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CONTENTS

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Behavior Simulation: A Model for the Study of the Simulation Aspect of Psychodrama

David A. Kipper

The fact that the simulation of human experience is a basic principle of psychodrama, and that psychodrama is the one psychotherapeutic method which uses it most systematically and extensively is developed in this paper into a broader conceptual framework. The concept of behavior simulation and a heuristic model are suggested. Since behavior simulation pertains to *all* forms of simulation, it is also viewed as a bridge between psychodrama and other methods. It is hypothesized that behavior evident in behavior simulation situations may be categorized into three kinds: spontaneous behavior, mimetic-replication behavior, and mimetic-pretend behavior. A theoretical paradigm shows the relationships of these to observable criteria, which also form six basic behavior simulation conditions. Initial research data appear to support the new concept, and suggest a new direction for psychodrama and behavior simulation research.

Since the time that psychodrama was formulated as a systematic method of psychotherapy there has been agreement by both skeptics and proponents that it represented a novel approach compared with traditional forms of psychotherapy (e.g., Biddle, 1979). Consequently, there have been numerous attempts to identify the salient characteristics of psychodrama, especially those believed to account for its unique standing among other psychotherapies. These endeavors resulted in a list of several such characteristics. Among the most frequently noted ones were, for example, the theoretical–and the practical–sociometric basis of psychodrama, the focus on the enhancement of spontaneous approach to the solving of day-to-day problems and conflicts, the emphasis on the fostering of creativity and creative acts, the importance attached to the use of dramatic behavior, that is, the actional language, as a vehicle for self-development, and

the concentration on a methodology which concretizes psychological process, emotional as well as cognitive. Some users of psychodrama tended to emphasize one of these characteristics more than the others, and some stressed equally a few or even all of them.

There is, however, an additional basic characteristic of psychodrama which unfortunately did not receive sufficient attention in recent psychodrama literature (Blatner, 1973; Corsini, 1966; Starr, 1977; Yablonsky, 1976). It pertains to the early conceptualization of psychodrama, the underlying notion which led to the formulation of this psychotherapeutic method. Psychodrama was originally designed to serve as a medium for temporary, corrective *substitution* of natural behavior, a miniature replication of life or some of its aspects. Thus, psychodrama was constructed as an *in vitro* situation, a sheltered laboratory setting modeled after human behavior as manifested in real life. On this, Moreno (1966) wrote as follows: "We live within the framework of time, space, and reality, but time learning, space learning, and reality learning cannot take place and be improved unless they are tested in an experimental setting, where they are experienced, expressed, practiced and reintegrated within the framework of a psychiatry which is modeled after life itself" (p. 157).

The principle that psychodrama models itself after life clearly classifies it, using contemporary behavioral science terminology, as a method of simulation or specifically a method of *behavior simulation*. The therapeutic process, therefore, takes place under a simulation condition where the protagonist demonstrates his or her interpersonal communication skills, psychological reactions to critical situations, and the impact of moral and cultural influences on such behavior. Behavior is simulated beginning with the recreation of the protagonist's actual life experiences, past and present, and then it might be expanded to include the simulation of unfulfilled aspirations, hopes, ambitions, and even fantasies. The simulation property has always been a central characteristic of psychodrama. Moreno's introduction to the third edition of his book: *Psychodrama Volume 1* (1964, p. xxii) contains an explicit reference to this point:

> The psychodramatic method rests upon the hypothesis that, in order to provide patients, singly or in groups, with a new opportunity for a psychodynamic and sociocultural reintegration "therapeutic cultures in miniature" are required, in lieu or in extension of unsatisfactory natural habitats. Vehicles for carrying out this project are (1) existential psychodrama within the framework of community life, itself, *in situ*, and (2) the neutral, objective, and flexible therapeutic theater. The latter represents the laboratory method in contrast to the method of nature and is structured to meet the sociocultural needs of the protagonist.

Regarding the concept of simulation, Moreno differentiated between two forms of psychodrama. The first represents an *in vivo* approach, that is, treat-

ments in the natural environment. When this becomes impractical, a second form of psychodrama must be employed where the natural environment is recreated, that is, simulated in a "neutral, objective, and flexible laboratory setting." The latter form, of course, is the one most frequently used in psychotherapy.

At this point it would be helpful to elaborate further on the difference between the concept *simulation* as it is commonly understood and our newly proposed concept *behavior simulation*. Simulation generally refers to techniques of eliciting certain behavior through the manipulation of the external environment. It is the setting of situations so "that their elements comprise a more or less accurate representation or model of some external reality with which the players interact in much the same way they would with the actual reality" (Horn & Cleaves, 1980, p. 7). In that respect psychodrama is a method which uses simulations extensively. At the same time it is not limited to the representations of external realities. It also concentrates on the representations of other kinds of realities, e.g., internal, fantasies, as well as "surplus" reality (Moreno, 1965). *Behavior simulation* is a new, broader concept which includes the simulation of external environments, internal behavior, psychological processes, and direct modifications of the responses themselves. It is more accurate, therefore, to describe psychodrama as a method in which one of its basic characteristics is the use of *behavior simulation interventions* (see also Kipper, 1981).

The purpose of the present paper is to offer a general frame of reference, a *heuristic paradigm*, for the concept of behavior simulation. There seem to be several reasons which call for such a discussion. One is that the simulation or behavior simulation aspect of psychodrama has been hitherto de-emphasized if not overlooked. Second, behavior simulation is a generic concept which transcends the affiliation to any particular psychotherapeutic approach. While it represents an integral component of psychodrama it is also used in other methods of behavioral change such as family therapy, behavior rehearsal, skill training, computer games, and group exercises, to mention only a few. It is a concept which offers an opportunity to widen the scope of psychodrama to include other practices of assessing and changing human behavior through the concretization of personal experiences. Finally, a behavior simulation paradigm may open new avenues for research in an effort to increase understanding of the impact of psychodramatic techniques, to introduce a measure of greater refinement in structuring psychodramatic situations, and to increase the effectiveness of the therapeutic endeavor.

Definitions of Terms and Concepts

In the discussion of behavior simulation a number of specific terms and concepts will be used. Some of these are well known and some are new or redefined

in a new way. In the interest of having a systematic presentation, all these terms and concepts will be listed.

The participants in a behavior simulation session are identified by their psychodramatic roles and functions. Thus, the *director* is the main therapist, and the *protagonist* is the person whose presenting complaint(s) are the focus of the session. The *auxiliaries* are the persons who serve as helpers to the protagonist, to the director, or to both. The *group* or the *group members* are the persons who participate in the session as the recipients of the treatment.

Other specific terms and concepts are as follows:

1. *Scene.* A scene is an enacted episode anchored in a specific situation and in a defined time frame of reference. It may involve either real or imaginal interactions with people or objects. The scene is always portrayed as a concrete situation regardless of whether or not it actually happened.

2. *Model.* The term model refers to the concrete responses and the behavioral patterns of a person. It can also be a set of norms or concepts regarding a desirable mode of conduct which can be translated into observable behavior.

3. *Spontaneous behavior.* Spontaneous behavior is a term which describes one of three kinds of behavior evident in behavior simulation situations. It is an authentic form of expressing one's own feelings, perceptions, attitudes, beliefs, and internal tendencies. But at the same time it is also a *stimulus bound* set of responses primarily triggered by the characteristics of the simulated situation. Moreno's definition of spontaneous behavior (1964) is somewhat similar, yet not identical, to the present definition.

4. *Mimetic-replication behavior.* Mimetic-replication is another kind of behavior evident in behavior simulation situations. It is characterized by the attempt to imitate accurately, to replicate, the behavior of a specific model. The model must be *concrete* and *visible*. It can be an external model or an internal one, that is, a repetition of past self-performance.

5. *Mimetic-pretend behavior.* Mimetic-pretend is the third kind of behavior evident in behavior simulation situations. It is the imitation of the general characteristics of an external model who is *absent* from the treatment session. The imitated model is not personally known to the player and it can also exist as an ideal or in the form of a normative description of a certain mode of conduct. Mimetic-pretend is displayed while the protagonist or the auxiliary acts under an assumed identity and/or in a hypothetical situation.

6. *Simulation.* This term refers to various techniques and procedures of reproducing situations from the real world in the laboratory. This is achieved through the use of artificial means such as technical instruments, electronic devices, and behavioral procedures capable of providing a close approximation of the original, natural conditions.

7. *Role playing.* The term role playing is defined here in a very specific sense. It refers to a form of expression characterized by concrete manifestations of thoughts, attitudes, feelings, and fantasies. Role playing, therefore, refers to the use of actional language.

There are two additional concepts which belong to this list but which will be described separately. The reason for this is that each of these two, in a way, represents a system rather than a component of a system. The two concepts are as follows:

Psychodrama. Psychodrama is a complete psychotherapeutic method originally created by J. L. Moreno on the basis of his theory of personality development and group behavior (e.g., Moreno, 1953; 1956; 1964; Moreno & Moreno, 1969). It was first introduced as a form of group psychotherapy, but it can also be used in individual therapy, the treatment of dyads, families, and large groups.

Behavior simulation. Behavior simulation is a system for designing and structuring real life behavior and experiences in a laboratory setting. It is based on classifying behavior displayed in simulation situations into three predominant kinds: spontaneous, mimetic-replication, and mimetic-pretend. It utilizes the characteristics of each of these three for a more effective attainment of the therapeutic goals. Behavior simulation, therefore, represents a *subsystem* of psychodrama.

Spontaneous and Mimetic Behavior

In principle, there are two content elements in every psychotherapeutic session that can be expressed in a simulated fashion. One is the situational backgrounds where the protagonist's complaints manifest themselves. These backgrounds, henceforth referred to as the E factor, are the real-life *environments* which pose coping difficulties for the protagonist. The second element is the actual responses, i.e., the *behavior* of the main participants in the enactment. The behavior, henceforth referred to as the B factor, refers to the model(s) that the protagonist and the auxiliaries have in mind while they encounter the simulated situation, that which provides them with guidelines and examples as to how to respond to it.

A treatment session becomes a behavior simulation intervention once the therapist-director has decided to use one or more of the following three behavior simulation strategies: He or she may choose to simulate the original situation, namely, to design or structure the E factor alone, leaving the B factor untouched. Another strategy will be to simulate, design, and structure both the E factor and the B factor. The third strategy is, of course, to simulate, i.e., to provide a specific model for the B factor, only without simulating the E factor. The latter strategy implies the structuring of a role to be performed without any connection to a particular situation. While in clinical practice this strategy is occasion-

ally used, it is not considered a classic simulation situation. This is perhaps one of the reasons for the requirement that every role playing and psychodramatic enactment ought to be anchored in a scene, in a well defined situation.

Spontaneous behavior. The present definition of spontaneous behavior is *ipso facto* related to the first of the above mentioned three strategies. It is the participant's response patterns which occur in a behavior simulation session where the E factor has been simulated while the B factor was left untouched.

