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Psychotherapy With Command Hallucinations in Chronic Schizophrenia: The Use of Action Techniques Within a Surrogate Family Setting

ALBERT M. HONIG

ABSTRACT. *Most patients who hear command hallucinations ignore them.* Patients who hear repetitive commands with an intrusive preemptory quality or for an extended period of time are at high risk. They remain dangerous to themselves or others, with deficit symptoms that have proved stubbornly resistant to traditional treatment strategies. I have developed action psychotherapeutic techniques, using the principles of psychodrama, that, in theory, take a strong oppositional position to command hallucinations in a battle for the patient's mind. The techniques described here are active, emotion-laden. They are designed to alter the whole-person system, either structurally or communicatively rather than in only one dimension. They are imaginative and often produce a sudden or radical quantum jump in the system to a different and higher level of functioning.

HALLUCINATIONS HAVE BEEN DEFINED as morbid phenomena caused by dissociated cerebral action that results in perceptions with no objective basis in reality, being subjectively perceived in an individual's conscious mind and projected externally (Macpherson, 1899). Command hallucinations are dicta, decrees, and edicts that, when heard, have a great pressure for obeyance.

Studies with hospitalized schizophrenics suggest that, although some experience hallucinations of all senses, the majority speak only of voices (Field, 1985). Auditory hallucinations have been reported in other psychiatric disorders but are more characteristic of schizophrenia (Assad and Shapiro, 1986). Larkin (1979) states that the content of a hallucination is more likely to be threatening, antagonistic, or isolating during acute psychosis and to be helpful, friendly, and socially focused in remission. Chronic schizophrenic patients prefer to deny rather than to admit

to having hallucinations. And an atmosphere of fear predominates. Some patients attack as if they are defending their lives; most withdraw into a protective shell of anhedonia. Perhaps 80% of hallucinations are destructive or self-deprecating, and the remaining 20% are seductively flattering, supportive, even instructive (Van Dusen, 1974). Other observers describe hallucinations as helpful and beneficial rather than persecutory (Modell, 1958).

Historical and Contemporary Treatment Approaches and Techniques

When the medical model for treatment of patients with mental disorders is being evaluated, emphasis is often placed on the rigidity of hospital policy and on what physicians do to and for the patient. Thus, the patient shares little in the process of getting well. This position seems to have the most validity with individuals who exhibit a strong self and can speak of themselves as "I." At the other extreme are those who speak of themselves as "they," "we," "you," or "it" or do not speak at all. Such patients are that remnant of the psychotic population that functions only with a brittle shell of self. In the approximately 25% to 30% of the mentally ill whose illness becomes chronic, the positive symptomatology—hallucinations and delusions—does not respond to medication and continues into chronicity. The positive symptoms join with the negative ones—loss of goal-directed behavior, blunting of affect, and verbal paucity—and are indicative of a poor prognosis (Strauss et al., 1974). These individuals are lingering problems for mental health professionals. They are usually unable to care for themselves and are sometimes dangerous. They are tossed among cost-effective, third-party payers, civil-rights advocates, families that cannot live with the mentally ill person's behavioral eccentricities, and frustrated practitioners who are told that these patients are too ill to respond to any treatment or are too disturbed to be treated under present regulations.

Despite today's difficult therapeutic climate, a dedication to finding new understanding of chronic schizophrenia remains. Genetic, radiologic-anatomical, and neurobiological research abounds, with exciting new findings that are beyond the scope of this article, which concentrates on the psychology of hallucinations, use of action techniques, and the therapeutic process.

Although the efficacy of a "talking treatment" for schizophrenia (including outcome studies) is often questioned, intensive psychotherapy for schizophrenia continues to be widely practiced (McLashen, 1983). Different therapists have developed theories and techniques in the individual psychotherapies that have produced positive results (Margo et al., 1981; Baskett, 1983; Fonargy and Slade, 1982; Field, 1985). Cancro (1983) em-

phasized the charisma and personality, rather than the theory or technique, of the therapist. These researchers' position is that psychotherapies with schizophrenia have been most effective in improving object relations and the quality of affective display.

Psychotherapists seem to take opposite views about the importance of hallucinations. One group maintains that hallucinations are not as important as the patient-therapist relationship, and therefore a therapist should concentrate not on the ideational or intellectual content of the hallucination but on the schizophrenic process (McLashen, 1983; Giovacchini, 1979; Arieti, 1980; Gunderson, 1979). Another group pays as close attention to ideational or intellectual content as one would to the content of a dream (Freud, 1955; Rosen, 1962).

Therapists disagree about the degree of intrusion. Some therapists suggest a relatively stoic and nonintrusive approach (McLashen, 1983; Arieti, 1974; Pao, 1979). On the other hand, Frank sees "an emotionally charged confining relationship that facilitates the arousal of emotion and the strengthening of hope" as the most effective atmosphere for the therapeutic relationship. There is even more confusion about the treatment of the hallucinatory process. Most interesting is the lack of relevant and adequate psychotherapeutic techniques for understanding the hallucinatory process better.

Command Hallucinations

The phrase *command auditory hallucination* is not widespread in the literature. This concept was discussed by Hall et al. (1981). They report that 38.4% of patients with auditory hallucinations said they heard commands, but the researchers concluded that most patients ignored the commands. These researchers believed that patients who hear repetitive commands with an intrusive, peremptory quality or for an extended period of time are at a high risk for dangerous behavior. Discharged psychiatric patients, who later commit homicides, admitted readily when apprehended that these murders were commanded by "Satan" or other voices. In the formation of chronic schizophrenia, hints or assumptions, advice and counsel, and simple orders may, in time, become commandments or ultimatums.

A Discriminative Approach and Technique of Therapy

As schizophrenia becomes chronic, the patient develops a new way of life that appears automatic, repetitious, and ritualistic. Command hallucinations take over with ever-increasing assault waves that include threats of pain, loss, or death, insults or deceit, all with a paralyzing, brainwashing

effect. Through fear, intimidation, and guilt, the hallucinations deflate and pulverize the ego ideal (Honig, 1988). Through a process of inner indoctrination, the hallucinations maintain dominance over the true self (ego) that remains submerged. The true self, deep within the person, still becomes more or less unidentifiable, unrecognizable, unreachable. These hallucinations are the mainstay to the continuum of the chronic state. They become its regulator—the false self, which Winnicott (1965) describes as a derivative not of the individual but of infant-mother coupling, or as Moreno views this process—"infant spontaneity" (Starr, 1977). Thus, command auditory hallucinations are at the center of and the key to the treatment of chronic schizophrenia.

I find that, in the most recalcitrant cases, the patient has kept the command hallucinations a secret. In my approach and style of psychotherapy, I take a strong position against the core of the command hallucination. This "control center" is engaged in a war of authority for the patient's mind. I hope that by taking this posture I can identify its "modus vivendi," expose its fraudulent, antiperson base, defeat it, and then reach inside and rescue the enfeebled self.

Most psychotherapies for schizophrenia employ techniques that involve continuous, repetitive, linear, mechanistic, step-by-step ways of making change. Educational and structural tasks that modify behavior, such as token economies, and level-privilege systems, are logical and easy for the patient to understand. These techniques depend on positive feedback and work by motivating the self. They are least effective when command hallucinations dominate.

With command hallucinations in control, the therapist may have to design techniques that attempt to jolt the whole psychotic system and restructure a relationship and open up communication. Although sometimes controversial, these imaginative techniques often produce a quantum jump in the system to a different level of functioning. The outcome is rarely logical or predictable. Rather, it appears abrupt, illogical, and unexpected. In theory, an emotionally laden system allows for both positive and negative feedback and accepts the existence of opposites (Watzlawick, 1974).

Action Techniques

The following techniques provide a way to pay attention to process and content at the same time and consequently are easily accepted by the patient. These methods are action models rather than interactional or transactional models (Dewey, 1949; Treadwell et al., 1990). Command hallucinations are primitive defense mechanisms and are attributed to abstract, undefinable, nonspecific origins with imagined or hypothesized internal

states that direct the individual to act irrationally (Weeks and L'Abate, 1982). Action techniques are used to exsufflate or exorcize the madness from patients who consider themselves victims of circumstance with no power to do anything to change. The techniques are psychodramatic and integrate the modes of cognitive analysis with the dimensions of experiential and participatory involvement. All the techniques are based on the theory of spontaneity and creativity, the very root of vitality and spiritual and behavioral development (Moreno, 1953; Bischof, 1970).

Implementing Action Techniques Within the Surrogate Family Setting

In a unique psychiatric setting, seven patients live 24 hours a day with a married couple (surrogate parents) and ancillary personnel working 8-hour shifts as helpers to the house parents (Honig, 1972). The primary therapist, who is responsible for the therapy of these seven patients in the home, spends as much time as is necessary working with one patient and uses the expertise of other patients and staff as protagonists and auxiliary egos. All assist one another in improving their understanding of intrafamilial and interpersonal conflicts.

The psychodramatic techniques used include joining with the hallucination, applying magic against magic, and employing humor, metaphor, analogy, simile, and ridicule of the psychosis. Dynamic intrusion, paradox, transitional objects and props, and *charivari*, a sociodramatic technique (Moreno, 1953), are also part of the procedure. The approaches described here were applied to two patients. In each case, a separate set of action techniques was used, and both patients met the DSM III criteria for a diagnosis of chronic schizophrenia. Adequate trials of pharmacologic treatments provided a supportive base for psychotherapeutic intervention but had not alleviated the patients' hallucinations. Dialogue between patient and therapist is included in my description of technique.

The Case of Patient A

Patient A, a 30-year-old man, experienced a breakdown while a senior in college. Delusions made him feel that he was about to be castrated and murdered. Command hallucinations ordered him to attack his brother with a carving knife, to assail a helping psychiatrist in a restaurant, and to commit suicide. He was referred to us 9 years after his primary breakdown. Unfortunately, adequate psychotropic medication produced a severe dyskinesia, and dosages had to be reduced. He rejected all interpretations and maintained a bullying, threatening posture that was difficult to penetrate. The treatment team decided on a series of action techniques

from less restrictive to more restrictive, depending on the patient's counterdefense. The therapist, through psychodramatic enactment, infuses his or her emotion into the patient. With this borrowed energy, the patient, for the first time, may show mastery over the command hallucinations and, through the repetition of these experiences and with time, develop his or her own strength of self.

