaced it by "encounter group." This term and concept was first suggested by Moreno in *Group Training vs. Group Therapy* (Edited by Robert R. Blake, Sociometry Monograph No. 35, Beacon House, 1958) p. 80: "I differentiate natural groups, like the family, from synthetic groups like therapy and training groups and further, the *encounter group* which is neither, although it has elements of both. In the encounter group the private as well as the collective individual, both are eliminated."

This leads directly to the question as to who put forth first the idea of "training in groups"? This too, can be traced to Moreno, see *Who Shall Survive?* (Nervous and Mental Disease Publishing Co., 1934), chapter on "Spontaneity Training," p. 321-331.

3. One hears the term "inter-personal therapy" used often these days. Whence does it stem?

This concept is increasingly used in the therapy of dyads, intimate ensembles and small groups, in conjoint therapy, family therapy, matrimonial therapy, etc.

Dr. R. Grinker Jr., in an article entitled "Complementary Psychotherapy" in the *American Journal of Psychiatry*, December 1966, p. 633-638, speaks of "associated pairs." In the May, 1967 issue of the *American Journal of Psychiatry*, p. 1463, Moreno commented on this article as follows: "It is a

* A quarterly magazine, of which J. L. Moreno was editor in chief, published by Anzengruber Verlag, Vienna, 1918.

hopeful sign of the times that a psychoanalyst of Dr. Grinker's reputation has shown an open mind toward the treatment of "associated" pairs. But it is unfortunate that authors referred to by him in his references are limited to psychoanalytically-oriented workers, since the implication is that the "leaders for change" have come from the psychoanalytic establishment. Dr. Grinker fails to mention contributions from other sources. But as in many other areas of community-related psychiatry, the original and continuous insistence upon interpersonal and joint treatment of marriage partners (See J. L. Moreno, "Interpersonal Therapy and the psychopathology of Interpersonal Relations," *Sociometry,* Vol. I, p. 9-76, 1937; J. L. Moreno, "Psychodramatic Treatment of Marriage Problems," *Sociometry,* Vol. III, p. 1-23, 1939; and Bruno Solby, "Psychodramatic Treatment of Marriage Problems," *American Sociological Review,* Vol. 6: 523-530, 1941) has not come from the representatives of the classic psychoanalytic school but from other schools of psychotherapy. (See B. J. Biddle and E. J. Thomas, *Role Theory,* John Wiley & Sons, p. 5-19, 1966, and J. Spiegel and N. Bell, "The Family of the Psychiatric Patient," in S. Arieti, *American Handbook of Psychiatry,* Vol. I, Basic Books, p. 136, 1959). The development of community-related psychiatry is, for instance, greatly indebted to interpersonal therapy, interactional group psychotherapy, sociometry, psychodrama, group dynamics, and reality practice. This should not be obliterated from the consciousness of the younger generation of psychotherapists."

As an observer of history in the making, I might add a fact which shows some of the networks of influence at work, in our own lifetime. Dr. Grinker, in the above-named article on associated pairs (husband-wife, mother-daughter, etc.), lists among others in his references, articles by Dr. Bela Mittelman, "The Concurrent Analysis of Married Couples," *Psychoanalytic Quarterly,* Vol. 17, p. 182-197, 1948; "Simultaneous Treatment of Both Parents and their Child," in G. Bychowski and J. L. Despert, *Specialized Techniques in Psychotherapy,* Grove Press, p. 103-118, 1952. Dr. Mittelman's publication dates are the earliest in Dr. Grinker's reference list, 1948 and 1952. These dates are significant: Dr. Bela Mittelman was well known to the author, as he had been a student, enrolled in a seminar at the Psychodrama Institute in Beacon, a regular attendant at open sessions at the New York City Psychodramatic Institute at 101 Park Avenue from 1942 and throughout the middle forties. Indeed, he was much intrigued by psychodrama and became involved as auxiliary ego in psychodrama sessions with a *mother-daughter pair* then under treatment in Beacon by Moreno. He often stayed after sessions in the theater at 101 Park, entering into long discussions with

me on the interpersonal dynamics operating between patient and auxiliary ego, showing particular interest between patient and auxiliary ego, showing particular interest in the "double" technique which we were in the process of subjecting to severe clinical and experimental tests, as reported by myself (as Zerka Tocman) in *Sociometry,* Vol. 9, p. 178-183, 1946, and again in *Sociatry,* Vol. I, p. 436-446, 1948.