Interestingly enough, most of the procedures commonly subsumed under the concept *simulation techniques* fall within this strategy. An examination of the literature on simulation reveals a wide range of techniques that have been invented. Generally, they may be classified into three broad groups. First, techniques that aim at achieving a *complete replication* of the external environment. Examples of these are the simulation of pilot's cockpit (e.g., Stave, 1977), car driving simulations, or the supertanker simulator (Wagenaar, 1975). Second, there are techniques aimed at producing only *partial replications* of the real-life environments typically with the aid of electronic devices, e.g., computer simulations (e.g., Lehman, 1977) or videotapes (e.g., Berger, 1978). Lastly, there are techniques that elicit *symbolic* or *imaginary replications* of the original reality as often seen in the use of social and business games, group exercises, and role playing (e.g., Kenderdine & Keyes, 1974).

Obviously, some of these specific simulation techniques can be used only in standardized skill training situations and not in the unpredictable context of psychotherapy. But in principle, behavior simulation and psychodramatic treatments can use techniques that may be classified under any of these three groups. It is possible to simulate the E factor using techniques of complete replications. An example of this is the case of family treatment where all the concerned members are present in the session. Most frequently, however, the partial replication techniques are used when there is no need to produce an exact replication or when such a replication is impractical. Of course, psychodramatic and role playing treatments use techniques that produce symbolic or imaginary replications quite extensively.

To summarize, then, spontaneous behavior is expressed when only the E factor is simulated while the B factor is left untouched. It is behavior that emanates from one's natural feelings, perceptions, attitudes, and internal tendencies. It appears more or less as an immediate, direct, and straightforward response to the stimuli in the simulated environment, and it has highly idiosyncratic qualities.

Mimetic behavior. The term mimetic is described in the dictionary as "apt to," the "resemblance to other forms," and pertains to the act of mimicry and imitation. It originates from the Greek word mimos, meaning akin to. In the present context, however, it is used in a broader sense than that which implies a mere superficial imitation of a given behavior. Mimetic behavior involves a wide range of abilities such as the ability to use external imitations, to shape

one's behavior through modeling procedures, to retrieve past behavioral patterns *from one's memory and reproduce them in the here-and-now, and to translate* abstract codes of behavior into concrete forms. This is, therefore, a complex and creative behavior that requires the intervention of cognitive processes such as selection and screening, to mention only two.

The present definition of mimetic behavior is related to the adoption of the second and the third behavior simulation strategies. It might be recalled that the second behavior simulation strategy involves the simulation of both B and E factors, while the third is limited to the simulation of B factor alone. Mimetic behavior is always shaped after a given model which can be past self-performance or the behavior of others. Since this is a more or less defined behavior, it appears under conditions where the B factor is simulated, that is, designed, structured, and following certain guidelines. A close examination of this behavior reveals two distinct and separate kinds of mimetic behavior: *mimetic-replication*, and *mimetic-pretend.*

Mimetic-replication. This behavior is characterized by accurate imitations of a *personally known* model, one with which the respondent is thoroughly familiar. The model must be concrete and specific. It also must be replicated as accurately as possible. The replicated model may be *external* and visible. A classic example of such mimetic-replication is learning through direct or vicarious modeling. The replicated model can also be *internal* as in the case of using *one's own past performance* as a model for current behavior. In either instance, whether the model is externally visible or internally known through memory, mimetic-replication requires having clear ideas (or instructions) of what is to be imitated prior to the actual act of replication.

Mimetic-pretend. This behavior is characterized by the imitation of *external* models only. These, however, are certain kinds of models. They may be composites of traits and qualities that exist only as an ideal, e.g., the perfect lover, the ideal mother, etc. They may be codes of behavior shared by members of a given culture, e.g., altruistic behavior. They may also be ideas and goals one may have for which there is only a general model to follow. Mimetic-pretend is carried out under one or more of the following conditions: The portrayed role is defined as *impersonal*, but it allows for a considerable degree of personal involvement. The model is absent from the treatment session. If the model represents one individual person, it must not be personally known to the player. The behavior is displayed under an assumed identity.

A brief comparison between mimetic-replication and mimetic-pretend behavior may clarify some of their special characteristics.

- In mimetic-replication, the model is a full participant, accurately portrayed in the simulation enactment. In mimetic-pretend, it is represented in absentia as a general approximation of the original.

- In mimetic-replication, the model can either be internal or external. In mimetic-pretend, it is always external.
- In mimetic-replication, the model is clearly defined hardly allowing any personal input. In mimetic-pretend it is loosely structured and thus it is susceptible to personal improvizations.
- In mimetic-replication, the player always behaves as himself or herself. In mimetic-pretend, the model is imitated under an assumed identity or in a hypothetical situation.
- In mimetic-replication, the imitated behavior must be specific and well defined. In mimetic-pretend, the emphasis is on portraying the general characteristics of the model.

There are instances where it might be quite difficult to differentiate between behavior that is essentially *mimetic* and that which is essentially *spontaneous.* A seemingly spontaneous behavior expressed under conditions where only the E factor has been simulated may in fact be an internalized external model or the replication of past self-performance that became a readily available habit. Therefore, the question is: Where does one draw the line and can one speak of a pure spontaneous behavior? Obviously, there is no simple answer to this question. It is also clear that mimetic and spontaneous behavior can be interrelated. Personal and authentic behavior is shaped and formed through the process of socialization and the continuous interaction with the external environment. Thus, originally mimetic behavior, once internalized, becomes spontaneous behavior. Often, a protagonist may be able to tell whether or not this behavior followed a distinct model. But such self reports are not always very reliable.

Our proposal is to use external criteria in determining which is mimetic and which is spontaneous behavior. Such criteria should also help in differentiating between the two mimetic kinds of behavior: mimetic-replication and mimetic pretend. One criterion was already mentioned. It concerns the three behavior simulation strategies regarding the manipulation of the E factor, the B factor, or both. Another criterion is the kind of instructions given to the player. For eliciting spontaneous behavior the instruction should essentially be "Behave as naturally as you can." For eliciting mimetic-replication behavior it should essentially be "Behave exactly like him, her, or them." For eliciting mimetic-pretend behavior the essential ingredient in the instruction should be "*Imagine* that you are . . . who is supposed to do . . . ."

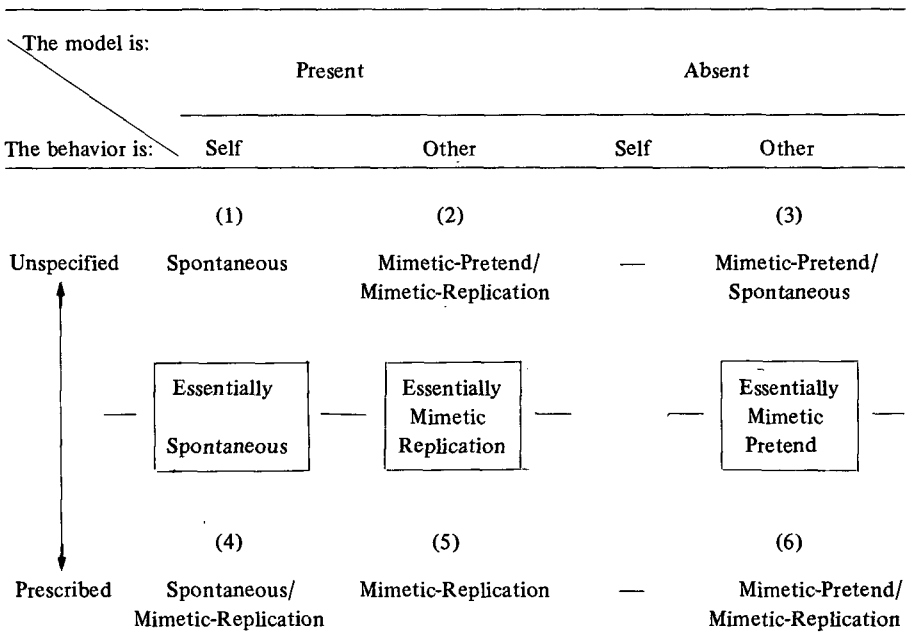
The Behavior Simulation Paradigm

In the foregoing discussion a distinction was made between the terms simulation and behavior simulation. While simulation was understood as the tech-

nology that provides ways of structuring the E factor, behavior simulation was defined as a broader concept referring to interventions that facilitate the expression of the B factor in a role playing manner, either in conjunction with or separate from the manipulation of the E factor.

What are the basic characteristics of the B factor? By definition, behavior expressed in a simulated scene has two elements: the *source* of the behavior, i.e., the model, and its *scope*, i.e., the degree of constraints imposed on the content of the role. It is proposed here that these two elements can be used as an external criterion for defining each of the three kinds of behavior evident in behavior simulation situations. Furthermore, their relationships to each other form sets of combinations, that is, simulated conditions that could predict the emergence of spontaneous behavior, mimetic-replication behavior, or mimetic-pretend behavior as well as two of these three combined. Figure 1 shows a behavior simulation paradigm that illustrates these points.

Figure 1: The Behavior-Simulation Paradigm



The top two lines in Figure 1 describe the characteristics of the model, i.e., the *source* of the behavior. In any given behavior simulation case the model may be either *present* or *absent* from the treatment session. When the model is *present* it can represent the *self*, i.e., when the protagonist (or the auxiliary) portrays himself or herself, or it can represent the *other*, i.e., when the behavior of some-

one else who is *in the session* is portrayed. But when the model is *absent* from the treatment session, obviously it can only represent the *other*, i.e., someone else. (Hence the empty cells in the second column from the right.)

The left column in Figure 1 describes the characteristics of the second element, that is, the *scope* of the behavior in terms of the specificity of the enacted role. The role behavior one may be asked to portray could range from that which is relatively *unspecified,* e.g., "Just behave naturally," to that which is very specific or *prescribed*, e.g., "Try to be as obstinate as you can." Since the specificity of the role behavior is a matter of degrees, the unspecified and the prescribed categories appear as the extreme ends of a continuum represented in Figure 1 by the two-way arrow. With regard to the *unspecified* end of the continuum it should be remembered that all roles portrayed in behavior simulation are somewhat prescribed by virtue of the fact that they are concrete and occur in a defined situation. Unspecified behavior, therefore, does not imply a complete lack of constraints on the role, but rather a relatively low degree of specificity.

The combinations of the characteristics of these two elements form six different behavior simulation conditions. These are represented in Figure 1 as six cells numbered 1, 2, 3, 4, 5, and 6. (Actually, the paradigm is comprised of eight cells, or combination conditions, but two of them–the column under "the model is *absent*" and "the model is the self"–are empty, inapplicable.)

Six Conditions of the Paradigm

In the condition marked as (1) the player portrays himself or herself (the model is *present* and *self*) under *unspecified* role behavior. This is a constellation most conducive for the emergence of spontaneous behavior. In clinical practice one would structure such a condition for general diagnostic purposes or in order to evaluate the progress made in the course of the treatment.