Psychodramatic Techniques for Chronic Schizophrenia

Joining With the Hallucination

With this technique, the therapist persuades the patient to reveal the command. To gain the patient's confidence, the therapist shows the patient that he understands that the voices are real and that it might be better if the two reacted together.

Patient A's command hallucinations ordered him not to trust psychiatrists and to find all his answers in the Bible. As treatment proceeded, however, Patient A began to need and even like his therapist, but he could only accept the therapist as Uncle Danny, his mother's weak and noninvolved brother. When the session began, Patient A was pacing, shouting, "Get out of my way, Danny; can't you see I have important work to do today on this book!" He waved a Bible at the therapist while he paced in front of what he believed to be a supportive audience, the roomful of patients and staff.

The therapist spoke: "Come over and sit down next to your Uncle Danny. That no-good doctor says you are listening to voices telling you what to do every moment of your life. Psychiatrists are all crazy themselves! As we read the Bible together, we'll find the real truth about insanity."

With this comment, the therapist accepted the auxiliary role (Uncle Danny) that the patient found nonthreatening and condemned the use of psychiatric techniques. Together, they used the Bible as a means for psychological exploration. In effect, the patient allowed the therapist to join his psychotic world.

Magic Against the Vagary of Magic

Command hallucinations often mesmerize and paralyze a patient. The therapist must use a dramatic technique to break the spell and establish eye contact.

When the therapist entered the room, he sensed Patient A's isolation and loneliness and sat down next to him. He tried to talk with the patient

as he read his Bible, but the patient would not look up. Command hallucinations were forcing him to read passages.

The patient shouted, "And He smote of the men of Beth-shemesh because they had gazed upon the ark of the Lord" . . . "the Lord had smitten the people with a great slaughter" (Samuel 6:19).

The therapist concluded that the patient was now more frightened and paralyzed by the voices than in the previous session and believed he would be killed if he did not continue his Bible reading. The therapist realized that a more dramatic encounter command was necessary to gain his patient's attention and enter his world. The director therapist then shouted (see Starr, 1977), "Stand up. Look at me. When I count to 10, I will clap my hands, and the voices will go away!" The patient dropped the Bible, stood up, and followed the therapist's counting and clapping.

Although such a technique might bring only a moment of relief, it did interrupt the bombardment of voices so that the therapist could introduce yet another action technique.

The Use of Humor, Metaphor, Analogy, Simile, and Ridicule of the Patient's Insanity

Command hallucinations are concrete, and a patient believes every command must be followed to the letter. A therapist, through humor, metaphor, and satire, can reassure the patient.

The therapist spoke to Patient A: "So God says He's going to castrate you—kill you. Well, I've got to talk to that old S.O.B. I don't like the way He speaks to you. You know, I play cards with Him—pinochle—every Friday night. Anyway, I can't picture you without a penis, a girl with a long beard. Maybe you could get a job in a circus."

Such humor is dark, and the analogies are seemingly cruel. Nonetheless, the language and style are helpful in establishing the therapist's credentials as a no-nonsense dealer confronting terror and dread. In this case, Patient A laughed in relief and reached out to hug the therapist. The session ended in a warm embrace.

The Use of Paradox

This technique is effective with very stubborn patients who resist everything suggested and do the opposite. Folk paradox has provided moments of relief, sometimes even avenues for change, interjecting bits of humor between the tragic interface of life and death. Similarly, paradox has demonstrated its effectiveness with the negativistic chronic schizophrenic. It

sometimes produces the dramatic reorientation of individuals from a disabling command hallucination system to a person-to-person system.

Weeks (1982) suggests that the therapist's command brings the opposite behavior from the patient. He prescribes following the very thought pattern of behavior that the patient wants to change, thus placing the patient in an impossible situation, a therapeutic double-bind. The patient attempts to gain control by either disobeying the therapeutic command or acting on it. Even if the patient bursts out in confused emotionality, the material presented is therapeutic. With command hallucinations, the intent of the treatment is to enable the patient to recognize the hallucinations, see them as destructive, gain control over them, and eventually extinguish the voices. By using paradox, the therapist brings the problem to the surface, and reality boundaries are better outlined and identified.

Patient A had been expressing feelings of hopelessness for several days. His therapists were concerned because he had been psychotic for 12 years, and even though improvement both in mood and behavior was substantial, the hallucinations still dominated. The patient despaired of ever being able to gain control of his life. The treatment team believed that a sudden, self-destructive act was very possible. They decided that a dynamic intrusion, confronting the idea of suicide, but using paradoxical language, should be tried. The team members were fully aware of the precautions in case management that would be necessary both during and after the session. They locked the doors to the unit and began the session.

Therapist: "Tell those rotten voices that you are the worst suicide case I have ever seen. I'll never forget the day you killed yourself!"

Patient (pointing to himself): "Doctor, look, look, doctor. I'm still alive!"

Therapist: "Barely! The whole world knows that you did it! When you were in that coma it was only the doctors who kept you alive!"

On another occasion, an actual prescription was given to Patient A when he continued listening to commands of the voices. The treatment team reasoned that there would be conscious resistance to the prescription because the patient was extremely stubborn. They felt that, if the prescription were given, the patient would act strongly against the request and do the opposite.

The therapist directed Patient A to hallucinate with such volume that the walls would shake and people would cover their ears to protect themselves.

Patient A looked pensive, smiled shyly, stopped hallucinating, and joined the group in conversation.

No new behavior was prescribed in the first example, but paradoxical language was used to reacquaint the patient with his dangerous suicidal ideation and its possible consequences. In the second situation, the use of paradox brought the patient back to the world about him.

Dynamic Intrusion

Dynamic intrusion is a therapeutic technique employing immediate, firm verbalization in an attempt to overcome resistance (Honig, 1972). The use of a dynamic, explosive, direct, intrusive interpretation will arouse emotion, but the direction of change is not always predictable. Both process (quick, direct, face to face) and content are important.

Patient A's parents made an impromptu visit to the hospital and asked entrance to the cottage where their son resided. They were worried. The father's company was changing insurance carriers, and they did not think the new carrier would honor the old contract. They also stated clearly that they were too old to take Patient A home if he had to leave.

The treatment team met and decided that immediate, positive action was necessary. Arguments during the meeting were evenly split between beliefs that Patient A was able to function at a higher level and that he would regress, never to chance another try at recovery (a danger of an ill-timed dynamic intrusion). All agreed on A's deep-rooted attachment to his cottage and to his therapist.

An addendum to the treatment plan was written to include jogging ½ hour per day before breakfast, training at the vocational program luncheonette, continuing education to complete his college degree, applying for part-time employment off the grounds, visiting a transition (halfway) house overnight every week, and listening to an affirmation tape, "You can do it, Son," spoken by his father.

The addendum placed increased stress on Patient A, and the therapist did not know in what way he would react.

The next morning I walked into the cottage to find Patient A refusing to jog, bullying the surrogate parents, demanding his pipe, and shouting, "A baby was murdered in my sleep!" The scene was now set for a dynamic intrusion.

Therapist (gesticulating and shouting): "Every adult has a baby inside of them. You'll have time to nurture yours when you finish your schedule. Now quickly put on your jogging suit and go outside and run. We can't waste time; we have a full day's work to do!"

Patient A (answering in a whining voice): "My mother, my father, I want to go home."

The male surrogate parent said firmly, "A, now stop this nonsense, and go out and jog."

Patient A paused, looked around, and said, "I'll do it for you, Uncle Danny, I'll do it for you!" He slowly walked outside, shouting at the hallucinations, "You put me in the concentration camp for being bright. I'll call the Marines." He jogged for the allotted ½ hour, came in refreshed and smiling, and gave me a huge hug. The directed dynamic intrusion had shifted A's focus; he was able to castigate the commanding voices, not himself or his supporters.

Dynamic intrusion is rooted in the theory of creativity, whereby the "personality must not only meet new situations but create them, a task for which it can be prepared" (Bischof, 1970).

The Case of Patient B

Patient B, a 24-year-old single woman with a premorbid personality, showed much developmental psychopathology. She had been hyperactive since the age of 3. After the parents separated when she was 10, she was increasingly difficult to treat with psychotherapy. At age 13, she was placed in a group home after physically attacking her mother. She was chronically truant from school, smoked marijuana, and ran away with a boy on a round of hitchhiking. Six months later, she returned home, totally disoriented. She tried hanging herself, then slashed her wrists.

After 10 hospitalizations, she entered our mental health facility. She was combative, mobile, yet withdrawn. She laughed and rocked continually and "talked" incessantly to a well-known rock singer. She was constantly hyperactive during the day, awake all night. Adequate pharmacologic intervention quieted her without dulling mental activity but had little effect on hallucinations.

The problems facing a therapist treating Patient B would be different from those involving Patient A. Patient A was near to completing a B.S. degree, so he had the intellectual capacity to understand concepts of time, space, and contextual relationships. While he was ill, his associations loosened and his thinking became illogical, enabling him to invent ideas that, combined with neologisms, became delusions of exaltation. He displayed a veneer of ultimate power and could play with people's minds. Nevertheless, he found no way to extricate himself from the grip of the hallucinatory apparatus.

Patient B had few academic talents. Very early in infancy, she had moved away from nurturance into autism, hyperactivity, and hallucinosis. She completed nine grades of formal schooling, but now she could not concentrate and was unable to learn from books. She was cunning and

crafty in street matters, whereas Patient A was naive and impeded. As the more obvious and superficial defenses disappeared, what became visible in Patient B was a barren, emotionally deprived, infantalized individual with almost no sense of self. Command hallucinations, such as Heinlein's (1952) swarm of slugs that invade the Earth and attach themselves parasitically to the deepest organs of man, had sapped her life away.