The history of a science is permeated with such direct but meaningful interpersonal contacts, and frequently change the direction of a man's thinking. They are too often overlooked and even less frequently put on record.

4. In which setting were the terms group therapy and group psychotherapy introduced?

A classic reference for this has become a statement read by Dr. William Alanson White, on the occasion of a Conference on the Group Method, during the annual meeting of the American Psychiatric Association at the Bellevue-Stratford Hotel, May 31, 1932. The meeting was chaired by Dr. White; the title of his presentation was "Proposal of a Plan of Group Psychotherapy," and was introduced by him as follows: "The proposal for the Application of the Group Method to the Classification of Prisoners has grown out of a luncheon conference arranged by the National Committee on Prisons and Prison Labor through the courtesy of the American Psychiatric Association at our meeting in Toronto, last year, 1931, at which many of you were present. Dr. J. L. Moreno suggested group psychotherapy of prisoners and as a result the authorities of the New York State Department of Correction permitted Dr. Moreno in collaboration with Dr. E. Stagg Whitin, Chairman of the Executive Council of the National Committee on Prisons and Prison Labor, to carry on research at Sing Sing Prison." The reader is referred to a publication called *Application of the Group Method to Classification,* published in 1932 by the National Committee on Prisons and Prison Labor, p. 109.

In this same book, the reader will find on p. 60, a chapter heading by Moreno, "Concerning Group Therapy," in which he launches into the method of therapeutic assignment of men to the same group, for rehabilitation purposes in the penal system. The original publication is out of date, but it is now available as *The First Book on Group Psychotherapy,* Beacon House, 1957.

5. How did the concept "inter-personal sensitivity" emerge? Moreno observed "that some real process in one person's life situation is sensitive and corresponds to some real process in another person's life situation and that there are numerous degrees, positive and negative, of these inter-personal sensitivities." He was especially concerned with defining and measuring interpersonal processes and arrived at a system of quantifying the choice

process, establishing mathematically, clinically and experimentally, via the choice-rejection axis, that there is a factor which is responsible for the two-way attraction and rejection interaction between persons.

The inter-personal sensitivities were subjected to careful scrutiny, in action, in spontaneity testing and training. The reader is referred to the following publications: "Statistics of Social Configurations," J. L. Moreno and H. H. Jennings, *Sociometry,* Vol. I, p. 342-374, 1937. A detailed description of how interpersonal sensitivity operates, for instance, between husband and wife, is given in Moreno's "Inter-Personal Therapy and the Psychopathology of Inter-Personal Relations," *Sociometry,* Vol. I, p. 9-80, 1937.

6. When was the concept "group cohesion" first suggested and discussed?

The first edition of Moreno's *Who Shall Survive?,* 1934, contains the following statement on p. 103: "We had found that the desire to remain in the present cottages—the ratio of interest summed up for all the cottages—is 44.81%. Hence it is evident that *the cohesive forces at work in Hudson were stronger than the forces drawing the girls away from their groupings.*"

In "Statistics of Social Configurations" (see above, p. 363), Moreno states: "The study of the cohesion of forces within a group can be made through an analysis of choices made and choices received, the choices going to individuals inside and to individuals outside of this constellation. A different study of cohesion is based upon the configurational aspect. It considers, instead of single elements, choices, the inter-personal structures and the degree of cohesion produced by them. Cohesion would be very low, for instance, if a large number of choices going to the individuals of a group were unreciprocated." The principle of group cohesion is formulated by Moreno also in *Who Shall Survive?,* second, revised and enlarged edition, 1953, on p. 454, as follows: "The larger the number of mutual pairs the wider will be the rate of interaction and the probability of a high group cohesion. The larger the number of individuals involved in positive tele communication the greater the group cohesion."

The superiority of Moreno's hypotheses on interaction to those of George C. Homans' who wrote many years later a book, *The Human Group,* Harcourt Brace, 1950, largely based on sociometric findings, have been demonstrated by many leading authorities in the field of human relations. For one of the most recent critiques of Homans, see Professor P. Sorokin's *Sociological Theories Today,* Harper & Row, 1966.