The condition marked as (4) also involves the player portraying himself or herself (the model is *present* and *self*) but under a *prescribed* role behavior. It is predicted that this constellation will elicit a *combination of spontaneous and mimetic-replication* behavior. This behavior simulation situation is when the protagonist is instructed, for example, to "act the same way you did when you spoke with your spouse in the kitchen last week." It generates mimetic-replication behavior because one has to emulate and repeat something that has happened before. But since the protagonist plays himself or herself, part of the expressed behavior can be responses directed to the here-and-now situation and hence spontaneous. In clinical practice one would structure such a condition for specific diagnostic purposes, in order to understand particular components of the protagonist's behavior. In general, in both conditions marked as (1) and (4) it is predicted that *spontaneous* behavior will constitute a major component of the performance.

The next set of conditions to be described are those shown in the third column from the left in Figure 1. In the condition marked as (2) the player portrays another person who is present in the treatment session (the model is *present* and *other*) under *unspecified* role behavior. These are expected to produce behavior that is a combination of *mimetic-pretend* and *mimetic-replication.* This could be a scene where the protagonist (or the auxiliary) is instructed, for instance, to "try to be Pat (who is in the session) the best you can." It generates mimetic-pretend behavior because the player operates under an assumed identity, that of someone else. But since that model is visible to the player he or she can imitate specific behavior of that model hence it will have substantial mimetic-replication characteristics. In clinical practice one would structure such a condition in marital counseling or in family therapy, especially when it becomes important that one member (or a spouse) remains outside the action as an observer to gain a better perspective of the problem at hand. That person will be portrayed by an auxiliary. In this example, however, the scene involves two behavior simulation conditions. While the auxiliary plays under the condition marked as (2), the protagonist, the other spouse, is cast in the condition marked as (1), playing himself or herself.

The condition marked as (5) also involves the player portraying another person who is present in the treatment session (the model is *present* and *other*) but this time under *prescribed* role behavior. This is a classic direct or vicarious modeling situation where the protagonist is asked to imitate or repeat the specific behavior demonstrated by one of the people participating in the session. This is a constellation that will produce *mimetic-replication* behavior. In general, in both conditions marked as (2) and (5) it is predicted that *mimetic-replication* will constitute a major component of the performance.

What happens when the model, i.e., the *source* of the behavior, is *not* present in the session? This situation almost always occurs in one way or another in psychodramatic treatments. Again, there are essentially two such conditions both shown on the right column of Figure 1.

In the condition marked as (3) the player portrays another model who is not available in the treatment session (*absent* and *other*) under *unspecified* role behavior. One example of this condition is when the auxiliary is asked to portray the role of, say, the mother of a protagonist, whom she never met and knows very little about. Another example is when the protagonist is asked to portray a role which, though culturally fairly well described, is not part-and-parcel of his or her role repertoire, e.g., "try and be God," or "be the good fairy," or "be an ideal parent but not your own or a parent you know personally." This condition is expected to produce behavior that is a *combination of mimetic-pretend and spontaneous.* It is mimetic-pretend because the player operates under an *assumed* identity of being someone or something else who is not even present in the session. It is also expected to have a spontaneous

component because, since the player does not know the model personally, he or she is most likely to improvize and project his or her own behavior into the role as a direct response to the situation proper. Clinically, one would structure such a condition out of sheer necessity, that is, when the model needs to be represented in the scene to make the simulation meaningful but is unavailable or when the protagonist needs to be warmed-up, be less inhibited and freer in his or her behavior. One would also introduce this behavior simulation condition where training in creativity is called for.

The condition marked as (6) also involves the player portraying another model who is not present in the session (*absent* and *other*) but this time under *prescribed* role behavior. An important difference between this and the former condition (3) is that here, because the role is specific and prescribed, the player must either know the model personally or receive a detailed description of characteristic behavior. The prediction is that in this condition the behavior will be a *combination of mimetic-pretend and mimetic-replication*—mimetic-pretend because the player behaves under an *assumed* identity rather than his or her own and mimetic-replication because the role imitates and repeats specific responses that were displayed in the past. This condition is typical of many of the so-called role-playing training exercises where the players enact a written case or roles that are described on a sheet of paper. It is also frequently used in psychodrama, e.g., when the protagonist reverses role with an auxiliary who portrays, say, his mother, in order to demonstrate how she really behaves. Clinically, one would structure such a condition to obtain further precise information or to make the scene more realistic and meaningful. In general, in both conditions marked as (3) and (6) it is predicted that *mimetic-pretend* will constitute a major component of the performance.

Finally, a glance at the paradigm shown in Figure 1 reveals that when the role behavior is unspecified, the spontaneous behavior is likely to emerge, at least to some extent (conditions 1, 2 and 3). It should be remembered that mimetic-pretend allows for ample degree of personal improvization in the form of direct responses to the simulated situation, hence it includes some measure of spontaneous behavior. On the other hand, when the role behavior is prescribed, mimetic-replication behavior tends to be fairly pronounced (conditions 4, 5, and 6).

Research: Initial Evidence and Implications

The paradigm discussed in the previous section identified six basic behavior simulation conditions. It also offered several predictions, or hypotheses, concerning the relationships between each of these conditions and the emergence of the spontaneous, the mimetic-replication, and the mimetic-pretend types of behavior including some of their combinations. It is quite clear, however, that the most important conceptual foundation of the paradigm is the proposition

that behavior displayed under behavior simulation situations may follow several patterns, that is, it can be categorized according to three predominant modes or kinds. The usefulness of the paradigm both as a conceptual frame of reference and for practical applications depends on further validation of this proposition or hypothesis.

One way of substantiating this proposition would be to identify a set of external criteria that characterize simulated behavior, and then use these in order to formulate differential definitions for each of the spontaneous, the mimetic-replication, and the mimetic-pretend kinds of behavior. As shown earlier we were able to identify a number of criteria that were considered indispensable components of any simulated experience. These were: the *source* of the behavior, or the model, i.e., its presence or absence from the treatment session, and its reference to the self or to other people, and the degree of *specificity* of the role played behavior. It was found that the proposed three kinds of behavior were characterized by different sets of combinations of these criteria.

Aside from the conceptual analysis there is a basic question that still awaits an empirically based answer: Is the classification of behavior displayed under behavior simulation situations into three kinds merely a conceptual one, and if not, does it also express itself in the form of different behavioral outcomes? In other words, given a certain problem situation or a certain task to be acted out in a simulated scene, would each of the three kinds of behavior activate different psychological processes and hence produce different results?

At the moment, the *direct* supportive research evidence is scant but the initial data is encouraging. For example, there are results from two unpublished preliminary studies that compared the behavioral outcomes of mimetic-replication and mimetic-pretend performances (Kipper & Har-Even, Note 1; Kipper, Gay & Schwartz, Note 2). In one study (Kipper & Har-Even, Note 2) 27 Israeli students participated in an attitude change experiment. The subjects were selected on the basis of their unfavorable attitude towards granting new immigrants substantial tax privileges, as measured by an attitude questionnaire. The subjects were randomly assigned to three groups representing different experimental conditions. The mimetic-replication condition involved 10 minutes of interaction between each subject and a confederate who expressed the opposite, i.e., the favorable, attitude. Following five minutes of arguing and defending their respective views, the two reversed roles and the subject was asked to defend the "other side" by repeating the arguments put forward by the confederate. The mimetic-pretend condition began identically as the mimetic-replication condition. Only a few minutes later the subject was asked to imagine that he or she is "a typical middle class new immigrant" who is about to settle in Israel. The description of that person was very general to fit the stereotyped description of "a newcomer" to the country. The subject, then, was asked to argue

for having tax privileges from the role of "the new immigrant" (only subjects who did not have a close, personal familiarity with such a person were retained in this group). The third condition was a control group where each subject argued for 10 minutes with a confederate, defending his or her initial position. At the end of the experiment all the subjects were again administered the attitude questionnaire. The results showed that significant changes towards the favorable position occurred only among the subjects in the mimetic-pretend and the control groups ($t = 5.78, p < .001$ and $t = 2.08, p < .04$, respectively). A covariance analysis for testing the differences among the changes revealed a significant result ($F_{2,23} = 6.17, p < .001$). A Scheffe analysis showed that the difference emerged from the nonsignificant change observed in the mimetic-replication condition and the significant changes that occurred in both the mimetic-pretend and the control groups (which, incidentally, did not differ in the amount of change that they produced). The part of the results that concerns the present discussion is that mimetic-pretend behavior produced a different behavioral, i.e., attitude change, outcome than mimetic-replication behavior.

In another small study (Kipper, Gay & Schwartz, Note 2) 14 nonassertive students participated in an assertive training program. The subjects were assigned to two experimental groups, mimetic-replication and mimetic-pretend, on the basis of their initial scores on two tests of assertiveness. In the mimetic-replication condition each subject was shown, through videotape, six different situations where assertive behavior was modeled. The situations were moderately elaborated, each comprised of four parts. Following each presentation, the subject was asked to repeat the behavior of the model, and was aided by auxiliaries, i.e., two other subjects. In the mimetic-pretend condition subjects were asked to role play the same six situations *without* modeling, pretending that they are assertive persons. Each subject participated in six such sessions over a period of 3-4 weeks. Two weeks following the end of the program the subjects were again administered the two tests of assertiveness. The results showed that on one of the tests (the Rathus Assertive Scale) only subjects in the mimetic-replication condition significantly improved their assertive scores ($t = 6.05$, $p < .001$). On the other test (the College Self-Expression Scale) subjects in both the mimetic-replication and the mimetic-pretend group significantly improved their scores ($t = 8.74, p < .001$ and $t = 2.39, p = .03$, respectively). But when the overall scores on this test were broken into subscores for each of its four factors, the results showed that subjects in the mimetic-replication condition significantly improved their scores on *all four* factors while subjects in the mimetic-pretend condition *did not* show statistically significant improvement on three of the four factors. Again, the part of the results that concerns the present discussion is that with regard to assertive (skill) training programs. The mimetic-replication behavior produced a different outcome than the mimetic-pretend behavior.

In another study (Kipper & Ben-Eli, 1979) the effectiveness of the double method, the reflection method, and lecturing in the training of empathy was investigated. Though initially this study was not designed to compare the effect of mimetic-pretend and mimetic-replication behavior, nonetheless it has some bearing on this issue. In that study, 64 high school sophomores were assigned randomly to four groups of 16 subjects each. One group received training in the double method that can be construed as predominantly a mimetic-pretend condition since the double performs under an assumed identity of the protagonist. Another group received training in the reflection method that can be construed as predominantly a mimetic-replication condition (no. 5 in the paradigm) since the subject repeats selected phrases or words said by the counterpart and reflects them back to him or her. The third group received lectures on empathy. This condition is not a simulated, role-playing situation and, therefore, is irrelevant to the present discussion. The fourth group was a no-training control. The results showed that all three training methods produced significant improvements compared with the control group. The effect of the double method (the mimetic-pretend condition) was significantly greater than the other two. The reflection method (the mimetic-replication condition) ranked second, yet was not significantly better than the lecture method. These results may be considered only as an *indirect* support but they too suggest that mimetic-pretend and mimetic-replication behavior do not produce the same behavioral outcome. The advantage of one over the other may vary from one problem situation to another depending on the psychological qualities necessary in order to solve or cope effectively with the specific situation.