If she were to respond at all, the therapy would have to be with basic concrete symbols and, if verbal, simple and elementary. At the same time, the techniques would have to be vigorous, challenging the power of the command hallucinations that had orchestrated her suicide attempt, her use of drugs, and her runaway behavior.

Techniques With Patient B

Transitional Objects and Props as Rewards for Cooperation

The following six techniques are based on the cultural conserve theory. According to Bischof (1970), persons with poor personality integration are relieved in the security of the conserve and avoid the unpredictability of inventing something new from the old.

In the locked cottage, Patient B was placed on a positive token economy in which she was rewarded for her cooperative behavior with the only pleasure that mattered to her—cigarettes. Cigarettes were bestowed for personal hygiene (showering, brushing teeth, etc.); more cigarettes for cleaning her room, doing her laundry. She received cigarettes for writing down and reading aloud her secret thoughts and hallucinations. Time on the exercise bike bought cigarettes, and working in the vocational cottage industry earned cigarette tokens and wages.

The art therapist helped Patient B create transitional bracers. For example, she made a life-sized stuffed doll with graphically delineated features to which the patient could react with all of her emotions. Patients construct these fetish dolls, tracing an outline of themselves or family members, and they then stuff, sew, and clothe the dolls. At first, Patient B was resistive and uninterested in the doll, but, as time went on, she hugged and even slept with it. Once she ripped the doll's head off, only to sew it on again.

Nurturing bottles of sweet, warm milk reactivated the lost sensations around Patient B's mouth, chest, and upper abdomen. She went outside for walks, using the lifeline, which is a long ribbon tied to the waist of the patient and a staff member to minimize escape and symbolize attachment. When her urge to steal other patients' clothes or cigarettes was high, Patient B wore boxing gloves as a deterrent. She also wore colorful chest

signs with such messages as: Please love me, or, I need a hug badly. Both Patient B and her one-to-one therapist wore clownlike theatrical paint on their faces to counter morbid feelings in the patient. These methods helped wear down the chronic boredom of repetitive behaviors that had become habitual for B. The problem of what to do with the voices persisted, however. Patient B constantly carried on conversations with the rock star and tried to dress like a man, saying she was the rock star. She would often scream, "Why are you inside of me? Why can't I get what I want?"

When a nurturing bottle was given to her by her mother who visited frequently and became integrated into the surrogate-family system, neither could accept this procedure at first. On subsequent visits, B relaxed, tolerated and even began to relish the bottles from her mother. She appeared happier and more feminine and became interested in women's clothes. As she felt better, the voices would assault her in waves, torture her, and bring on feelings of dread. A seesaw battle between sanity and insanity was reaching a raging climax. The treatment team decided to venture past Patient B's structured reality. A sociodramatic concept, the charivari, was necessary to test and reinforce the forces of sanity.

Charivari is a village-type celebration in which the entire therapeutic community participates, and the patient is helped to enact a problem instead of just talking about it. In ancient times, a charivari was a noisy, public demonstration, a court of fools used to subject wayward individuals to humiliation in the eyes of the community (Shorter, 1975). Traditional communities of medieval Europe were able to compel individual family members to follow collective rules through a colorful, playful, Mardi Gras-like celebration. At the therapy session in this surrogate-family setting, a charivari was chosen as the therapeutic strategy not to reinforce community rules but to help the individual patient distance herself from both the repetitive commands and the maladaptive behaviors of a chronic psychosis. The total community, through group concern and the sharing of similar feelings and experiences, joined with Patient B and her cottage mates in a search for healthy interactions.

In Patient B's case, the charivari included a steal-all and a smokeout as well as a funeral for the psychosis and rebirth. The steal-all and smokeout were designed to divert Patient B's stealing and hoarding and her secret smoking of 5 packs of cigarettes each day. Reducing the quantity would eliminate the hacking cough and would also interrupt the constant cacophony of voices and sounds that seemed to dance on the rising clouds of white smoke coming from her mouth and nose. Although through the token economy B earned from 10 to 20 cigarettes a day and was motivated toward daily activity, she received little joy from this. According to the charivari strategy, at 2 o'clock every Saturday afternoon, the entire thera-

peutic community gathered in the living room, where 12 packs of Marlboros were hidden. Patient B was allowed 15 minutes to hunt for cigarettes and 30 minutes to smoke. At first, she puffed 20 to 30 cigarettes, cheered on by the crowd. Six months later, she was satisfied by 5 to 10 half-finished cigarettes. As a result of the community's efforts, she announced one day that she would rather earn her cigarettes than hunt for them and smoke her findings.

Having a funeral for the psychosis and a rebirth observance helps the patient bridge the gap from psychosis to reality. The ceremony recognizes that the patient has lived with the voices, delusions, mannerisms, and the diagnosis of schizophrenia for many years. Although a woeful, destructive, and dreadful existence, the psychosis provided fact and certainty, and deserves to be mourned. After bereavement, the celebration of rebirth follows.

Patient B's observance took several days. She selected a place in the field and dug a mock grave. Then everybody proceeded to the burial site. Patient B voluntarily placed everything she associated with her illness—torn jeans, oversized shirts, rock records and posters, cigarette butts—into the grave. All bowed heads for a minute of silence. Patient B and her friends, the staff, and patients threw dirt into the hole and covered it with flowers. A week later, after a period of mourning, everyone walked hand in hand to the nearby lake, where Patient B was immersed in water —a baptism. Patient B, beaming with pride, wore on her blouse a pin marked with her newly chosen name, a name she had secretly always wanted to be called.

Current Status of Patients A and B

As of this writing, both Patients A and B are in treatment. Patient A is no longer harassed by command hallucinations. His terror is almost gone, showing now in his dreams but not in the working day. He works as a dishwasher in a local restaurant and sees a tutor to prepare him to complete his last year of college. His budding ego responds to a more-supportive, person-to-person psychotherapy. On occasion, we joke about the "primitive" treatment methods that were directed against the command hallucinations.

Patient B's responses have not been so dramatic. She still struggles against the commands, sometimes showing more control, other times less. Her therapists constantly search for new ways to point out the absurdity and the mind tricks of the hallucinatory-delusional process and, at times, are successful. More and more, she thanks them for being her allies.

Discussion and Conclusion

Assumptions or hints, advice and counsel, or simple orders, present at the onset of the mental disorder, become, with time, commandments or ultimatums. As the schizophrenic process continues into chronicity, command hallucinations take over with ever-increasing assault waves that have a paralyzing, brainwashing effect on the patient, eventually maintaining dominance over the mind and body of the ill person. Command hallucinations become a false self—the regulator of, and the mainstay to, the continuum of the chronic process.

The key to the psychotherapy of each individual case is finding ways to free the true self and to restore its dominance over the organism. With feelings such as world-ending catastrophic fear, hyperesthesia to pain, anhedonia, techniques that are expressive, arouse emotion, and focus on reality are indicated. Recently, I have been using an amplifier with earphones so that the patient could hear her voice magnified to decibels adjusted higher than the internal voices.

With the examples presented in this article, I have engaged the command hallucination in a war of authority as I try to help the patient retrieve his or her mind. The content of the hallucination is as important as the content of a dream. Often the hallucination is acted out in the form of a psychodrama, showing the meaning to the patient rather than merely telling him about the hallucination. Breaching the barrier to solutions from chronic psychosis is a difficult and dismal task that is better negotiated by a team than through a one-person approach. Because the psychosis changes both in content and mood, ways to combat the illness require creativity from the treatment team. Success is measured in simple terms: The patient is able to care for himself, live in a less-supervised level of care, and will not end up among the homeless, in jail, or in another mental institution. When command hallucinations dominate, separation of the therapy for the illness from the management of problems in living, as suggested by Goodwin (1988), would be cost effective but difficult. Mastering a problem as simple as brushing one's teeth, eating, or dressing means defying commands that prohibit these actions. To defy a command that threatens severe consequences—for example, eternal burning in hell—will empower that person to further defiance and set up a chain of behaviors toward recovery. In such circumstances, simply brushing one's teeth becomes a courageous act and a critical part of the treatment process.

Therapy with chronic psychosis is analogous to sculpturing a human form from granite. In both, one just chips and chips away. I must confess that during my 30 years of working with command hallucinations, I have sometimes fantasized about a powerful machine that would extin-

guish the malignant voices, leaving the individual happy, whole, and reborn. Sadly, as I labor, I settle for a bag of techniques and interpretations, maneuvers within the bounds of the adamantine family model, that might enable my patients to gain strength enough to fear no longer the hellish punishment meted out by command hallucinations. Techniques are created as the need arises, and perhaps the best are never written down as the therapist helps the patient express his or her feelings (Rabson, 1979; Vander May, 1981). The therapist also offers himself or herself to the patient as a bridge out of insanity and a source of courage to keep trying to get well.

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An Essay on the Metascience of Psychodrama

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ABSTRACT. To pave the way for the development of a solid foundation upon which psychodrama techniques can be properly based, I wish in this article to validate Moreno's theories from a metascientific point of view by examining the governing assumptions of psychodrama when regarded as natural and as human science and by discussing the possibility for integrative solutions. I have concluded that the natural and human science aspects of psychodrama cross-pollinate one another and that both together are more complete than either one alone and create an outline of integrative psychodrama.

PSYCHODRAMA SEEMS TO BE KNOWN more for its application than for its theories. According to reviews of the literature, there are comparatively few people developing theory, and there is little going on in systematic research. Instead, we find a large number of practitioners using techniques without any firm theoretical basis. Farson (1978) pointed out that most humanistic psychologists are antitheoretical. This, I believe, holds true also for psychodramatists in general. It seems to me that they have a preference for spontaneous action, emotional experience, and release of feelings at the expense of healthy skepticism, critical questioning, and solid research. As a result, the theories upon which psychodrama is based have not been sufficiently expanded, revised, or tested and remain a hodgepodge of unrelated thoughts, unintegrated by any one systematic framework.