7. When were motion pictures and television first used in a therapeutic setting?

In this area, the following references are available: *Psychodrama, Vol. I,*

1946, Section IX, "Therapeutic Motion Pictures," p. 385-420. From p. 402-420 the chapter deals specifically with the *television* medium. We quote from p. 403: "One of the most important aspects in the study of interpersonal relations is the interactive performance of a group of persons in a medium which is continuously changing, and in which the attention of the participants is shifting from one task to another without warning. Under these conditions, split-second judgment and responsive spontaneity will be most rigorously challenged. Television is a medium in which interpersonal action of the moment is the final desideratum.

"A new opportunity for testing interpersonal productivity is given in television broadcasting, since it can combine in a unique fashion spontaneity of human interaction with the flexibility of a technical instrument well attuned to such intent. The human organism, singly and collectively, has in the past been so overconditioned and made so responsive to cultural conserve stimuli that new methods and procedures must be investigated in order to develop new reaction-patterns."

Motion pictures of psychodrama with genuine protagonists were first introduced by Moreno in Hudson, N.Y., in 1933, while he was Director of Research at the New York State Training School for Girls. This film dealt with the spontaneity testing and training, and role training of the girls for vocational goals; it was shown at the Department of Psychology, Columbia University, where it was seen by Professor Gardner Murphy and Dr. Kurt Lewin, to mention but a few disseminators of ideas who were present. The production of motion pictures with and by patients was continued in Beacon, N.Y., throughout the forties.

Films specifically made for television were produced by us in Paris, for the French Radio and Television Center in 1955 and 1956, and were repeatedly shown on public television. We had the amazing experience one night of walking innocently into the entrance hall of the Hotel Lutetia in Paris, only to see our own faces staring at us from the television screen; it was being watched with wrapt attention by numerous guests who recognized us at once!

Films of patients, actual protagonists in psychodrama, were made in the forties at the Psychiatric Department of the Medical School at McGill University; at the University of California at Los Angeles Robert Haas made a film "Psychodrama in Guidance" in 1948.

A television breakthrough in this country came when Dr. Verna Minear made a television broadcast, using psychodrama with alcoholic patients, for the general public, in 1953. She reports this in our journal, *Group Psychotherapy*, Vol. VI, p. 115-117, 1953, under the title "An Initial Venture in the

Use of Television as a Medium for Psychodrama," from which we quote: "A psychodrama session was televised for the first time on Station WTOP in Washington, D.C. on the 19th of April, 1953. It was one of a series of thirteen programs produced by the Committee on Education of the Alcoholic Rehabilitation Program of the District of Columbia.

Following her pioneering venture, Drs. Abel Ossorio and Leon J. Fine, of the St. Louis State Hospital, made a television film in 1959, shown publicly, through the courtesy of the CBS Network, in a series called "Montage." This series won the Albert Lasker Award for outstanding television programs.

The next original venture came in the use of closed circuit TV for patients' benefit at the Camarillo State Hospital in May, 1964. Moreno was televised while conducting a psychodrama session with patients and the entire patient population watched from their screens, thoroughout the institution. The production was recorded in videotape as it proceeded and is shown weekly on the closed circuit to the patients. The complete protocol of this production was published in this journal, *Group Psychotherapy*, Vol. XVIII, 1965, p. 87-117, under the title "Psychodrama in Action."

Another first came about in September 1964 in Paris, during the First International Congress of Psychodrama, when unbeknownst to Moreno, a complete motion picture set-up was organized in a large reception room at the old Faculte de Medicine. When he entered the room, there it was, and a group of several hundred participants were breathless waiting, expecting a psychodrama demonstration, right there and then, and . . . they got it. This production, also on film, was the psychodramatic treatment of a marital problem, with both partners participating in the psychodrama. This film, too, was under the sponsorship of the French government, the same Radio and Television Center of France, which had so graciously been involved in our two earlier undertakings there during the fifties. The complete report of this film is contained in *Group Psychotherapy*, Vol. XIX, 1966, which is part of the Proceedings of that memorable First International Congress of Psychodrama, under the title "Psychodrama of a Marriage," p. 49-93. The film is especially noteworthy because its second reel consists of the Psychodrama of a Dream—of the wife—also a first of its kind. In psychodramatic dream production the dream is enacted by the protagonist, with the aid of auxiliary egos who closely follow the directions of the protagonist, moving and speaking only when the protagonist directs them to, like wax figures which spring to life at the touch of the good fairy's magic wand. According to recurrent reports from France, this film is repeatedly shown on the public television network and is a great

favorite with the French public who are proud that Paris was the scene of this unusual event.