Obviously, further research is needed in order to identify the conditions under which mimetic-pretend behavior is more advantageous than mimetic-replication, and vice versa. It is also important to discover which psychological processes are activated by each of these two kinds of behavior. Research should investigate whether or not spontaneous behavior produces different outcomes than mimetic-pretend behavior and/or mimetic-replication. Given the initial evidence, the proposed paradigm opens a new direction for behavior simulation and psychodrama research.

Discussion

One of the advantages of the concept of behavior simulation and its paradigm is that they provide a new system for conducting comparative analyses regarding the effects of a variety of role playing and simulation procedures. Psychodrama is perhaps the only method where concrete enactments of real life behavior are used systematically as an indispensable component of the therapeutic process. But there are other forms of training and therapy which use such enactments too. These were labeled by a variety of terms such as behavior rehearsal, modeling, mathematical modeling, heuristic modeling, simulations, computer simula-

tions, games, group exercises, and role playing, to mention only a few. The profusion of labels, the continuous advent of many techniques, and the differences among the theories underlying many of these interventions caused a great deal of confusion. Some therapists who were using similar techniques called them by different names, while others who employed different procedures labeled them with identical terms. Under these circumstances it became increasingly difficult to compare the relative merit of these techniques in a meaningful way. Occasionally, a conceptual integration between different theories was achieved as exemplified in Sturm's (1965) effort regarding psychodrama and behavior modification. But generally, efforts of this kind are not successful.

Behavior simulation offers a new system of concepts and definitions that is unaffected by different theories of human behavior. It provides a new common denominator for comparing a variety of behavior simulation interventions that hitherto were not amenable to comparative analysis. For instance, conditions that elicit spontaneous behavior may be created with the use of a wide range of interventions such as computer simulations, behavior rehearsal techniques, group exercises, or psychodramatic techniques. The same applies for conditions that may produce mimetic-replication or mimetic-pretend behavior.

On the practical level, research derived from the concept of behavior simulation may lead to the accumulation of knowledge beneficial to the practitioner. It could facilitate the design of more refined interventions by providing a better fit between the technical aspects of the interventions and their intended treatment goals. It could also lead to refinements in the formulation of guidelines as to when a given technique is clinically indicated and when it is not.

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Psychodramatic Crisis Intervention to Treat a Psychophysiological Hysterical Reaction

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The use of concretization and amplification of the psychophysiological symptom caused the client to maximize and mobilize her own defense to overcome the reaction and thereby make the psychodramatic treatment possible. The psychodrama allowed this client the opportunity to complete some unfinished business and to go on with her life in a more self-determined and tension-free way.

The present case report illustrates the successful use of psychodramatic techniques and psychodrama to interrupt and treat an anxiety-induced respiratory ataxia in a 2½-hour therapy session. While several reports of psychodramatic treatment have already appeared regarding the work of J. L. Moreno, the present report illustrates the use of specific techniques used to intervene in a crisis situation that prevented the client from making any therapeutic progress. Follow-up information was obtained over a two-year period from the client.

Case Report

Linda S., a 27-year-old mother of one child, was referred to treatment by her obstetrician after a complete physical revealed no basis for her respiratory complaints. She came to the office with her husband who was at a complete loss as to what to do for his wife. She reported feelings of anxiousness and depression but could identify no real reason for these feelings. During the clinical interview the feelings toward the present pregnancy were questioned, especially how it differed from the first. The client indicated no problem with her former pregnancy. The husband began to remind the client of the tragic circumstances in her life during the last pregnancy concerning her mother's untimely death due to a brain tumor. The client began to recount how she was unable to travel and visit her mother very often since her mother was hospitalized in a distant town over 100 miles away. Tears came to the client's eyes and she began to gasp for breath. She reached out in the direction of her husband while grasping her chest and

pleading, "Please help me, here it comes again." The client jumped to her feet while clutching at her chest and begging for help. The visible dilation of the veins in this client's head and neck, paired with the slight cyanosis noticed around her lips caused the therapist to initiate the psychodramatic procedure of concretization of the pain and pressure.

In the psychodramatic context concretization means to induce physically the feelings the client describes so that the client can separate the one feeling from any other feelings and deal with it individually. The client suggested that a pressure in her upper chest was disrupting her ability to breathe. This pressure was physically imitated by the therapist applying pressure with his fist on the upper chest. This feeling of pain was described by the client as just about the same in intensity and location as the pain she was feeling. The pressure induced on her chest was increased or amplified by the therapist in order to mobilize the client's own defenses so she could put into action, physically and verbally, her power to overcome it.

After the client was able physically to overcome the pressure and pain, she regained and verbalized an increased perception of control over her physiology. She was able to dramatize and experience again, through psychodrama, the events that were causal factors to this anxiety reaction. The use of this physical concretization and amplification is explained below.

Concretization and Amplification

The client indicated the pain and pressure were localized in the center of her upper chest by grasping at the base of her throat. The therapist placed one hand on the client's back for support. Forming a fist with the other hand, the therapist placed it on the front of the client's upper chest where she had indicated the pain originated. When the client acknowledged the location and approximate intensity of the slight pressure, the therapist amplified the intensity of the pressure by pressing the fist harder on the chest. She was encouraged to push the fist away. The client feebly pushed on the therapist's arm stating she could no longer tolerate the pressure. The therapist increased the pressure stating, "You don't have to take it; you can push it away. Push harder and use your voice." With this, the client gave one giant push, screamed, "Get off me!" then physically pushed the therapist off her chest and back almost three feet across the room. The client at this point took a deep breath and began walking back and forth in the room. Her breathing was somewhat rapid. She stated that she felt so good that she would like to walk out in the hall to get some air. While the client was walking in the hall, the husband told the therapist that he had asked his wife several times if her mother's death caused her any problems. She had denied any problems with the death. The client re-entered the office and stated that she felt better but wanted to know what she could do from now on to maintain this control.

Psychodramatic Treatment

From the "warm-up" to her mother's death and the events surrounding the death, it was clearly apparent that the client was ready to proceed with investigating her feelings. The client was directed to walk in a small circle with each lap designated as a regression of six months into her past. As the client walked past the therapist the date, in six month intervals, was given with each date being earlier in time. The client was asked to relate what was going on in her life and how she was feeling. On the first lap the client stated that she and her husband were discussing having another child. "The baby is about one year old and will need a brother or sister to play with," the husband reportedly said; the wife did not feel that she wanted any more children. The second lap consisted of the client talking about trying to get the new baby on a schedule for feeding and about her grief over her mother's death. The third lap was very slow and difficult. The client recalled with emotion that her mother had died in the hospital, and she, herself, had just had her baby. The fourth lap revealed the client's disgust with her mother's hospitalization and her own inability to visit her mother. The client stated, "Mom is in real bad shape and everyone keeps lying to me about it. I wish I weren't pregnant so I could be with her." The client was stopped at this point and asked to present her mother's reaction to the pregnancy.

The scene she related was set in the mother's home as the client entered with the good news about the pregnancy. The client's mother was portrayed by the client through a "role reversal" as very pleased that she was going to be a grandmother. The mother stated she was very happy but needed to go to bed because of the severe migraine she had been having. The client, in her own role, stated that a few days later she heard that her mother had been having more problems with fainting spells and had been hospitalized. The client reported that she went to the hospital every week for about a month; however, her mother's condition continued to deteriorate. "Nobody will tell me anything," the client said. "Mom is in and out so much I can't talk to her." The client shared having a difficult time going such a distance each week to visit. Her husband kept telling her she should stay home because the mother was in a coma and did not even know who was there most of the time.

The last visit before the mother's death was set up and re-enacted in the psychodrama. The client was very tense and described herself as alone in the hospital room at her mother's bedside. The client was weeping softly, telling her mother how sorry she was that she could not make her understand that she did not mean to be pregnant and unable to stay with the mother. As the client sobbed more and more, she shouted, "I hate being pregnant and hate you for being sick." "If you die of a brain tumor and give it to me, I'll die and give the same horrible death to my baby!" "Oh, Mother, do you hear me?" "I hate you!" "I mean, I love you and

hate me!" "I mean I don't know what I mean, just don't die!" The client then broke into uncontrollable sobbing.

The husband stated that when this happened in life, he and a nurse had to remove his wife from her mother's room. He was directed by the therapist to enter the scene and to enact the drive home. The client cried all the way home and stayed in bed for the next three weeks, unable to do a thing. Through a "role reversal," the client-as-the-husband stated "He" was quite worried about his wife and that he had called the family doctor who put his wife on some light nerve medicine.

The client in her own role reported having little recollection of those three weeks and only regained a sense of reality upon notification of her mother's death. The client's father had come by their house to tell them that mother had passed away without ever regaining consciousness. The client reported and demonstrated the mixed emotions of happiness and guilt because her mother's suffering was ended. The guilt was mixed with shame because she could not be with her or help her because of the pregnancy. Again the client reported being overcome with fear that she and her baby would die the same way. This depression and fear had kept her confined to her bed almost continually until the baby's birth. The client also reported several days and nights of sleeplessness after the funeral.

This cue caused the therapist to direct the client to set the scene and re-enact the mother's funeral. The therapist's desk was designated as the casket, and chairs were placed around to represent each family member. The conspicuous distance between the client and her father was questioned. The client stated that her father had tried to be really close to her at the funeral, but the things he had said caused him to be separated in the client's setting up of the scene. Through a "role reversal" the client, in the role of the father, came up to the chair representing herself in an attempt to comfort her. The client as father said, "The baby you are carrying will take the place of your mother; for some to be born, others must die." A "role reversal" was directed and the client in her own role demonstrated complete aphemia. Her soliloquy revealed her contempt for the father's statement and absolute rage toward her father for saying such a thing. The client was instructed to finish the scene just the way she remembered it, and she sat mute through the services and the journey to and from the cemetery. After a time she stated, "That's just the way it was and I haven't, nor will I, speak to my father to this day." The client was thanked for sharing this traumatic scene and asked if there was any part she left out. She stated there was not, and the therapist told her the memory does not have to remain that way any longer.

She was told that in psychodrama she could re-enact the scene and say and do anything she wanted to. She can change the scene right now, if she would like. With her affirmative response, the funeral scene was again set up and the client was directed to clarify her appreciation of other family members' feelings through assuming their roles. In the role of her father she again made the statement of the

baby taking the mother's place. Returning to her own role, she was directed not to swallow her feelings or hide her anger, but to let them all out toward the father now. The client, with clenched fists and stomping feet, told the father he did not have any right to accuse her baby of killing her mother and that he was stupid to think that a poor baby could ever replace her mother. She spoke louder with each statement saying that the mother had died because of a brain tumor and she hoped that the brain tumor had nothing to do with her baby or herself in any way. This emotional catharsis was encouraged and the client brought out several more repressed feelings of anger directed toward her father and her mother. The catharsis intensified and became more focused on the mother's death and how it had prevented the client from having closure with the mother. The therapist directed the client to set up the scene of her mother's hospital room to obtain this closure with the unfinished business. This last visit showed the client pleading for understanding. "Please don't die; I'm afraid if you die I will die too." "Please hear me, Mother, I'm so afraid."