In an earlier paper (Kellermann, 1987), I proposed a "theory free," procedural definition of psychodrama. I did this not because I believe that psychodrama shall be viewed in a pragmatic, atheoretical fashion as a collection of unsystematic treatment interventions but because I wished to unite practitioners of diverse persuasions within one common framework. I had hoped that this framework would be sufficiently broad to include a wide range of theoretical views of psychodrama. Kipper's (1988) response

that "a procedure (a method) requires a rationale, a model, or a theoretical foundation of its own" (p. 165), goes without saying. From what I can see, however, such a theoretical framework has not yet been developed. I agree with Boria (1989) that "the theoretical structure of psychodrama is not more than a framework or a 'skeleton' of a body still to be built" (p. 166). This is, according to Polansky and Harkins (1969), one of the reasons why psychodrama has not gained more popularity: "Most therapists prefer a method of treatment grounded on a reasonably well-developed general theory of personality, such as the psychoanalytic" (p. 74).

It is my position that we must make a commitment to theory if we want psychodrama to grow. Such a theory should provide the psychodrama practitioner with a framework from which to view the protagonist and with a rationale for intervention. It should further be evaluated continually and revised according to ongoing observations.

Several practitioners justify their practice with the help of theories adapted from psychoanalysis, social psychology, Gestalt psychology, transactional analysis, self/ego-psychology, behavioral learning, eclecticism, existential philosophy, interpersonal approaches, or humanistic psychology. Most of them probably refer to the classical formulations of J. L. Moreno when asked to provide a rationale for their work. "Psychodrama's scientific roots are buried deep in Moreno's philosophies of spontaneity, creativity, the moment, and theories of role and interaction" (Yablonsky and Enneis, 1956, p. 149).

It is my feeling that, although Moreno's theories are useful to explain many clinical situations, they fail to provide a sufficiently uniform and comprehensive theoretical structure for psychodrama therapy. Moreno was a creative inventor in his own way, but he never paid enough attention to the consistent validation of his system. In a desperate effort to create one unified theory of the universe, he attempted to bring together mutually exclusive viewpoints that were often based on contradictory assumptions.

The purpose of this article is to lend validation to Moreno's theories from a metascientific point of view by examining the governing assumptions of psychodrama when regarded as natural or human science and by discussing the possibility for integrative solutions. My hope is that this examination will lead to the development of a consistent theoretical basis for the practice of psychodrama that is based upon existing tenets of Morenean concepts.

A Metascientific Frame of Reference

Many writers, in and out of psychology, have dealt with the ways in which theories are used in science (Kuhn, 1970; Radnitzky, 1970; Hempel,

1965; Lesche, 1962). The present study has grown out of the suggestions of the writers who employ "metascience," or "philosophy of science," as a means of structuring and understanding theories and describing them on a metalevel. Schematically, the levels of observation are illustrated in Figure 1 with examples from psychodrama.

According to a division proposed by Dilthey (1944), there are two highly influential "schools" of metascience: the natural and the human sciences, each reflecting a unique perspective toward the social world. The natural science approach is characterized as being empirical, positivistic, reductionistic, objective, analytic, quantitative, deterministic, concerned with prediction, and largely operating with the assumptions of an independent observer. The human science approach is concerned with meaning, description, qualitative differences, the process of explication, investigating intentional relations, articulating the phenomena of human consciousness and behavior within the context of a broadened conception of nature, and assuming the privileged position of the life-world, the primacy of relations, and the presence of an involved scientist (Giorgi, 1970).

Corresponding to these two schools of metascience, the metatheory of psychodrama will be divided into one natural and one human science part —the natural science approach illustrated by "behavioral" psychodrama and the human science approach by "existential" (or phenomenological) psychodrama. The reason for this division is not to create two separate systems but to determine the fundamental viewpoints and governing assumptions that guide the thinking in each tradition of scientific practice.

One may argue that it is impossible to separate psychodrama in such a dualistic manner and that this separation may introduce an artificial, unnecessary, and perhaps damaging split that would distort the integral psychodramatic system. I agree on the desirability of integration, which is shown by the illustration of "integral psychodrama," but insist on the temporary differentiation for heuristic purposes. An overview of the governing factors in psychodramatic theory is presented in Figure 2.

FIGURE 1. Levels of Observation

Metatheory	**Metascience**	**human/natural science**
▼		
Theory	**Theory of person, Theory of psychotherapy**	**spontaneity theory catharsis theory**
▼		
Practice	**Therapeutic practice**	**role playing**

FIGURE 2. The Governing Factors of Psychodrama as Natural and as Human Science.

Metascience	Psychodrama as natural science	Psychodrama as human science
Therapeutic Practice		
	Behavioral Psychodrama	Existential Psychodrama
Norms	Mental health	Awareness of existence
Values	Normal behavior	Emancipation, experience
Goals	Symptom removal	Spontaneity
	Adjustment	Self-actualization
Diagnosis	Relevant	Irrelevant
Respondents	Patients	Individuals
Interventions	Therapeutic	Dramatic self-presentation
Theoretic Assumptions		
Phenomena of interest	Overt behavior in a role player	Covert behavior in a coproducing actor
Image of person	Biological organism	Intentional person
	Mechanical being	Spontaneous being
Ideal of person	Adapted	Authentic
Ideal of science	"Quasi-naturalistic"	Humanistic
Ideal of knowledge	Neo-behaviorism	Intentional contexts
	Causal explanations	Understanding of acts
	Description of regularities	Historical biography
Ontology	Materialistic monism	Idealistic monism
Epistemology	Determinism	Nondeterminism
Research-guiding interests	Logical empiricism	Hermeneutic-dialectic
Status of research objects	Subject-object	Subject-subject

Therapeutic Practice

Behavioral psychodrama is based on medical thinking; the goal is to cure illness, remove symptoms, change behavior, or promote social adjustment. Being in good mental health is the same as exhibiting "normal" behavior, and its diagnosis is relevant and necessary. The main function of the psychodramatist is technical—to prescribe for patients specific technical interventions in order to achieve the predetermined goals. Some traces of this thinking may be found in Moreno's writings, such as: "Psychodrama puts the patient on a stage where he can work out his problems with the aid of a few therapeutic actors. It is a method of diagnosis as well as a method of treatment" (Moreno, 1946, p. 177). However, in spite of this

quasi-medical language, most often psychodrama adopts a more humanistic approach to personality change.

In existential psychodrama, there is no conception of what is healthy, normal, or pathological, and any diagnosis is therefore irrelevant and unnecessary. Psychodrama is not therapy in the medical sense of the word, but an emotional experience within the framework of an interpersonal encounter with spiritual values. This experience may or may not make the participants more aware of themselves or more balanced. In any case, the goal is not to produce a "cure" but simply to become as spontaneous and creative as possible within the boundaries of one's personal limitations. However, in order to differentiate this activity from dramatic entertainment and from spontaneous play in general, I still prefer to define existential psychodrama broadly as a kind of psychotherapy.

Integral psychodrama may be achieved through adapting the goals of technique to the needs of the respondents. The value conflict between health in behavioral psychodrama and awareness in existential psychodrama may perhaps be solved by the application of Maslow's hierarchical system of values. Behavioral psychodrama is used with patients who demand satisfaction of more fundamental needs, such as symptom removal. Existential psychodrama is used with anybody who is motivated to liberate himself or herself from false conceptions about self and others. They have already satisfied their basic needs and may therefore strive for more self-actualization and spontaneity.

An integrative approach to psychodrama research would take the position that no truly rigorous science can be accomplished until we analyze the pure phenomenal data themselves, free from any presuppositions. Thus, attempting to resolve the subjective-objective and the internal-external dichotomies, both sources of knowledge would be considered: interiority—introspection and involvement of the subject and subjective experience, to which the humanist refers—and exteriority—empirical data collected through the senses, to which the natural scientist refers.

Theoretical Assumptions

Phenomena of Interest

The subject matter of investigation in behavioral psychodrama is overt behavior—acts of a role player, eschewing all references to internal, mental-life phenomena. The emphasis on action-theory, action-language, and motor events in psychodrama, as well as the article on "behavioral psychodrama" (Moreno, 1963) and the general depreciation of the psycho-

analytic theory of the unconscious, are examples of Moreno's behavioral thinking.

But Moreno never adopted an extreme and pure behavioristic theory of the world. In reality, Moreno also investigated covert mental processes, subjective experiences, impulses, and psychic energies in a more existential manner.

The subjective, covert consciousness of an intentional person is brought into the field of investigation especially in existential psychodrama. In his article "Existentialism, Daseinanalyse, and Psychodrama," Moreno (1959) stated that "the full involvement of the actor in the act is a regular procedure, and emphasis is continually placed upon a subjectivistic frame of reference to the extreme" (p. 215). In line with this thinking, Jonathan Moreno (1974) characterized psychodrama as a form of phenomenological psychotherapy.

It should be mentioned that psychodrama does not only study the overt behaviors and covert consciousness of one individual but also studies the whole realm of interpersonal relations, the social interplay between individuals. According to Marineau (1989), the territory of psychodrama as it appears in Moreno's book *The Words of the Father* (1920) is "the family, the group, the world, the universe—the place where the person is expressing himself at any given moment" (p. 108).

Moreno (1959) acknowledged the two paradoxical principles operating in the therapeutic investigation: "One is the utterly subjective and existentialistic situation of the subject; the other is the objective requirements of the scientific method. The question is to reconcile the two extreme positions" (p. 216). The fundamental rift between those who emphasize subjective, inner experience, on the one hand, and those who stress objectivity and rationalism, on the other, may be repaired by a synthesis of the two points of view, as attempted in integrative psychodrama.