Several of Moreno's associates have also appeared on public television in this country. In November 1965, on the Hugh Downs' Show "Today" NBC broadcast a live production entitled "Alcoholism, America's Greatest Failure". Psychodrama was one of the methods dealt with and a psychodrama was conducted on the program with an actual patient and auxiliary egos, by Hannah B. Weiner, one of the Directors of the Moreno Institute.

In 1966, Dr. Lewis Yablonsky televised a live psychodrama production with a group of patients in Los Angeles in a series called "Therapy". Two marital partners are shown in interaction, attempting to resolve some of their conflicts, besides a number of scenes dealing with parent-adolescent conflicts involving several other members of the same group.

It is, therefore, rewarding to read in the *American Journal of Psychiatry,* Vol. 123, May 1967, dedicated to Innovative Approaches in Therapy, that other workers are rediscovering the usefulness of videotape in closed circuit TV. Drs. Ian Alger and Peter Hogan describe their application of the medium in "The Use of Videotape Recordings in Conjoint Marital Therapy", p. 1425-1430. Such confirmation of findings are absolutely imperative if we are to achieve growing understanding of person-to-person and person-to-group relations. It is noteworthy that the non-psychodramatic workers have restricted themselves largely to videotape recording for closed circuit television, whereas the action therapists have been involved from the onset in both closed and open circuit television broadcasting.

The pioneer in the field has something to say about the future of television broadcasting; he envisioned its use not only for closed circuits, but also for open circuits for large scale, therapeutic purposes, making the mass media of communication serve the public interest, rather than helping to line the pockets of commercial producers. To quote once more from *Psychodrama, Volume I,* p. 420: "I foresee that in the not too distant future theatres for therapeutic television and motion pictures will be just as commonplace as newsreel theatres are today (1946). Each will have a psychiatric consultant. They will provide the most effective vehicle for mass psychotherapy ever devised. 'Localized' group psychotherapy will have found a counterpart through which millions of local groups can be treated en masse."

8. Considering the constant fact of Negro-white problems in the USA, who was the prophet of the present race crisis?

Moreno's systematic investigation of inter-racial tensions were begun

and published in *Who Shall Survive?* in 1934, ten years before Gunnar Myrdal's book *An American Dilemma, The Negro Problem and Modern Democracy* (Harper & Row) appeared in 1944. On the basis of extensive sociometric research of small groups (schools and small communities) Moreno predicted that the latent social and emotional tensions between white and colored will eventually lead to violent outbreaks. He showed, on the basis of sociometric analysis of groups, that "there is a sociometric point of saturation of a specific homogeneous group for a specific other contrasting element under given conditions. In the case of social groups the point of saturation may change with the organization of the interrelated groups."

This work was further elaborated by Dr. Joan H. Criswell in 1935 and reported on by her in an article "Racial Cleavage in Negro-White Groups", *Sociometry,* Vol. I, p. 81-90, 1937.

9. Personality researchers, psychotherapists and educators are emphasizing the involvement of the body more and more. Who was responsible for this direction away from the word, to the act?

At the risk of being repetitious, it must be said: Moreno. In his *Psychodrama, Vol. I,* we find the following on p. 216, under the heading "Psychodrama Without Words, the Dance and Psychomusic": "We approach here new realms of the psychodrama, the realms of pantomime, the realm of rhythm, dance and music, and the realm of the (apparently) nonsensical. Methods for the exploration and development of a language-free, non-semantic psychopathology are needed. An illustration of such a method is the experimentation with the spontaneity states, with the warming up process, and with the body moving into space. We did not deal with word association primarily. No verbal process was expected." And on p. 140, under "Spontaneity Training of Children": "Education through action and for action has been neglected. The Spontaneity Theory and Method is an answer to this demand. Founded on known facts of physiology and psychology it offers a simple practical method for the direction of those forces which determine the development of personality." On p. 142 he speaks of "Body-to-Mind training" and of "Mind-to-Body training". He repeatedly emphasizes throughout his writing that we are engaged in "body-therapy, just as much as in psychotherapy". One of his most profound disagreements with Freud arose out of his observation that "The word is not the royal route to the psyche, in fact, there are parts of the psyche which are language-resistant". On p. 11 of *Psychodrama, Vol. I,* we read: "A psychology of action is more akin to the Americans (as opposed to Europeans), a motorically minded people, trained by a history of pioneering and the philosophy of pragmatism to favor motoric

ideas, and drama means action. 'Going places and doing things' is a more popular notion to them than 'sitting in a chair and reading a book.' It seems easier for them to accept a psychotherapy which is a battle of acts."