The roles were reversed and the client, in the role of her mother, was instructed to respond to her daughter. Even though she could not do so back then, she could now, and she could see that her daughter needed her very much. The client presented, through the role of her mother, an extended warm and supportive group of statements that are condensed here for clarity. The points made were: The client would surely be a good mother; the client should not feel bad since the mother had gone to be with God and did not hurt any more. Most important was the fact that the mother's death was in no way going to hurt the client or her baby because the tumor was the result of a head injury the mother had received as a young girl and could not be genetically transmitted. The client, in the role of her mother, instructed herself to stop worrying and to get on with the business of life and to be the best mother she could to her children. The client was directed to assume her own role and to respond to this. She presented herself as quite calm with a broad smile stating, "Thank you, Mother. I know I won't do a bad job at mothering. I had an excellent teacher, you. I do love you very much."

With this statement having been seen as indicating closure, the client was asked how she felt. Linda S. reported a feeling of great release and of understanding. She also stated that she was sure she would have no further problems with any of this. The drama was closed at this point because of the client's positive statements and her feelings about the future. She was also instructed to contact this office if she felt any of the symptoms returning.

Results

The psychodramatic treatment described here was only possible after the disruptive physiological symptom of respiratory ataxia could be dealt with and placed within the client's control. The resolution of the unfinished business with

the client's mother and the realization of the lack of genetic or biological factors involved in the mother's death were later described by the client as the things that allowed the delivery of the second child to go smoothly. At followup one year after the delivery, the client related that she had no problems and felt comfortable in most aspects of her life. She stated that the new baby was taking solid food and trying to walk. The client reported that the baby's older sister was quite a bit of help and played very well with her. A telephone interview at two years after her delivery revealed that the family had moved because of the husband's promotion to the area of the client's childhood home and that the family had re-established a very good relationship with the client's father through weekly visits and holiday celebrations.

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Group Therapy Techniques in Shamanistic Medicine

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The indigenous medical therapists of the Western Dakota (Sioux) offer a wide spectrum of medical advices and procedures. One group of these, the "nightsing" ceremonials of the yuwipi medicine men, have a structure and function comparable to modern group psychotherapy. Identifiable features in the nightsing" experience are careful selection of patients and problems, a meticulously-wrought therapeutic contract, extensive preparations, a prolonged group meeting under extraordinary conditions of attention, a recognized difference between the conscious and unconscious expectations of the therapist and the client, and an aftergroup facilitating reliving, review, and the integration of the process and the interpretations. Ethnographic studies suggest that the procedure has roots in remote antiquity, predating even classical methods in the treatment of patients in groups.

The works of Cooper (1944), Fugle (1966), Hurt and Howard (1942) trace the elements and origins of shamanism in Northern Plains tribes of North America to those practiced by Asian nomadic hunters before the Bering migrations about 40,000 years ago. One fraction of the descendants of these migrations, now known as the Sioux, lived and evolved in mid-continent and were first encountered by French explorers near the Great Lakes in the early 1600s. The reservation Sioux (1877-present) retained, often secretly, their old shaman and healing cults, as did many other Plains tribes. My particular interest from 1968 to 1972 was a study of the "night-sing" healing ceremonies of the Oglala division of the Sioux. These Yuwipi healers (and bear-cult, eagle-power, and many variants) of the indigenous healing-advising-predicting medicine men are characteristic of all of the divisions of the Western Dakota (Sioux) peoples. The analysis of their intricate and dramatic ceremonials was so intriguing that it was some time before I began to realize that a form of group therapy was going on which had a far

different rhythm than what I was used to in clinics and on hospital wards. Many of these healing ceremonies have been described from an anthropological point of view: Ray (1941), Ruby (1966), Dorsey (1894), Feraca (1961), Hurt (1960), and Kemnitzer (1969). The present description recognizes both the ancient and the continuing function of these shamanistic ceremonials as an aboriginal form of group therapy.

Aspects of Group Therapy in Shamanistic Medicine

1. *Selection of Group Members:* The person who seeks the services of an Oglala medicine man inadvertently embarks on an ongoing group experience. The applicant encounters preliminary arrangements which may seem protracted, contradictory, vague, and unpredictable. Eventually the seeker may come to realize he (or she) is involved in a long and on-going process which will change the rhythms of his interactions with the healer and with others, a long process of psychological preparation for a specific night-sing ritual at some unspecified time in the very indefinite future. To all of this he must eventually adapt his importunities and his so-important personal issues and schedules. The medicine man invites leisurely conversation about the problem, but first and later there are postponements, renewed supplications, restatements of purpose, reminders, after-thoughts and difficulties, all in the service of clarification of the problem and of testing the seriousness of the client.

The long waits allow assessment of the client by healer and healer by client. The difficulties discourage the ambivalent client and add to the involvement of the committed one. The restatements contribute to a growing implicit-explicit contract and obligation of both parties. The healer has time to select suitable clients and suitable problems, using his own criteria, and has time to assess the desire for help or change, and to weigh the probabilities of success with the issue at hand. One result of these prolonged processes is that the client's relationship to the community becomes clearer to the medicine man, and his problems are seen more and more in context of his family and neighbors. Clients are most often Oglala, but applicants from other tribal or racial affiliations, or from any "catchment area" may attend a healer to whom friends or reputation suggest referral. Those coming from great distance may be required to make repeated trips before all the preliminaries are satisfied.

2. *Preparations:* The eventual establishment of a fee and a date for the night-sing ceremony strengthens the contract further. The fee in money or goods, first of all, may be high enough to cause considerable reflection, and negotiations may falter or fail. The preparations which are asked of the client, in addition to or in lieu of fee, may be too much to bear or may require much time. He may be daunted, for example, by being required to fast, to observe periods of prohibitions or prayer, periods of good thoughts, celibacy, avoidance-acts or avoidance-

thinking. He may be asked to collect food for a feast, and getting enough beef, canned goods, bread, and tobacco for 25 or more people may strain his budget. Besides, all of the provisions must be transported over the long distances and dirt roads of the reservation. The applicant may be asked to save up to purchase cloth offerings in symbolic colors, and one healer requires 405 individual tobacco-offering pouches which take days to prepare.

3. *The Therapy Experience:* When the day of the "sing" arrives, the participants make their journeys to the medicine man's often remote cabin. The "sponsor" of the ceremony discovers then whether he is the sole client or whether other people will be bringing problems of illness, indecision, or inquiry. Someone, for example, may want a prophecy or augury. Another may want primary medical care or advice about how to deal with hospital or physician instructions about themselves or a relative. A lost saddle or a group of horses may be sought through the yuwipi healer's knowledge. The sponsor/client/patient also discovers that not only patients attend. The healer's family also sits in, and his extended family, and people from nearby cabins "along the creek." One or more singers and drummers are needed, and apprentices, helpers, "co-therapists" may swell the group to 20 or 30. This assemblage, once gathered, talks away the daytime hours and aids in cooking and the final ceremonial preparations. The medicine pipe, rattles, bundles, offerings of water and tobacco, representations of the world and universe, and magical stones are arranged in symbolic fashion. When the sun sets and it becomes dark, all enter the house or lodge, walking always "sun-wise" to the right, and sit on the floor, leaning against the wall. The center is occupied by a blanket, a sand and sage altar, and the magic paraphernalia of the medicine man. All Christian pictures and symbols are put away. The doors and windows are covered with blankets. When the altar is ready, the kerosene lamp is blown out and singing and drumming begin in absolute darkness and continue for many hypnotic hours.

The night-sing is a long ritual, with prayers, chants, drumming, the calling and arrival of spirit helpers, their manifestations in the rooms, their conversation with the medicine man, and his translations, interpretations, and advices. At intervals between song and prayer, thunderous drumming and uncanny voices are heard. Blue lights flicker around the room, and heavy pounding of medicine stones seems to come from beneath the floor. The wings of "spirit birds" strike the faces of participants suddenly and frighteningly. The medicine man addresses the spirits. They answer in ventriloquistic voices and in secret language. Suddenly the client is asked to state the purpose of his attendance. In my first yuwipi session, as a "medical observer," my answer was too disconcerted, too quick and glib, and too slanted toward what I thought the audience would find plausible. I said I was anticipating a change in my academic duties and was unsure if I would encounter difficulties beyond my capacities (actually, I knew very well that problems with displaced colleagues lay ahead). It was an adequate answer,

I thought at the time. Also too simple and too revealing. The healer's comments, I feel now but denied then, accurately guessed at my murderous competitiveness and grandiosity, and gently interpreted them as aspects "of your opponents which you will overcome." Years later, his intuition still makes me uncomfortable. Other persons present, and better prepared, described such things as a symptom or chronic condition of health, or a dilemma in their lives. One woman described her inability to free herself of headaches. Another wanted her husband to refuse further surgery for cancer. With all the "chief complaints" stated, the medicine man consults with his spirit helpers and translates their advices and interpretations.

It is the manner of the yuwipi healer to speak with confidence and authority. He is omniscient and in touch with Powers even more awesomely omniscient. He is, by his own definition, an unfailing master of procedure. He holds himself beyond skepticism and challenge. His acts and words denote his ability to evoke the Powers Beyond, which no one else in the room can do. His statements have the ring of universal truth. The carefully nurtured concentration of his audience's attention, and of their dependency, regression, and expectation-of-goods-to come, all suggest some aspects of the psychotherapist. The medicine man's carefully formulated and carefully stated advice in the presence of a circle of helpers and neighbors and beneficiaries of ritual suggest the interpretations of a careful group psychotherapist. The interpretations of both are open to group emendation and restatement as the process goes on, as statement, restatement, and serial clarification of problems lead to cognitive reliving, affective abreaction, and useful resolution. The patient experiences a reintroduction to the lost times when dream, fantasy, and reality intermingled. Every sound and move, every symbolic gesture of the medicine man with the sacred objects focuses upon the evocation of an extraordinary experience. The evocation of such awesome and mutative moments may also be achieved in therapeutic groups, and may similarly have a mystic or inexplicable quality for some members.

4. *Similarities in Psychodynamics of Group Process and Ritual Process:* Intrinsic analogous dynamics in modern group psychotherapy and venerable ritual proceedings are the facilitation of a humanistic community concern in, and commitment to, the problems and pains of each individual, and a sharing in the personal conflicts and secrets of all members. Concomitantly, the individual's involvement in larger community concerns is encouraged, with an influence upon his narcissism and alienation. Both proceedings, the ancient and the modern, evoke observation, learning and integration. Both evoke intuitive and factual information, problem-solving, and summarization of the data at hand in a form both individual and generalizable. Both manifest the inevitable tension between the maturation and autonomy encouraged at least sometimes by the therapist and the group, and the individual's own yearning to surrender

autonomy and initiative in the hope that previous gratifications and benefits of submission will be repeated.

The requirement that the patient/client make a clear statement of the problem, in the presence of the group, is more fundamental than is often recognized. Indeed, in my own experience as a therapist, the formulation and reformulation of the problem sometimes has seemed the most important of all issues, in successive meetings, since it reveals so painfully the deceptions of the self and the evolution of the cure.