Integrative psychodrama is best understood within Moreno's role theory, where both overt and covert phenomena are taken into consideration. The role, according to Moreno (1946), is "a unit of synthetic experience into which private, social, and cultural elements have emerged" (p. 184). Psychodramatic role theory was inspired by the functionalism of William James and John Dewey and by the social psychology of George Mead (1934), who wrote: "In social psychology we get at the social process from the inside as well as from the outside. Social psychology is behavioristic in the sense of starting off with an observable activity—the dynamic, on-going social process, and the social acts which are its component elements. But it is not behavioristic in the sense of ignoring the inner experience of the individual" (p. 7).

Image and Ideal of a Person

When discussing the ideal of a person in Moreno's theory, I will consider his basic concept of spontaneity, defined as "the variable degree of adequate response to a situation of variable degree of novelty" (Moreno, 1953, p. 722). This definition is clearly behavioristic, emphasizing normal, adequate, and optimally adaptive behavior. Moreno's definition of spontaneity, however, has been frequently criticized for inconsistency (for example, by Aulicino [1954]).

As far as I can see, and according to the works of Bergson (1928) and Peirce (1931), who are quoted frequently in Moreno's writing, the concept of spontaneity is a most existential concept. Spontaneity in existential psychodrama would be defined as an uninhibited, immediate, and first response, impossible to quantify or measure. In line with this understanding, the image and ideal of a person in psychodrama is explicitly humanistic, viewing human beings as intentional and authentic, striving for genuine expression from within. Human beings should be considered as a whole, as living, and as becoming, in and out of the world, in a particular situation and in a personal encounter with another person, doing something that expresses something significant in his or her life.

But Moreno (1951) did not take an either/or position because he felt that "man is more than a psychological, social, or biological being" (p. 201). This view of a person led Bischof (1964) to classify Moreno's personality theory as a biosocial interaction theory, a theory postulating that human beings have developing functions taking form through constant interaction between the biological organism and the social environment, and where every aspect of this complex duality stands in a dynamic relationship to one another.

Thus, the image and ideal of a person in integral psychodrama are explicitly holistic, attempting to give a complete picture of human beings rather than partial ones. Holism, according to Farson (1978), "considers the person as a complex dynamic system in interaction with a continually expanding physical, social, and temporal context" (p. 27).

Ideals of Science and Knowledge

On the one hand, Moreno's investigations had a natural science ideal of logical-deductive reasoning, with experimental research following the criteria of objectivity. On the other hand, Moreno was an existentialist, deeply involved in phenomenological philosophy and metaphysical speculations following the ideals of subjectivity.

An example of the natural science ideal in Moreno's writings may be found in articles Moreno (1953) wrote in which he advocated sociometric empirical research on spontaneity: "Sociometry has taken the concept of spontaneity from the metaphysical and philosophical level and brought it to empirical test" (p. 39). This position is incompatible with a pure humanistic ideal of science. Moreno's research, however, was never pure natural science, and when he spoke of "empirical tests," these tests did not meet the general requirements of experimental or quasi-experimental research.

In reality, Moreno's humanistic bias does show through in most of his writing, as, for example, in his studies of the Encounter. According to Moreno (1960), "The clinical encounter is the primary method for studying the personality of another person, and the data derived therefrom provide the criteria on which all other possible data should be evaluated" (p. 145). Moreno's humanistic studies emphasize the hidden spiritual dimensions of reality and the intuitive, mystical sources of truth that cannot be investigated by the experimental approach. Moreno (1953) felt that the scientific-technological civilization denigrated humanistic values and threatened human survival and that objective methods of knowing neglected the creative dimensions of experience.

It can be said that Moreno's research had neither subjectivity nor objectivity as ideals but was "quasi-objective," according to moreno (1959, p. 215). A better understanding between phenomenologists, existentialists, and empirical scientists could, he believed, be successfully reached in sociometric theory and that "objective" and "subjective" validation did not exclude one another but could be constructed as a continuum.

Moreno was influenced by European existentialist philosophy until 1925 when he moved to the United States. From that time, he observed that "a psychology of action is more akin to the Americans" (Moreno, 1946, p. 11) and became influenced by the pragmatism of C. S. Peirce, W. James, and J. Dewey and by the empirical behaviorism that was then dominating the academic community in America. But he never took an either/or position.

Ontology

I would assume that most psychodramatists agree with the commonsense view of ontology that body and mind interact and that both behavioral and existential events are emphasized in psychodrama. However, some probably have a preference for the behavioral side, adopting a materialistic monism (there is only body); whereas others have a preference for the existential side, adopting an idealistic monism (there is only mind).

This has more than theoretical relevance. If we believe that we *are* our bodies, that we are "some-body," we will then emphasize physical expressions in therapy, such as concretizing feelings and using bioenergetic techniques. If, on the other hand, we emphasize the "mind," we will emphasize mental imagery and cognitive insight.

Neither of the ontological positions reflects Moreno's view or the pluralist solution of William James (1909). This view assumes that "mind and body are but two of many aspects of reality and that there may be a continuum of cosmic consciousness behind the material world" (Knight, 1950, p. 72).

Integral psychodrama is perhaps most compatible with the monistic double-aspect view of Spinoza who argued that mind and body are but two aspects of a single underlying reality. What appears to be mind from one perspective appears as body from another. This may be illustrated by the use of psychodramatic action techniques that emphasize the expression of the whole person (mind and body).

Epistemology

Epistemology is concerned with the question of how we know, the relationship between body and mind, the problem of cause and effect, and with determinism.

The methodological dichotomy that was introduced by Dilthey (1944) suggested that natural sciences are concerned with explanation while human sciences are concerned with understanding.

Behavioral psychodrama is based on determinism, demanding scientific explanation of behavioral events in terms of independent variables. Similarly, psychoanalytic psychodrama is based on determinism when it attempts to explain a person's behavior in terms of antecedent events.

Existential psychodrama is nondeterministic in its attempt to understand human motives and intentions. Existential psychodramatists prefer to ask how a person is acting in a descriptive manner rather than why a person is behaving in a certain way. Because the realities of existence are probable rather than absolute, existential psychodrama cannot answer the question "why," which appears to require ultimate and absolute causes.

Moreno criticized Freud for relying too much on psychic determinism and not leaving enough room for spontaneity. He criticized Bergson for going to the other extreme. Within his spontaneity theory, Moreno (1946) tried to create a functional, operational determinism where "in the development of a person, there can be original moments, truly creative and decisive beginnings without any horror vacui, that is, a fear that there is no comfortable past behind it from which it springs" (p. 103). These

moments, according to Moreno (1951), "operate in a totally different dimension from the past-present-future continuum and are not submitted to causality and determinism" (p. 208).

Integrative psychodrama attempts to encompass both positions. On the one hand, memories of past events are presented in psychodrama in order to gain insight about how those events influenced the present behavior. On the other, present (and future) experiences are externalized in order to perceive more fully the immediate existence of here and now.

Research—Guiding Interests

If the main motive is to gain information about objective processes, a logical-empirical approach should be taken. If the motive is emancipatory self-understanding, a descriptive, phenomenological or a process-oriented (hermeneutic-dialectic) research approach should be taken.

Behavioral psychodrama is oriented toward hard facts, quantitative studies, and controlled-outcome research. Existential psychodrama is oriented more toward qualitative studies, process research, and single case studies ($N = 1$).

Integral psychodrama makes a point of combining both qualitative and quantitative methods of research in any single study.

Status of Research Objects

In psychodrama research that is based on the natural science model, researchers must relate to research objects with neutrality in order for the observations to be objective. Natural science, however, is unable to provide a context within which people and their interactions "make sense."

Moreno (1953) took a decidedly opposite, subjective, humanistic position on the status of research objects, similar to researchers of the Malinowsky tradition in anthropology, fieldwork sociologists, symbolic interactionists, and, more recently, ethnomethodologists in sociology. Moreno wrote: "Social sciences like psychology, sociology, and anthropology require that its objects be given 'research status' and a certain degree of scientific authority in order to raise their level from a pseudo-objective discipline to a science which operates on the highest level of its material dynamics. It accomplishes this aim by considering the research objects not only as objects, but also as research actors, not only as objects of observation and manipulation, but as co-scientists and co-producers in the experimental design they are going to set up" (p. 64).

A basic starting point of this qualitative paradigm in conceptualizing the social world is to understand situations from the perspective of the partici-

pants in the situation. To understand the world, the investigator must go out into the world, live among the people as they live, learn their language, and participate in their rituals and routines. Basing research on the principle of role reversal, the investigator must become a part of and at the same time remain apart from the phenomena of interest.

Integrative psychodrama attempts to comprise both closeness and distance, laboratory research and field- and action-research, observation and participation, passive interpretation and active involvement.

Discussion

I have presented examples of some natural and human science aspects of psychodrama as they appear in Moreno's writings and suggested an outline of integrative psychodrama. But is it possible to justify such an integrative approach?

According to Giorgi (1970), the attempt to integrate is often more "a sign of wishful thinking than an actual integration of viewpoints and the synthesis is a simple juxtaposition of opposition in a side-by-side manner rather than one integral scientific approach. Fundamental views in natural science are contradictory to the views in human science. This makes a combination difficult, if not impossible, to justify. To deny contradictions in order to facilitate integration is of course a distorted position" (p. 54).

Moreno did not deny that contradictions existed, but, in order not to think in black-and-white dichotomies, he never abandoned the wish to find integrative solutions. Recognizing the paradoxical nature of human experience, Moreno appreciated that opposites do coexist and, in fact, define each other. Neither side gives the whole picture, and both together are more complete than either is alone. Jonathan Moreno (1974), Leutz (1976; 1977), Petzold (1980), and Marineau (1989) considered Moreno's work to be a successful synthesis of opposite viewpoints.

Moreno refused to compartmentalize reality, wanting to achieve synthesis at all cost. He had a preference for combining contraries into unities and tried hard to discover similarities rather than differences between opposite conceptions. Moreno (1951) said, "I attempted a synthesis, not only for science's sake but also in order to maintain my own mental equilibrium" (p. 205). He was just not content with divisions and felt that he had to bridge a gap between different parts in order to create a synthesis.