From body-therapy of the individual it is a logical next step to move into bodily contact, applying physiodramatic techniques, especially to non-cooperative patients who are not reached or moved by words. With them, the psychodramatists enter into combat, wrestling, boxing, hitting, pinching, slapping, caressing, gymnastics, ball games, dancing, rhythmic movements of all kinds, embodiments of animals, plants, objects, parts of the human body, etc.

During the early fifties we admitted to the hospital in Beacon a mute, catatonic adolescent male, who had been in this condition for seven years during his stay at a state hospital. He was given a psychiatric aid, a young, strong and athletic male who was his constant companion. They attended sessions in the theater together, ate together, went for walks, in short, did everything together. Although Richard liked his "auxiliary ego" and did not resist him, he remained mute. Moreno then devised a program for him; he scheduled boxing and wrestling matches for Richard twice a week. The theater was turned into a ring, patients, students and staff came to watch while the two young men showed their physical prowess. The auxiliary ego was instructed not to be "soft" with him, to counter every blow, as he normally would when engaged in such a fight.

Richard responded positively to this. After six months of this completely non-verbal approach, he began to participate in psychodramas with other patients, first making astute but sparse comments as an observer, gradually as an auxiliary ego in behalf of other patients. Although always a "man of few words", he was extremely effective, sensitive and to the point as an auxiliary ego, but it was impossible to get him to cooperate in the production of his own psychodrama. Nevertheless, he was discharged as much improved and returned to the community after approximately fourteen months and achieved a fair social recovery.

Moreno pioneered yet another undertaking in the area of body movement: the scientific study of boxers (which led him to the above described form of treatment). He observed boxers in action in the ring, and, on the basis of this and numerous other areas of research which I shall describe later, predicted the outcome of the fight during the championship fight for which they were preparing themselves. He was hired in this capacity by the Associated Press between 1935 and 1958 repeatedly. He went to the boxers training camps, made action studies of the boxers while sparring with their part-

ners, counted the number of times they connected per minute, recorded the complete set of movements used, measured bloodpressure, breathing rate, checked the amount of perspiration both in action and while resting. To understand the psychological pressures they were enduring—besides their physical hardship—he tirelessly investigated their sociometric relationships to trainers, promoters, members of their family. Psychodramatically he explored their perceptions of themselves and of their opponent while in action in the ring, their fears of losing and how they manifested themselves in their dream and wake states, etc. He was even interested in what they read, ate, and their belief in God. I went along with him on a great many of these occasions and assisted in the recording. He thus investigated all the major champions and made very acute predictions—even to the number of rounds they would be able to carry—about their performance; the Associated Press carried world-wide releases on his findings concerning championship fights of Joe Louis, Max Baer, Max Schmeling, Jersey Joe Wolcott, Rocky Marciano, Ezzard Charles and others. Even famous sportwriters as Damon Runyon listened with awe to his predictions and came to rely on them for betting purposes!

He made a fascinating series of discoveries while doing all this, not the least of which being that trainers intuitively choose sparring partners who represent the fighting style of the opponent he was training to encounter. He designated the sparring partners—naturally—as auxiliary egos, stand-ins for the real person and the real event, very much the way the psychodramatic chief therapist proceeds to prepare his patients by means of auxiliary egos for his eventual return to his own real life partners and the inevitable encounter with them. I attended Joe Louis' final championship fight at Yankee Stadium in 1949, and observed the various phenomena Moreno had trained us to look for, at firsthand. Regrettably, neither of the two aged champion-protagonists were at the height of their action power. The event left its mark in my memory nevertheless, in a heightened awareness of the multiple psychodramas which had preceded this final "physiodrama".

A number of the younger, eclectic psychotherapists, as Fritz Perls and William Schultz, are using these body methods. For a long time, we stood alone. It was assumed by others that all this bodily involvement was harmful for the patient, especially as it changed his relationship to his therapist, from an objective to a highly subjective one. The use of auxiliary egos as go-betweens, was never completely appreciated or understood. Moreno stuck to his guns. The only concern, he preached, is whether all this is done for the welfare of the patient. It is never intended to fill needs of the therapist. After all, how could a dentist, a surgeon, a gynecologist or obstetrician, or a derma-

tologist, practice his skills without "touching"? Is the psyche more, or less, sacrosanct than the body? Where does one begin and the other end?