5. *Aftergroup:* A yuwipi ceremony may last many hours. The possible intensity of the emotional participation of the individual in either yuwipi or group therapy seems often to call for a decathexis, a "recovery" mechanism, an after-group review, a social hour. For the Sioux it takes the predictable form of the feast. When the lamp is re-lit, the audience's silence gives way to dyadic conversation. The healer may draw a client to one side for additional advice or take another out-of-doors for a prayer and an offering of food or tobacco to the spirits. Meanwhile, the kitchen workers serve out the meal, followed by coffee and cigarettes. A terminating ritual, the water ceremony, follows. A bucket and dipper are passed around, each drinking with the prayer "all my relatives" (*mitakuye oyasin*) to bring past friends and family members into memory and to include them in the ritual. After that, the long, thought-filled ride home across the dark prairie lies ahead.

6. *Review and Integration of the Group Experience:* On a summer evening the heat and airlessness of a prairie cabin are significant endurance factors. Add to this the slow, methodical preparations, the anticipation and waiting, the detailed instructions about presenting the ceremonial pipe and walking and sitting correctly, all serve powerfully to focus the group's attention. The skillful use of discomfort, heat or winter's cold, repetition, sensory overload and sensory deprivation lead step by step to altered consciousness states, hypnotic waiting, trance, or sleep. That critical judgment and reality-testing are strained by the long experience of a ceremony is often revealed after the "sing," when the participants spend hours or days in bemused wondering about what they had actually experienced, and long hours in trying to integrate what they remember. Any therapist, the medicine man not excepted, is pleased to hear that patients so value the experience that they strive to remember, to re-experience and to reintegrate what they learned.

7. *General Medical Functions:* An Oglala yuwipi medicine man (there are medicine women, but in lesser number) provides immediate practical medical advice to his rural clients. He gives "preliminary care," "family medicine" and referrals. He evaluates advice and care given elsewhere and has considerable influence in either supporting or opposing what the patient and family hear at the clinic, hospital, or the courts. With a shrewd attentiveness to reservation news, "moccasin telegraph," and gossip, he is a social mediator with ability to

de-fuse conflicts and to dispense conventional wisdom, to affirm and direct action, and to prevent impulsive behavior. He underscores and strengthens Sioux identity. He provides a fascinating nighttime recreation to his community, a wilderness theater endlessly repeated, like a morality play, like a medieval Ordinalia, like a cowboy story. But beyond that, he conducts a community group therapy and everyone "along the creek" attends. His "spirit advice" is clearly an interpretation aimed simultaneously at the individual and the group.

Evidence for the Antiquity of Group Therapy Techniques

Any effort to understand the mind of earlier men must rest precariously upon fragmentary evidence and bulky extrapolation. Granting this, Howard and Hurt (1942), Cooper (1944), and Fugle (1966) have been able to show that fundamental elements of North American shamanism are related genetically to the conjure-shamans of northern and eastern Asia, and that the former repeated the rituals of the latter long after the trans-Bering migrations. Shamanistic healing is ancient beyond all literature, and the group therapy imbedded in it, in the sense I have used and in the comparisons I have made above, may be a comparably ancient human activity. In addition to such a speculation is the nature and quality of native American religion, mythology, and ritual. These cultural elements are endlessly varied but remarkably enduring in their fundamental structure across recorded time. One can entertain the possibility that we have in them a window across the entire aspect of human occupation of the Americas, measured in geologic rather than archeologic or historical units. That aspect, however dimly, suggests that Siberian shamans used ritual and group-influencing techniques, that the tribes carried them along during the emigrations, and constantly changing yet always the same, the Dakota shaman-healers have been using comparable therapeutic skills since the end of the Pleistocene.

Final Note: *The medicine men who worked with me during several years of experience of night-sing ceremonies and conversations on Oglala history and tradition, were self-sufficient practitioners. They welcomed and indulged my interest, but had no experience (and little wish for it) with my medical world. The comparisons that I make here, therefore, are my own.*

Dr. Raymond J. DeMallie, Associate Professor, Department of Anthropology, Indiana University, Bloomington, Indiana, and author of numerous articles on the Sioux, has with great kindness reviewed and improved upon this paper.

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Psychodrama and Sociometry Training: A Survey of Curriculums

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The survey was undertaken to examine curriculum requirements in various clinical and academic programs. Of the 95 trainers, educators and practitioners (TEP's) contacted, only 31 replied. Although limited, the survey helped raise a number of questions relating to curriculum, certification requirements, and the role of the three main organizations: the American Society of Group Psychotherapy and Psychodrama, the American Board of Examiners of Psychodrama, Sociometry, and Group Psychotherapy, and the Federation of Trainers and Training Programs in Psychodrama. The relative lack of emphasis on training for empirical work in psychodrama and sociometry seemed to be prevalent within the various training programs in psychodrama.

J. L. Moreno (1953) pioneered the first formal training center in psychodrama and sociometry in Beacon, New York. The institute was approved by the State Education Department, Division of Special Occupational Services, Albany, New York, at the graduate level and offered an experientially based residential training program. The center awarded a variety of certificates ranging from "Certificate of Attendance" to "Certificate of Full Director." To be certified as a director, a student needed to complete twelve hours of residential training or sixteen weeks of training or earn a total of 96 points (Warner, 1968). Since the inception of the Moreno's Institute in 1937, a number of training centers have been established all over the world. It is noteworthy that until his death in 1974, Moreno was the certifying officer for practicing psychodrama. In 1974, the American Board of Examiners of Psychodrama, Sociometry and Group Psychotherapy (ABE) was formed and established certification guidelines at two levels: (1) Practitioner and (b) Trainer, Educator and Practitioner (TEP). According to the ABE's guidelines, a trainee needs to complete a minimum of 780 hours of supervised training at any center and the completion of evaluation requirements im-

plemented by the ABE. To be certified as a TEP, a trainee needs certification at the practitioner level, three additional years of supervised training and completion of evaluation requirements implemented by the ABE.

Although the ABE has specified evaluation requirements for certification, it has not thus far developed any curricular guidelines for training at the two levels. Neither has there been any publication from individuals that suggests curricular requirements for training at these two levels. Interestingly, however, there have been publications suggesting requirements for setting up psychodrama programs for therapeutic purposes (e.g., Enneis, 1952, Hollander, 1968). Under these circumstances, one would expect a wide diversity of curricula offered at various institutes. This survey was primarily instituted to gather information on curricula used in psychodrama and sociometry training from practicing psychodramatists, Trainers, Educators and Practitioners. Originally this survey was undertaken to seek ideas for designing a psychodrama and sociometry training program in a university setting. After examining the responses, it was felt that a report of the analysis would be informative for TEP's who are in the process of either developing or redesigning their training program.

Method

Ninety-five Trainers, Educators and Practitioners (TEP's) in psychodrama, group therapy and sociometry listed in the *American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy Directory* were sent the following letter (by the first author) in July 1980:

> I am in the process of collecting psychodrama and sociometry course descriptions for the purpose of developing a curriculum in the action modalities. The program will be housed in the Psychology Department at West Chester State College. For this purpose, I would appreciate it if you would send me syllabi, bibliographies, course descriptions, workshop guides, etc., in the area. When I complete this task, I will share with you the results. I am looking forward to hearing from you.

Results

Rate of Return

Of the 95 TEP's contacted, only 31 (33%) responded. Two responses came from Canada, two from Europe, one from Australia, and 26 from nine states in the U.S.A. The responses included materials such as brochures, course descriptions, bibliographies, training program models, articles and conference brochures. Five TEP's who are not involved in teaching or training programs simply responded by a letter.

From the responses, it seemed that there were two basic types of training programs: (a) clinical/skill training programs housed in specialized training cen-

ters and (b) academically based training programs housed in colleges and universities.

Clinical/Skill Training Programs

Seventeen respondents (55%) indicated their involvement in a clinical/skill program. These individuals work out of specialized training centers with their primary focus on psychodrama and sociometry. From their responses, it seemed that the overall requirements for certification are similar in the various training centers and compliant with the American Board of Examiners in Psychodrama, Sociometry, and Group Psychotherapy (hereinafter referred to as the ABE) requirement of 780 hours of training. However, there are variations: One institute offers a total of 1080 hours of training, and another institute indicates a minimum of 600 hours. Furthermore, various institutes offer different levels of training which are not in compliance with the ABE: One institute uses three levels—psychodrama assistant, 260 hours; associate director, 520 hours; and director, 780 hours. The training institute that indicates a total of 1080 hours of training requires 360 hours for each level of proficiency; a third institute breaks down the 780 hours into six levels of proficiency (assistant director in training 100 hours, associate director in training 200 hours, director in training 300 hours, assistant director 400 hours, associate director 500, and director 780); a fourth institute uses three levels of proficiency (psychodrama assistant, 420 hours; psychodrama leader and/or psychodrama therapist, 600 hours). Another center offers a 200-hour training program but does not specify proficiency levels or any type of certification. Additionally, this center has a twelve-month program upon completion of which a student obtains a certificate of satisfactory completion of one year's training in psychodrama and sociometry. The graduates of this program are eligible to apply to the ABE for the certification examination.

Only four training centers sent details concerning course descriptions, course objectives, training schedules and/or bibliographies. All four programs combine theoretical with technical applications of psychodrama. The technology of psychodrama is traditional and derived from Moreno's classical description of psychodrama. The most comprehensive programs, in terms of content, appear to be the 200-hour program and the one-year program. These programs include theoretical, philosophical, technological as well as ethical components in the training program. Other unique features are learning sign language and psychodramatic applications to special populations, such as blind, deaf, Hispanic, police, alcoholic, children, adolescents and institutionalized populations. Their annotated bibliography categorized into 23 seminars is impressive and current. The other programs appear less comprehensive in the scope of content rather than in the number of hours required for training; for the most part their content seems to center around psychodramatic techniques and applications.

There seem to be varied practices concerning evaluation procedures. One program uses rating sheets for the evaluation of the individual participant as an auxiliary and as a director. It is not clear who carries out the ratings and how often the ratings are done. The students are also required to write group reports for which specific guidelines exist. The group reports center around warm up, action, closure, post-group activity and the role of the therapist. (It appears that this is an individual's perception of the drama itself.)

Another center requires two written papers on topics in psychodrama and sociometry, attendance and participation in a number of training sessions. In another training center, evaluation is conducted by a board of four members, two are chosen by the center and two are chosen by the applicant. The board uses written criteria (probably variable) for each candidate. They also require the student to submit a paper for publication. The objective of this assignment is to have the student integrate and apply concepts of psychodrama and/or sociometry. One of the centers requires a thesis but it is not clear what the thesis entails.