Moreno's integrative effort was predated by Stern (1938), who felt that psychology always should preserve the correlation between part and whole, figure and ground, analysis and totality, and methods of explanation with methods of understanding. Like Moreno, Stern was critical of one-sided approaches, rejecting behaviorism because it closed off intro-

spective, opposing psychoanalysis because it closed off the study of behavioral phenomena, and turning away from experimental psychology because it closed off experiential data.

We have a tendency to split and separate into bipolarities and to conceptualize phenomena in a dualistic manner. For example, many theories are described in terms of dichotomies and oppositional forces. Maslow (1968) emphasizes the importance of giving up this habit. "Difficult though it may be, we must learn to think holistically rather than atomistically. All these 'opposites' are in fact hierarchically-integrated, especially in healthier people, and one of the proper goals of therapy is to move from dichotomizing and splitting toward integration of seemingly irreconcilable opposites" (p. 174).

It is my position that psychodrama should strive toward such an integration. In the process of achieving this goal, psychodrama does not have to be either an integration or a separation. I would rather see it as an ongoing developmental movement where the natural and human aspects continually separate and differentiate while the whole theory individuates. Thus, in a way similar to the separation-individuation process of the human self (Mahler, 1968), a unified theory of psychodrama may develop. In the dialectic tradition of Hegel, this movement would be described as suggesting a thesis, contradicting it with an antithesis, and finally reaching a synthesis. According to Kuhn's (1970) theory of paradigmatic shifts, integral psychodrama would develop like a pendulum that swings from one side to the other, for example, from qualitative to quantitative studies, from subjective to objective, from mind to body, and from theology to science, all the while not being allowed to swing too far to either side. The middle ground of blending the aspects of both approaches would represent the optimal position.

Conclusion

Most psychodramatists have focused almost exclusively on technical problems, but the time has come to direct our interest also toward the examination of theoretical issues. Much work remains to be done in the field of theory building, including studies on such central concepts as dreams, motivation, conflict, regression, fixation, psychopathology, child development, stress, and perception. Furthermore, revisions of Moreno's theories of role playing and role taking, spontaneity-creativity, sociometry and sociatry, the "cosmic" man and the social atom and network and consideration of the political relevancy of his book *Who Shall Survive?* will be essential. I hope that this article will be of some help in making such work more integrative.

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Call for Papers for a Special Issue on Sociometry

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Role Dynamics: A Comprehensive Theory of Psychology

ADAM BLATNER

ABSTRACT. One of Moreno's major contributions was his approach to role theory, an approach that encouraged its practical application in both therapeutic settings and the community at large. I have systematized this way of using the concept of role, and the resulting theory has a number of advantages that allow it to be considered as a rational foundation not only for psychodrama but for the entire field of applied psychology and sociology.

ROLE DYNAMICS IS A TERM I have applied to my systemization of Dr. J. L. Moreno's approach to role theory. I believe it can serve as an integrative and comprehensive theory of psychology, a rational foundation not only for psychodrama but also for an eclectic approach to psychotherapy in general.

Moreno is best known for his creation of the method of psychodrama. Its major derivative, the technique of role playing, has come to be applied in education and business as well as in the field of mental health. Among those familiar with his work, Moreno is also recognized as a pioneer in the fields of group psychotherapy, applied sociology (related to his method of sociometry), and improvisational theory. Yet his theoretical contributions have been relatively unappreciated, perhaps because he failed to systematize them.

Moreno (1961) was also a pioneer in the field of role theory, being among the earliest writers on the subject. Others who developed this uniquely American contribution to social psychology in the 1930s and 1940s include George Herbert Mead (1934), Ralph Linton (1936), and Leonard Cottrell (1942). Later on, major leaders in the fields of social work (Perlman, 1968) and psychiatry (Ackerman, 1958; Spiegel, 1971) used role theory as a way of understanding the interactional nature of human experience.

Still, Moreno's emphasis deserves to be noted as differing in essence from the others. Role theory is generally presented as a way of describing human interactions, and this effort is more for an academic goal than for an applied one. Moreno's idea is that the concept of role is above all practical, aimed at helping people reflect on and change their own beliefs about themselves. Role dynamics, my systemization of this approach, is a clinically relevant theory and, because of the difference in emphasis, merits a name that differentiates it from the kinds of role theory described in most sociological texts (Biddle & Thomas, 1966; Biddle, 1979).

What Is Role Dynamics?

Simply stated, role dynamics is a language for psychology. It describes psychosocial phenomena in terms of the various roles and role components being played, how they are defined, and, most important, how they can be redefined, renegotiated, revised, and actively manipulated as a part of interpersonal interactions. The concept of role offers a general unit of interaction involving a complex of behavior, expectation, and overt or covert consensual agreement.

Role dynamics uses a dramaturgical model of human experience. People's interactions are seen as involving both expressed and unexpressed elements, and these unfold in a dialectical process that cannot easily be classified in terms of fixed personality types. People play a variety of roles; these often conflict, both intrapsychically and interpersonally. This theory has a number of advantages, some of which will be presented in order to demonstrate the viability of role dynamics as a candidate for an integrative theory of psychology.

Advantages of Role Dynamics

First, role dynamics is comprehensive, in that it is unique in its ability to address phenomena that occur at the many different levels of human organization: psychobiological; intrapsychic; interpersonal; family and other small group phenomena; organizational and large group phenomena; and the interactions that occur between the individual, group, and society or culture as a whole. The concept of role is applicable when used by an ethologist (who studies comparative animal behavior), an anthropologist, a sociologist, a developmental psychologist, or a clinical psychotherapist.

This flexibility of the concept of role is both a strength and a weakness. As a clinical tool, it is most valuable; as a research tool, however, the elusiveness of definition associated with this term makes it more dif-

ficult to work with. Nevertheless, this difficulty does not mean that role dynamics cannot be subjected to scientific analysis but only that more precise definitions will have to be constructed for the limited scope of whaever is being studied. Some dimensions of the role process are likely to transcend these more limited definitions.

For most clinical settings, the concept of role offers a second major advantage: it is relatively more understandable than most other psychological systems of terminology. People know about roles because they are exposed to the dramaturgical model by watching television, movies, and other derivatives of the theater. The idea of acting and taking on roles is familiar, even to children. In practice, inviting patients to take stock of their lives in terms of the various roles they play offers a very plausible structure to the early phases of the psychotherapeutic process.

A related advantage of the language of role dynamics is that the terminology is relatively neutral in the sense of not suggesting pathology. Many other psychological systems use words that imply that there is something wrong, weak, and in other ways negative, such as neurosis, fixations, and conditioning, for example. Role dynamics can allow people to describe their situations in terms of "imbalance," "need more development," "requiring a redefinition," and the like. The potential for reframing feelings and behaviors with an emphasis on strength and health is greater. This makes psychology more palatable to nonpsychiatric physicians, school personnel, and others who prefer less jargon-laden language for thinking about psychosocial phenomena. For this reason, role dynamics may be one of the first user-friendly languages. (Transactional Analysis, in its early phases, was an effort in this direction, but it soon became quite complex and convoluted and lacked some of the subtleties of the intrapsychic, biopsychological, and sociocultural dimensions of life.)

The concept of role and its associated dramaturgical model constitute a powerfully evocative metaphor. The function of a metaphor is to facilitate a deeper comprehension of an idea by comparing it to another familiar object or process. In this sense, life is compared to a dramatic performance. (There are many other metaphors for life, such as progress, coming to terms with limitation, or struggle). An effective metaphor suggests a complex of associations, the richness of which leads to its relative effectiveness. The idea of thinking about the various dimensions of psychosocial functioning in terms of the many roles involved and how they are defined and played suggests a number of related notions.

A pluralistic model (as differentiated from a reductionistic model) of human experience encourages a wider range of involvements. In the realm of drama, many roles may be played, not only basic social and or-

ganizational roles but also character roles, combinations of roles, and roles that are played in different ways. Beginners are different from those who are more experienced; performances can illustrate wisdom or foolishness; roles are inherited, earned, stripped away, and relinquished. Instead of attempting to interpret human behavior in terms of a few basic drives or mental mechanisms, role dynamics celebrates the possibility of thousands of different motivations and ways that people interact. In this sense, it represents a more humanistic approach to psychology that recognizes that the human psyche is far more complex and subtle than the nervous systems of laboratory animals.

A practical corollary of the pluralistic orientation of role dynamics is that it encourages people to think of themselves as containing many parts. Attempts to find a real self that is in some ways definable and unified may lead to an artificial constriction of a truly flexible and vigorously open-ended sense of self. Instead, role dynamics encourages what I have jokingly called the multiple personality order (instead of disorder). That is, patients are invited to respect their many different roles as vital facets of their being, with the added implication that they can coordinate the expression of these various parts of themselves in a healthy manner.

Role Distance

The fourth advantage of role dynamics, and its most valuable and central concept, is that there can be a role in the personality that is in charge of how the other roles are played. In drama, too, actors not only perform their parts but also rehearse those parts, refine those parts, and discuss with the director and playwright how those parts should be played. Indeed, in drama, the roles of playwright, director, producer, audience, and agent also indicate a parallel drama. The actor as person is involved in a creative process that interpenetrates but is yet different from the part written in the script (Blatner, 1989).

In this dimension, the actor plays the part but is not totally identified with the part. In most of the role theory literature, people seem to be described as being immersed in their roles, playing them without being aware of their capacity to break out of role at any time. Moreno's special contribution, and the emphasis of role dynamics, is the introduction of the idea that people can use just that capacity to liberate themselves from many of their psychosocially imposed predicaments. (This is, in one sense, the aim of the existentialist philosophers, and the theme of reduction of attachment to one's roles is also an essential theme in Buddhism and transpersonal psychotherapy.)