We are happy to see this barrier, too, is finally being surmounted.

9. There is a general trend in psychotherapy away from the negative view of life, to an affirmative, positive position. Who is responsible for this mood?

A social psychologist, William Schultz, recently had the courage to re-emphasize one of Moreno's cardinal ideas, to replace the therapy of negativism and depression by the therapy of gaiety and joy. This can be seen from his book *Joy, Expanding Human Awareness,* Grove Press, 1967. In a now classic quote, Moreno, when he met Freud, told him in 1912 (See *Psychodrama, Vol. I,* p. 6): "You analyze their dreams. I try to give them the courage to dream again. I teach the people how to play God." Elsewhere on the same page he continues: "psychoanalysis had developed an atmosphere of fear among young people. Fear of neurosis was the measure of the day. A heroic gesture, a noble aspiration made its bearer immediately suspect."

Existential validation came to us from a practicing psychodramatist, Dr. Marvin Wellman, then Clinical Director of the Northeast Florida State Hospital at Macclenny, who wrote me in a letter on October 15, 1963: "I think the greatest contribution which Dr. Moreno has made to medicine is the possibility of treatment with joy. We have all known the burden of therapy both on the physician and on the patient, but frequently enough in the Moreno therapy, and no place else in medicine, there is joy which is as spontaneous and as deep as the burbling of a baby. Unfortunately, Hamlet has more prestige than the Merry Wives of Windsor."

Thousands of the participants in sessions of the Moreno Institute will remember one of the oldest, most persistent sayings of Moreno: "I would like my tombstone to carry an epitaph which reads "Here lies the man who brought joy and laughter into psychiatry'." He may well have his wish fulfilled.

## ANNOUNCEMENTS

*American Society of Group Psychotherapy and Psychodrama*

President: 1966-1968, Jack L. Ward, M.D.

Nominations: President-Elect, Hannah B. Weiner, M.A.; First Vice-President Elect, Doris T. Allen, Ph.D.; Second Vice-President Elect, Abel K. Fink, Ph.D.

Ballots will be mailed between February 1st and February 15th, 1968.

27th Annual Meeting: Statler Hilton Hotel, New York City, March 28 to 30, 1968. Program Chairman, Hannah B. Weiner. Send inquiries and papers to the Program Chairman, Hannah B. Weiner, 1323 Ave. N., Brooklyn, N.Y., 11230. Preliminary program is being prepared.

*Moreno Institute and Moreno Academy*

Training Institute to be held at the Moreno Institute, 236 West 78 Street, New York, following the annual meeting of the American Society of Group Psychotherapy and Psychodrama, Sunday, March 31, 1968 and Monday, April 1, 1968. Those who wish to participate may write for further information to Zerka T. Moreno, Moreno Institute, 259 Wolcott Ave., Beacon, N.Y., 12508.

*Moreno Institute*

Sessions are conducted each evening including Sunday, at 8:30 p.m. at the Moreno Institute, 236 West 78 Street, New York. The fee per person is $3.00.

*Moreno Academy Training Center, Beacon, N.Y.*

Training Seminars are held continuously throughout the year at the Moreno Academy in Beacon, N.Y. For further information and training bulletin write to Zerka T. Moreno, Director of Training, Moreno Academy, 259 Wolcott Ave., Beacon, N.Y., 12508.

*Three International Congresses, 1968, Group Psychotherapy, Psychodrama and Sociometry*

The Fourth International Congress of Group Psychotherapy will be held in Vienna from September 16-21, 1968.

The Third International Congress of Psychodrama and Sociodrama will be held in Prague from September 23-25, 1968.

The First International Congress of Sociometry and Social Psychology will be held in Prague from September 26-28, 1968.

Preliminary announcements of these Congresses are herewith enclosed.

*Lecture Tours, Dr. J. L. Moreno and Mrs. Zerka T. Moreno, 1967-1968*

Brandeis University, Lowell Mental Health Center, McLean Hospital, Harvard University, Tulane University, Harlingen Adult Mental Health Clinic. California—Los Angeles, Long Beach, Berkeley, Sacramento.

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