Academic Program

Nine respondents (29%) indicate their affiliation with academic institutions. Two of the respondents are also involved in a separate clinical skills program as well. One recognizable feature of the responses is that psychodrama training is simply a part of either undergraduate or graduate degree programs in various fields: theater, continuing education, psychology, sociology, communications and social work. Only two of the programs indicate that they are recognized by the American Board of Examiners as counting towards the certification in psychodrama, sociometry and group psychotherapy. The University of Arkansas Graduate School of Social Work offers a specialization in action methodology (psychodrama, sociometry, sociatry and related experiential approaches) in which twelve out of the 20 months of training are spent in the action methodology course sequence (a total of seven courses). All courses include theoretical as well as experimental training. However, their announcement does not specify how many hours a student accumulates toward the certification process. Lesley College of Cambridge, Massachusetts, offers a Master of Arts degree in expressive therapies with psychodrama as one of the areas of specialization along with a program for post-doctoral Visiting Fellows for Advanced Study in Expressive Therapies. The psychodrama specialty involves 36 hours (credits) of course work split into 12 courses of three credits each or 45 contact hours per course. The course work is divided equally into theory and practice. An additional feature of their program is the requirement that the students write a thesis. To date 15-20 theses, based on a review of literature, have been written on psychodrama and sociometry. Furthermore, it is not clear how many hours a student accumulates towards the certification process.

There was only one school in the U.S.A., the University of Humanistic Studies, that offered the M.A. and Ph.D. degree programs in counseling psychology with emphasis in psychodrama. According to their 1980-81 catalog this program does not exist any more. Although psychodrama courses and workshops are still being offered at this school, it is not clear whether any TEP's are involved in their training program.

It appears that in the past there has been only one attempt to initiate a full-fledged Master's degree program in psychodrama and sociometry in the U.S.A. This effort was made by the Psychodrama Section of St. Elizabeths Hospital, some years back, to house the program in the American University. Their proposal was not accepted.

Private Practice Response

This category includes private practitioners who do not hold part- or full-time positions with either college/university or training centers. Six people (16%) who responded simply forwarded names of persons and training centers that trained them to be contacted for details on curricula.

Discussion

It was disappointing to receive responses from only 33% of the TEP's contacted. Hence, the results reported in this study are of limited scope and must be treated with caution for their generalizability.

An examination of the clinical/skill programs reveals an integrated approach of theoretical and technical aspects of psychodrama. In the programs surveyed, the classical Morenean model of psychodrama appears to be the major focus. One obvious weakness in these programs is the lack of emphasis on both theoretical and applied aspects of sociometry. Moreover, it is not clear how much of total training time is devoted to theoretical concerns via lecture and/or discussion and how much time is devoted to experiential psychodrama. It was also noted that different institutes employ different terminologies concerning proficiency levels. The number of hours required to attain these levels is also variable. However, it is not apparent what course work or content is actually involved in the attainment of different proficiency levels, even though the number of hours required (e.g., 260 hours for assistant director) are specified. The most comprehensive psychodrama training programs (200 hours and one year) seem to be at the St. Elizabeths Hospital located in Washington, D.C., which cover experiential, theoretical, philosophical, and ethical aspects related to psychodrama. However, it is not clear where their training of 200 hours leads to in terms of certification as a psychodramatist. It is suggested that a breakdown of requirements in terms of courses (theoretical and experiential), and specifying time as well as cost, would be very helpful to both trainers and trainees. This suggestion applies to all training institutions. It is worth noting that St. Eliza-

beths Hospital Psychodrama Section is the only institution in the country that offers a full year stipend to the trainees.

A source of confusion about the various training programs is the titles used for various proficiency levels. The comparability of the proficiency levels across institutions is not clear. For example, the Camelback Hospital's Western Institute for Psychodrama requires 360 hours or 36 credits to become a psychodrama assistant; the Psychodrama Center of New York requires 100 hours to become assistant director in training. In addition, the Camelback Hospital's Western Institute for Psychodrama requires a total of 1080 hours to earn the title of psychodrama director, but the Psychodrama Center of New York requires 780 hours to achieve the title of director.

One major concern that we have is with the titles used with the proficiency levels. Obviously, these titles serve only an "in house" function while in training, although the Camelback Hospital certifies at three levels, viz., assistant, associate and director. Such titles and institutional certification at various levels may mislead potential trainees and trainers to believe that they would be able to practice psychodrama in some capacity. This danger is more pronounced when titles such as assistant or associate director are used. In other words, a certified associate director may come to believe that s/he has license to practice in a directorial capacity. It is recommended that the ABE or perhaps the Federation of Trainers examine the relevance of institutional certification at various levels and also the titles used for various proficiency levels. In any case, it is necessary that announcements of training programs must specify that only those people can practice psychodrama who have been certified by the ABE. A related issue is the requirement of 780 hours for certification by the ABE. It is recommended that this requirement be re-examined from the point of view of more specific curricular and experiential requirements which first would have to be identified and detailed. Perhaps a task force of the ABE might undertake to develop guidelines with a regard to specific curricular and experiential requirements. In other words, the ABE must clarify what the 780 hours mean. It may also be pointed out that all other requirements of the ABE need further examination and clarification. Perhaps the principles and guidelines prepared by the American Psychological Association (June, 1981) may be helpful in this regard.

Despite the inclusion of theoretical aspects in the clinical/skill programs, it appears that the training is practitioner oriented. It is suggested that the training curriculum should include at least one or two courses in statistics and research design. A research-based thesis might also help in the advancement of the field, especially with regard to the implementation of various psychodramatic techniques. There is no doubt that there is a need for more research on the effectiveness of psychodrama as a modality and also research on developing the various psychodramatic techniques. Perhaps the ABE might include such a thesis as one of the requirements for certification.

Regarding evaluation procedures, it was noted that the practices vary across institutions. To create a system in which credits obtained in one institution are honored by another institution it would be useful to develop standard procedures for evaluation. In other words, there should be some common understanding about what it means (in terms of degree of proficiency) for someone to have completed X number of hours of training in psychodrama. Perhaps a set of rating scales need to be devised that are to be filled in by trainers on the proficiency achieved by students in various roles (for example, doubling and mirroring) in the process of training. Used on a regular basis, these scales may also help chart the progress of a student through a program and would provide a basis for evaluating the student. It is not clear from this survey how many training centers use such procedures. It is important that institutions attempt to make evaluations more objective.

In reference to the academic programs, there appeared to be two comprehensive programs, viz., University of Arkansas and Lesley College. It is worth noting that the University of Arkansas was first in offering a *specialization in action methodology* with emphasis on psychodrama and sociometry. Lesley College, to our knowledge, is the only one in the country that offers a Master's degree in expressive therapy with a *concentration in psychodrama.* This concentration is offered in conjunction with other expressive modalities, art, dance and music. It is important to note that students specializing in psychodrama must take at least 12 elective credits in expressive modalities outside their area of specialization. This is commendable as it provides the student an opportunity to learn about related modalities and how they can be used in conjunction with their primary therapeutic modality. However, the University of Arkansas provides a balanced approach by way of including sociometry and sociatry as part of the curriculum. Lesley College does offer an introductory course in sociometry and socioanalysis, but it would appear that at least three additional courses should be introduced in order to balance their psychodrama program. It is recommended that the academic programs devote at least six hours (two courses) in statistics and research design. It is somewhat disheartening that the academic institutions, such as Lesley College and the University of Arkansas, do not encourage research based theses on psychodrama and sociometry. It is felt that research design training and research based theses would help develop a more experimental orientation toward the theory and practice of psychodrama and sociometry. It appears that the classical Morenean model has remained unchanged for many generations except in terms of applications and scope of its use. Experimental work is imperative not only for advancement in theoretical aspects but also to establish psychodrama as an area of study that is amenable to scientific investigation. Kipper (1978) had likewise stressed a need for empirical validation of assumptions and the underlying rationale in psychodramatic theory. From a review of research done on psychodrama, Kipper concluded that the data on the validity of psycho-

drama is scarce. We feel that Lesley College does have an excellent setting for promoting research within the aegis of their Center for Advanced Study in Expressive Therapy which is primarily geared to the training of doctoral fellows.

Although it is an achievement for Lesley College to have a Master's program in psychodrama, it is not clear how many hours of the Master's program count towards certification as a practicing psychodramatist or if they actually count at all. It is also not clear whether a Lesley College graduate in psychodrama can serve as a director of psychodrama, or that further training is required to be certified by the ABE. A closer look is required at the academic programs including the need for a Master's degree in psychodrama.

Conclusions

It is re-emphasized that this survey was limited by the number of responses received and hence cannot be taken as a comprehensive review of the state of training in the U.S.A. or other parts of the world. However, the responses received did serve to raise some important questions concerning curriculum, proficiency levels, certification and degree programs in psychodrama and sociometry. It is hoped that this paper will serve the professional community as a starting point for discussion to bring about changes to improve our training programs and stimulate empirical research in psychodrama and sociometry.

The survey points to the need for a clearer definition of purposes for the American Board of Examiners as well as for the Federation of Trainers and Training Programs in Psychodrama. The two bodies need to work in concert to develop more detailed guidelines than those which exist concerning certification requirements. Lastly, it is not clear what role, if any, the American Society of Group Psychotherapy and Psychodrama plays in the certification process.

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Theoretical Applications of Symbolic Interactionism and Psychodrama

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This article explores symbolic interactionism and psychodrama for conceptual links which can form the basis of an empirical theory of group practice. George H. Mead's process oriented theory is enhanced by Jacob L. Moreno's dramaturgical approach on four critical fronts. The resulting synthesis begins to articulate universal themes which appear to be present in all groups as having potential for intervention by a trained facilitator. Such formal dialogue on a theoretical level has been neglected in previous methodological development and is a prerequisite for the production of viable models on small group theory.

Psychodrama and the principles of sociometry are frequently acknowledged as interesting approaches to group process, but peripheral to systematic theories of group interaction. In contrast, the application of psychodramatic techniques enjoys wide appeal among group leaders who seek to operationalize one or another theoretical model. The net result is a misrepresentation of both the substance and elegance of the classic paradigm founded by Jacob L. Moreno over a half-century ago.

While it is true that Moreno did not explicate a coherent system of group practice principles in the usual scientific fashion, his thought and techniques reflect a strong reliance on theory. In many ways, Moreno was one of the earliest practitioners to theorize what occurs within a small group structure. To highlight his contribution the present article identifies some fundamental concepts underlying Moreno's psychodramatic-sociometric approach to human interaction and discusses their relation to the sociological construct known as Symbolic Interaction Theory. An earlier article explored whether Symbolic Interaction Theory could serve as a sound basis for evaluating the action techniques of psychodrama (Kelly, 1976). The present work continues a more formal effort toward the

establishment of conceptual links using a complementary blend of symbolic interaction and psychodramatic concepts at the theoretical level. An acceptable "fit" at this level would not only validate the place of the psychodramatic method within the realm of theory but would suggest elements which could guide practitioners who work with small groups. The need for a generic "practice" theory is shared among several of the helping disciplines and is indicated by the assortment of intervention modalities which have recently appeared in the literature. A synthesis of one theoretical model and one practice model should begin to articulate universal themes underlying small group interaction.