People not only perform roles but also often reflect on those roles—how they are being defined, performed, and received. That differentiation in which actors separate from the role they play is called role distance. The idea of role distance acknowledges the capacity of people to dis-identify partially with the limited definitions of the role they may be playing, and to identify simultaneously with the meta-roles of the director, playwright, or other personages beyond the drama. People are reminded to recognize that they are not identical to the parts they play and that their existence is complex, transcending any and all of the obvious roles they play. (This is also one of the goals of Roberto Assagioli's method of psychosynthesis.)

Role dynamics encourages the use of role distance as a conceptual vehicle for reflecting on, reevaluating, redefining, and renegotiating the various roles they play in life. This is also one of the purposes of insight-oriented psychotherapy. Moreno's method of sociometry also reflected this emphasis on making our role definitions explicit and, through sharing this knowledge, on the group's collective creation of new expectations, rules, and procedures.

Thus, the metaphor of role suggests not simply that we are immersed in our parts, performing them mindlessly as if we were reading some inner scripts. Rather, it suggests that we can become spontaneous, improvisational actors, creating our parts without scripts. We thus become not only actors but also playwrights. We can go further and question which roles we may want to take on, as if we were negotiating with an inner agent.

Fostering role distance develops what in psychoanalysis is termed the observing ego. This hypothetical structure is concretized as an image if therapists (using methods associated with role dynamics) suggest to patients that they allow a part of themselves to sit back and observe the process of the interaction with the therapist even as they participate in discussing the issues at hand. In short, it is possible to encourage the patient to join the therapist in what Harry Stack Sullivan called the participant-observer stance. There is also a concomitant suggestion that the patient begin to develop a capacity for diversified viewpoints, an ability to think on several levels simultaneously, or at least in rapid succession.

In fact, this ability is part of the intrinsic ability for play and is reflected in the natural imaginative play of childhood (Blatner & Blatner, 1988). Thinking on several levels simultaneously is the basis for imagination and creativity (Rothenberg, 1988). Role dynamics recognizes this multileveled process of cognition and encourages its use as a resource for insight and adaptation. George Kelly's role construct therapy has a number of similarities to the approach noted here, but role dynamics suggests

a more fundamental participation in the creative process that reinforces patients' awareness of themselves as creators (Bonney & Scott, 1983).

The fifth advantage to role dynamics is that the metaphor of role implies also an associated praxis, a method for utilizing this valuable set of ideas. Role playing, consciously shifting positions, replaying interactions, using dramatic techniques to bring out more self-disclosure—these and other techniques have application in a wide variety of settings. Again, ordinary people are familiar with these devices, for they see them on television. Voice-over is the equivalent of the aside or the double techniques; replay is used not only in sports but also to rehearse a given behavior. The power of watching oneself on video playback is the technical equivalent of the mirror technique.

Role Dynamics as a Vehicle for Integration in Psychotherapy

Role dynamics is a general theory that, in acknowledging the multifaceted nature of human existence, allows for a corresponding variety of psychosocial insights. There are aspects of life, developmental periods, and types of conditions that are addressed well by specific concepts elucidated by Sigmund Freud, Otto Rank, Wilhelm Reich, Eric Berne, or any of hundreds of other innovators in the field. The spiritual or existential crises of late maturity are often most effectively addressed through the conceptual lens of Jung's analytical psychology. The practical problems of child rearing are in many cases adequately dealt with by using the ideas of Alfred Adler and Rudolf Dreikurs. In some situations, Heinz Kohut's theories on self-psychology are useful, whereas in other situations, family systems theory can be more relevant.

Role dynamics allows for the best insights of the many theories of psychology to be integrated. It is not necessary to choose one theory and adhere to it exclusively. Role dynamics offers a rational foundation for a multimodal approach. Although eclecticism is often viewed by academicians as necessarily superficial, this is only because no integrative theory that can function as an intellectually rigorous basis for a broader approach to diagnosis and treatment has been widely accepted. Eclecticism is, in fact, the dominant mode of psychotherapy today, and an overarching theory is sorely needed to help this trend become more responsible.

Moreover, many of the insights of the various theories can be demystified through being translated into the terminology of role dynamics. For example, "object relations" and its associated psychoanalytic concepts can be expressed also as the inner dramas in which an individual imagines all the parts and sometimes confuses the roles played in imagination with the reality of the outside world. In supervising and teaching psychiatric

residents, I encourage their learning to express the various defense mechanisms in more concrete, dramatic terms, as if a person could express the magical belief associated with the ideation. For instance, the mechanism of "reaction formation" would be expressed in a particular case as the person thinking, "I'm not angry. I'm the most caring and concerned person imaginable."

One of the further advantages of role dynamics is that it includes a number of dimensions of life that tend to be neglected by other theories, such as play, spirituality, and cultural influences. Human beings have an innate capacity not only for reason and emotion but also for imagination, intuition, spontaneity, aesthetic elaboration, excitement, action, enthusiasm, and wonder. These can be used as powerful resources for courage, joy, problem solving, communications, and self-awareness.

The inclusion of these dimensions in life leads to a tendency to review strengths and talents in the early stages of diagnosis, which leads to a more positive light on the patient. In turn, being viewed as, at least in part, rather healthy and enjoyable leads to a more active and participatory treatment alliance. Further, the methodology of role playing is somewhat novel and intrinsically interesting because it draws on the wealth of imagery for elaborating the situation. The vividness and creativity implicit in the dramatic context offers a vehicle for self-expression and draws on that innate urge as a motivator for self-discovery.

Summary

The theory that Moreno used to explain the dynamics of psychodrama can be the basis for a more general theory of psychotherapy. When systematized, these ideas offer a number of advantages over other contemporary theories. Because it had not been systematized until now, psychodramatists often attempted to explain their method in terms of other theories, but a number of dimensions were never fully accounted for, such as the power of using the concept of surplus reality. Role dynamics is a systematized language that can be affirmed and presented as an integrative theory that allows for the use of many of the best insights of the other dominant theories while, at the same time, adding a number of important concepts not otherwise in the theoretical repertoire.

We need a way to integrate psychology into the general culture, into the schools and churches and businesses of our society. I believe role dynamics is an understandable and practical language of psychology, and, as such, it is an important tool for advancing the processes of working out conflicts, fostering the inclusion of greater numbers of people, and promoting harmony. This is what Moreno (in 1934) meant by therapeutic

when he said in the opening words of his magnum opus, *Who Shall Survive?*: "A truly therapeutic procedure cannot have less an objective than the whole of mankind."

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Brief Report: Why and When to Use "Hit and Run" Doubling

ELAINE ADES SACHNOFF

This article is based on my 20 years' experience in directing psychodramas with patients who were hospitalized with a wide variety of diagnoses, including those classed as dual diagnosis adolescents and paranoid schizophrenic adults.

In most of the hospitals, the ratio of floor staff to patients was low; thus, it was a rare occasion when a specific person was regularly assigned to the weekly psychodrama group. I therefore developed the following adaptation of the classic technique of doubling as described by J. L. Moreno (1959).

The double is presented to the protagonist with a statement by the director along the lines of "I'm going to give you a double who will function as a part of you and help you to express thoughts and feelings you have been unable to express. If she or he is wrong, you must correct her or him." The director may also add, "If what the double says is correct, try saying it yourself to see how it feels." This is especially useful if the director has any doubts concerning the protagonist's ability to stay in contact during the session.

The double takes the protagonist's body positions and imitates his or her movements, facial expressions, and breathing so that the two individuals become internally aligned. The double stands or sits when the protagonist does, in a location where she or he is able to see the protagonist's slightest change of expression or the smallest gesture. The position, however, should not be upstage, for that may cause the protagonist to turn away from the audience.

Speaking to the protagonist in the first person, the double may ask questions, interpret actions, make statements, or present a challenge. The double follows the lead of the director but can make feeling statements to guide the director should the director miss a cue. For example, the double may say, "I've already said how I feel about that. It hurts me that you don't hear me any better than my family does."

As Kipper (1986) stated,

> In terms of clinical responsibility, the auxiliary who assumes the role of the double has two functions to perform. The first is to serve as *an extension of the protagonist* with a duty to assist the therapist in understanding the protagonist. The double must continuously provide the therapist with clues and explanations regarding the protagonist's feelings and thoughts, and ascertain that the therapist is getting these messages. The second function is to serve as an *extension of the therapist*, that is, to act as an intermediary agent through which the therapist can implement desirable changes in the protagonist's behavior. The double therefore has a dual function: to be a co-protagonist as well as a co-therapist. (p. 155)

In contrast, when using "hit and run" doubling, the director encourages any member of the group who has an idea of what the protagonist (or in some cases, any character in the drama) may be feeling or thinking and not saying, stand behind the protagonist, perhaps with hands on his or her shoulders, and speak aloud in the first person. As in classic doubling, the protagonist can confirm or negate the statements.

In truly open "hit and run" doubling, any character in the scene may be doubled for, thus diminishing the problem of "inadequate auxiliaries." An inadequate auxiliary is often chosen because she or he is a sociometric star rather than the person with the ability to play a role.

This procedure is especially useful for inpatient groups of adults with multiple diagnoses, such as bipolar disorder, schizophrenia, major depressive episodes with psychotic features, and borderline disorders. It also is helpful with all inpatient dual diagnosis adolescents.

The "hit and run" doubling technique cuts down on anxiety for those patients who are too fragile or are unable to take on the role of another for any period of time, a situation that leads to inadequate auxiliaries. These persons also often find it difficult to sit in close proximity to another person for the length of a scene. The patients, especially hyperactive or manic adults, somnolent addicts, and easily bored and distracted adolescents, stay involved in the group activity. Patients who are unable to express anger for themselves begin expressing it as a double for another patient. Classic scenes of forgiveness by dead relatives and friends can be enacted so that several patients both give and receive forgiveness while they act as doubles for both roles. The technique allows the injection of reality by the staff or other patients who know the truth. An example is the following scene in which Joe, 15, is doing the rules for discharge with a person playing his mother. That double acquieses to everything very sweetly, as per Joe's prior role reversal, and says, "Of course, honey, I know you don't need a lot of sleep to work that job. Any time you want to come in on a school night is fine with me." Bonnie, a registered nurse who is his primary therapist, gets up to double for his mother with the real facts. "Are

you kidding? If you come in one minute after 10:00 p.m., it's out on the street for you, shithead."