Historically, psychodrama and symbolic interactionism emerged from a similar context. Both were reactions to the Watsonian explanation of social behavior and the Freudian portrayal of man as a product of intrapersonal drives. Both rebelled against a chronic inertia among the social sciences and focused on what was then considered a unique perspective of human behavior–the concrete human interact where one person meets another. Although psychodrama and symbolic interaction developed from different levels of concern, their point of convergence remained the unit of analysis identified as the social act. The "meeting" of persons in a social context was more than a response to external stimuli as concluded by the behaviorists. The interactional exchange was seen as a creative process where each person was fashioned and contributed to the fashioning of others. Social order existed not by reason of a master social plan or a chance occurrence of linked events, but through the constant evaluation of social behavior and personal reaction based on the evaluation. When a person interprets the social act of another he seeks meaning in that action. Only after surmising the meaning could he respond to it. The meaning of anything quite simply resides in how people behave in particular situations with respect to an object, event, person, or experience.

Unraveling the Complexities of Human Interaction

While Jacob Moreno distinguished the emotional and social factors in human behavior and corrected maladaptive functioning through the medium of group therapy, it was George Herbert Mead who formally crystallized symbolic interaction as a systematic theory by positing a relationship between the individual and the group. Moreno was clearly a practitioner and Mead a theoretician. Both unraveled the complexities of human interaction, yet neither strayed from focusing directly on the person in relation to others. Through their efforts interaction was given novel interpretation. Social order was seen to exist to the extent that people approached one another with similar understandings and expectations, and shared a common definition of the situation.

George Herbert Mead never published any full length development of his theories. His ideas were found in a collection of lecture notes and unpublished

essays which have led to considerable interpretation by his followers (Blumer, 1966). Mead's viewpoint, designated as "Social Behaviorism," stressed the covert as well as the overt social act for understanding human behavior. Human behavior he determined was accountable on a social basis. Society was seen as a series of behaviors and expectations. Through continual interaction and contact with others, each one's "self" emerged. Possessing a self meant that an individual could respond to one's self as another responds to it, could take part in one's own conversation with others, and be aware of what one is saying to determine what one is going to say thereafter (Mead, 1969). As a Social Darwinist, Mead saw man as the end product of evolution through his capacity for symbolic interaction. This capacity allowed man to become an object to himself and to examine his actions through the eyes of others. Mead postulated a "generalized other" which he interpreted as each person's collective embodiment of others' role expectations. Through selective perception and the unique organization of responses that others make to him, each person had a share in fashioning his private form of the generalized other. Many of these notions were a variation of Charles Horton Cooley's concept of the "looking-glass" self which illustrated the development of the self within the context of social relationships. The essential elements of Cooley's formulation were: how we imagine others see us; what we think their judgment is of us; and the feelings we have about the imagined judgment. Mead insisted that there was no fundamental difference in this social perceptual process from the manner in which any other object is perceived.

Humans respond on the basis of interpretation of the gesture and the gesture becomes symbolic. Language, for instance, is a most vital symbolic tool used by man. Communication among human beings is made possible by mutually understood symbols and the consensus of common understanding and expectations. It is these shared meanings which give order to society and it is the social act which serves as the foundation of the self. The Meadian components of the self are the "I" and the "me." The "I" includes the undirected, unorganized tendencies of the individual, yet the concept is not analogous to the Freudian notion of the unconscious. They are aspects of the self which are spontaneous, undisciplined and impulsive in moving the individual to act. The "me" represents the social phase of the self and is constituted by the attitudes and expectations common to the group which has been accepted by the individual.

Mead's Emphasis on Group Importance

Mead's analytical scheme was concerned more with the "how" than the "why" of human relations. He took the essential ingredients of all human interaction (symbols, roles, meaning, self) and wove them into an organic unity. Yet Mead's original symbolic interaction schema tended to overlook the affective side of human behavior. Although Mead emphasized the importance of the

group, he never explored symbolic interaction concepts in an actual group setting. By operationalizing these concepts he might have measured the strength of the social act both in terms of its influence on the self and the self's influence on the group members. This challenge he left to others who were sensitive to theory yet possessed first-hand experience in the practice of human behavior.

Although Jacob Moreno published prior to Mead and was cognizant of his work, Moreno developed a "practice" mode known as role playing which had all the elements consistent with the Meadian construct of symbolic interaction. Preludes to Moreno's thought are rooted in many disciplines including psychiatry, sociology, anthropology, philosophy, theater and his personal involvement with social action groups in Vienna during the first quarter of this century. Unlike Mead, Moreno observed social roles in process and operationalized them within the practical or pragmatic method of group psychotherapy (Moreno, 1978). Moreno attempted to bridge the concept of role in psychiatry with counterpart notions from the social sciences (Moreno, 1961). He developed his concept in a manner appropriate to the treatment of psychopathology and viewed social organization as a network of roles that constrained and channeled behavior (Turner, 1974). Roles were not merely a creation of society, but a spontaneous creation of man in interaction. In contrast to Mead, Moreno (1972, p. 157) stresses that "role playing is prior to the emergence of the self. Roles do not emerge from the self, but the self emerges from roles." A role is the actual and tangible form which the self takes (Moreno, 1972, p. 153).

Moreno differed from Mead by viewing man as an active agent in the creation of society. Through his dramaturgical perspective, man is both actor and author of his action. This supplements Mead's theory to a fuller dimension. Moreno's role conception is more inclusive of the emotional elements as crucial to interaction. By way of illustration Moreno's developmental theory distinguishes three types of roles: The "psychosomatic" which relates body language as an inference of (unconscious) biological needs; the "psychodramatic" which are imagined roles, either real or unreal; and the "social" which are roles typical of conventional social categories. Their importance, according to Turner (1974) comes not from their substantive content, but from their intent–to conceptualize social structures as organized networks of expectations that require various enactments by individuals. Moreno sees role interaction continually occurring on both the actual and the fantasy levels in response to the interpersonal situations of life. Roles can also be played with varying degrees of personal involvement. They may be assumed from a pre-existing role repertoire or copied from other members' role collections. They may be played with spontaneity, with variations introduced according to the interpretation and exigencies of the moment. Role perception is particularly important since both role performances and interpretations of the symbolic gestures of others can be colored by out-dated or false perceptions of former roles. The result may be the enactment of inappropriate

or irrational roles in social interaction. Whereas Mead allowed little place for creative or fantasy role exchange, Moreno is consistent with the symbolic interaction formulation, but attributes role differences to man's humanness and exercise of spontaneity, tele, and transference.

The Flow of the Psychodramatic Session

Psychodrama was Moreno's unique vehicle for developing the notion of role playing based on the actual interaction of persons in roles. Today, a variety of techniques and methods are used to enhance the development of a role repertoire and the adequacy of role performance (Moreno, 1969). The model continues to be utilized by a variety of professionals using a wide mix of goals. A typical psychodrama session consists of three phases: the warm up, the action, and a period of self-sharing by all group members (Blatner, 1973). The group process consists mainly in the use of five ingredients: (1) the stage, often a three-tier elevated circular structure without boundaries where the multidimensional facets of interaction may be "played"; (2) the protagonist, or sociometric star of the drama who enacts the interaction either from a personal investment or as the embodiment of group concerns; (3) the director, or group leader who is simultaneously producer, therapist, and analyst; (4) the auxiliary egos who serve in functional roles for the enactment of the protagonist's reality; and (5) the audience who may serve both to help in the sequence of action or be helped by the portrayal of the universal phenomenon of human interaction (Moreno, 1972). Throughout the entire flow of the psychodramatic session it is crucial to act out and not merely talk out the conflict or series of interacts involved. The focus is to help people continually alter perceptions about themselves and others so that they may behave and interact more adequately in the social context.

While the psychodrama model was devised as a method for developing role playing skills in group therapy, it has a clear relation to theory. Both symbolic interaction theory and psychodrama converge on the human act. Symbolic interaction provides a theory strength and psychodrama a pragmatic strength. A psychodrama session holds perhaps the greatest potential for enhancing the interplay between practice and theory. Chaiklin (1969) states that symbolic interaction theory offers social work a perspective that will help build a practice theory. It is a way of organizing information so that a practitioner has a systematic, logical, inductive, and theoretical basis for making decisions within a group. Not only does the group leader have a basis for making decisions, but these decisions can be "played out" in the group setting and an intervention tested "in situ." Persons involved in a psychodrama group setting have the advantage of experiencing perceptions as they unfold and rearranging behavior based on what is interpreted from the action. The group members form a genu-

ine social context wherein actions repeatedly occur and an action-response flows from interpretation of gesture. The classic act-interpretation-response model is an appropriate framework within which the psychodrama group leader can direct the emergent human experience. Although "staged," the drama, characters, and, most importantly, the perceptions are real. The entire drama is a microcosm of the larger social context of the world. Alterations made in group behavior have the potential to move beyond the stage and each session stands as a replication of the process described by formal symbolic interaction theory.

Moreno's Efforts Enhance Mead's

Mead's symbolic interaction theory emphasized communication processes and the meanings inherent within, between, and among persons. His format for developing personal identity lay in the dynamic tensions between the self and significant others. This format for each individual also represented a microcosm of human interplay at the interpersonal and social levels. Moreno's efforts enhanced Mead's process orientation on four fronts: (1) the first was in expanding Mead's conception of the spontaneous and impulsive "I" to include feelings and intrapersonal tensions as a source of action. (2) The second was in organizing the concomitants of intrapersonal strains into a conception of roles which reinforced and expanded Mead's interpersonal and social focus. In other words, inner feelings became a proper source of attention. (3) The third was to extend and apply Mead's process orientation to formed collectivities (groups) whereby person-roles could be reconstructed and managed within the context of other powerful and significant actors. Hence a person could not only "act out" a role dilemma, but examine and alter it with the help of other members, such as peers, and an expert facilitator. This is a critical point because the immediate group, unlike Mead's referent group, becomes the context for re-affirming or changing one's role perceptions, expectations, and performance at any of the intrapersonal, interpersonal, or social levels. (4) Finally, Moreno's use of the role construct is potentially measurable and as such paves the way for developing an empirically based practice. The result is that even idiosyncratic person-roles can be connected to group members' roles or expectations. The locus represents a choice point for the group facilitator's intervention:

> Symbolic interaction conceptually and logically leads to the psychodramatic stage where one can explore the dynamics surrounding the self, the other, and the emotional bonds which flow between them. Together, they affirm the contribution of practice to theory and clarify the place of theory in practice. A beginning synthesis, however, suggests the viability of such a model and those elements which may be universal to all small groups. An applied generic group theory necessarily begins with the facili-

tator being well grounded in a formal theory where intervention is based on knowledge rather than on generalizations. The more group practitioners attune themselves to the social act, the more consistent will be their impact on the daily lives of the individual group participants. Group leaders cannot be satisfied with anything less than theory-focused intervention since this is what the helping profession is all about.

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ERRATA

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On page 77, the significant differences in the questionnaire responses were $p > .05$. The information presented about question 8 in the table on page 79 included the mean rather than raw scores, $\bar{x}$ rather than X.

Forty-one Years of Psychodrama at St. Elizabeth's Hospital, which appeared on page 134, was also written by James M. Enneis.

HELDREF regrets any inconvenience these errors caused its readers and authors.

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