As Joe's primary therapist, she had worked closely with him and his mother and knew exactly how they spoke to each other. Her participation in the scene as a "hit and run" double provided a necessary jolt of reality that, incidentally, punctured his "macho" reputation, which this scene was intended to enhance.

Therapists need to be alert to the contraindicators for using this procedure. They should avoid its use with extremely fragile or paranoid protagonists. Because the director cannot censor the input from other patients, this type of doubling may be too confrontational. The protagonist may not be able to screen out those things that the other doubles say that may be directed to their own parents or voices. The therapist must be aware of the level of looseness of thought in the group. If the protagonist does not say aloud, "No, I don't feel that way," or "No, my mother is not like that," or "Yes, that is exactly what he'd say," the director must constantly check to see if the statements are valid and must get verbal confirmation, or at least a nod, before continuing the doubling. The director may call the scene to a halt if the doubling provides too much stimulation for the protagonist. The therapist may also discontinue the doubling if the protagonist is unable to process the amount of information being presented or if those waiting to act as doubles appear ready to say something nasty to the protagonist. Prior information from the unit's staff will enable the therapist to keep this to a minimum. Therapists who are mindful of these precautions will find "hit and run" doubling, an adaptation of the classic doubling technique of Moreno, useful with special patient populations.

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Research Report: Intrapersonal Communication and the Placebo Effect

ALTON BARBOUR

Pain is a mystery. Contrary to what we might expect, the severity of a wound often has little to do with how much pain a person feels. And even more amazingly, perhaps the most widespread pain reliever is a sugar pill or its equivalent. Studies show that the sugar pill or placebo is half as effective as aspirin, the most popular over-the-counter pain killer.

Dr. Roswitha Smale's recent research into how and why placebos work has produced some unexpected results that reinforce the connectedness of communication and health and have some implications for commonly used psychodramatic techniques. Her initial reasoning was that, because nothing in the pill created the placebo effect, something that was communicated to the patient along with the placebo must have had the effect and that the pill was incidental. Communication, not the placebo, had the medicinal effect, she theorized.

Research linking communication to physiological changes is scarce, so this line of reasoning seemed especially promising because it would explore the mind-body relationship. The specific approach that appeared most suitable was grounded theory, as developed by Glaser and Strauss (1967). Grounded theory is based on several tenets that differentiate it from more traditional deductive methodologies. It is aimed at theory generation rather than theory verification and is useful when no verifiable theory exists. It approaches problems broadly in order to capture as many essential elements as possible. Grounded theory lends itself to data that are primarily qualitative rather than quantitative. The situation that made this study possible was clinical research in which drugs were being tested and placebos given. The clinical investigator told patients about the clinical study, the treatment schedule, potential side effects, and the possible implications for their condition, which, in this case, was hypertension. Differences in the patients' understanding of what was communicated to them were linked to treatment outcome, namely, the effect or noneffect of the placebo.

that are primarily qualitative rather than quantitative. The situation that made this study possible was clinical research in which drugs were being tested and placebos given. The clinical investigator told patients about the clinical study, the treatment schedule, potential side effects, and the possible implications for their condition, which, in this case, was hypertension. Differences in the patients' understanding of what was communicated to them were linked to treatment outcome, namely, the effect or noneffect of the placebo.

Participants were recruited from five studies of different hypertension drugs conducted at three different medical settings. Clinical trials of various dosages resulting in lowered blood pressure readings were monitored. The patients were unaware that placebos were being administered.

The investigator compared placebo responders and nonresponders to determine whether different meanings had been communicated to them during the same event, the clinical instruction. To elicit the patients' understanding and interpretation of the clinical research, the investigator collected data through audio-taped interviews. Patients were unaware that a second study on what might have been communicated to them was also being conducted. This method of eliciting subjective information was developed by Norman Kagan (1984).

What emerged was quite different from what was being looked for. It did not seem to matter significantly what was said to the patient or how it was said when the placebo worked or did not work. What mattered, what distinguished between the two groups of placebo responders and nonresponders, was inner speech, or how the *patients* talked to *themselves* about whether the "medicine" they were given was going to work or not work. The inner speech, the thoughts, the mentation of responders is quite different from that of nonresponders. It is characterized by (1) the use of active voice, (2) internal locus of control, (3) initiating action, and (4) information seeking. Nonresponders were much more passive and ambivalent than responders.

These results may be interesting to psychodramatists or mental health workers who work in medical settings or whose patients, as a part of their treatment, are also receiving dosages of drugs. The investigation makes clear that what a patient thinks about what is going on may be more important than what is actually going on and that how a patient processes the information he or she has may affect treatment outcomes. Psychodramatists typically use the soliloquy, the walk-and-talk warm up, self-presentations, parts-of-psyche dialogues, and varieties of doubling to help protagonists articulate their thoughts. Dr. Smale's results suggest that these psychodramatic verbalizations can be monitored for such responder/nonresponder indicators as active voice, locus of con-

trol, initiation, and information seeking, and that possibly interventions might take place that also focus on those indicators. It is axiomatic that there are parallels between the fields of physical health and mental health and that the immune system of patients may be as important as the symptoms or the disease. This study is in the field of physical health, but it shows how it is possible to have an insight into patients' immune systems and that by paying attention to how they talk to themselves, we can anticipate whether patients are likely to respond or not to respond to psychotherapy. Dr. Smale can be reached at 1299 S. Gilpin Street, #7W, Denver, CO 80218.

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Book Review

Antony Williams's *The Passionate Technique: Strategic Psychodrama With Individuals, Families, and Groups* (Tavistock/Routledge, 1989) is such a clear, well-written book that you find yourself accepting the author's way of thinking although you cannot quite figure out how you have been converted. In this unique psychodrama textbook, Williams expands psychodrama's potential by combining it with a systems approach to psychotherapy. In fusing these two points of view, Williams has been forced to tease out and clarify aspects of psychodrama and psychotherapy that are not apparent when they are described in isolation.

Williams calls his adaptation of psychodrama "strategic," meaning that the sessions are aimed at highly specific goals rather than at serving as a vehicle for emotional inspiration or general personality exploration. Primarily a family therapist, he is attracted to psychodrama as the closest approximation for reproducing a pathological system in the absence of the significant others. His purpose is always to unmask rigid, dysfunctional interpersonal systems, and psychodrama is his vehicle of choice both for exposing an existing system and for experimenting with new ones. He uses role reversal, for example, to enable protagonists to see parts of a system that are inside of others and therefore not normally visible. I was delighted to see that he includes as "rigid systems" not only old family patterns but also rigid models that protagonists have set up for themselves in previous dramas.

One interesting systems/psychodrama hybrid technique that Williams uses to good effect is his "circular" interview in role. In warming up a protagonist, he confronts him with a series of questions to facilitate his shift of identity and to bring out important aspects of the interpersonal system. He might ask, for example, "How would your mother feel if you actually passed the exam? how would your father react to your mother's pride in you? how will you react to your father's jealous anger about your mother's pride in you?" Within the dramas, everything the protagonist does is followed up by an exploration into what the others do, think, and feel in response, in order to establish the circular causal system.

Williams assumes that protagonists have such very strong reasons for clinging to patently maladaptive behavior that they will change only if and when the interpersonal reasons for the behavior are exposed and obviated. Unless there is real understanding of the systemic strains that produce the

"symptom" and a better solution is offered, the new behavior cannot be experienced as superior to the old.

In the Morenean tradition, Williams essentially equates "spontaneity/creativity" with mental health as a whole. (We must recall how many of history's most spontaneous and creative geniuses have been tragically neurotic.) Nevertheless, he is careful to interpret these terms so as not to foster general disinhibition or a simple return to the pleasure principle. In fact, he warns against the danger that the artificial world of psychodrama, with its spontaneity and creativity, can come to substitute for the real one. He describes psychodramatists who become part of the problem by pandering to interminable patients who wait from session to session for their "fix" as protagonists.

For each session, Williams sets simple goals drawn from the group's central concern and compatible with the informal sociometry. Goals are explicitly contracted for with the protagonist at the outset. Early sessions are allowed to proceed in a wish-fulfilling direction (e.g., abused protagonist seeks psychological justice in his inner world by castigating "bad" parent). Each such situation, however, is given a "double description," in the sense that any interpersonal event is seen from the point of view of the other people involved. Furthermore, these points of view are constantly interactive. To understand the system fully, one must see the interactions from the points of view of all parties concerned. Psychodrama, with its techniques of interviewing in role, enactment, role reversal, doubling, and so on, can bring interpersonal causal sequences into direct observation.

The need to stabilize gains is strongly emphasized, not only because we all tend to revert to habitual patterns even when more gratifying ones have been discovered but also because the other members of our social atom have a stake in maintaining the status quo.

Williams applies his principles from family therapy to therapy groups and, by further extension, to the transference/countertransference system. He then attempts to expand the same principles to include the intrapsychic system of the individual, but here he is less persuasive. An interpersonal system of real individuals relating to each other is one thing. The intrapersonal system of the self and parts of the self relating to intrapsychic representations of others is quite another.

On balance, the book is really excellent. It is hard to imagine a psychodramatist's work remaining the same after reading it. The classical Morenean, the analytic psychodramatist, and the "role-play" behaviorist cannot fail to see that attention to interpersonal systems offers a fresh and a major application of our unique craft.

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Information for Authors

The *Journal of Group Psychotherapy, Psychodrama and Sociometry* publishes manuscripts that deal with the application of group psychotherapy, psychodrama, sociometry, role playing, life skills training, and other action methods to the fields of psychotherapy, counseling, and education. Preference will be given to articles dealing with experimental research and empirical studies. The journal will continue to publish reviews of the literature, case reports, and action techniques. Theoretical articles will be published if they have practical application. Theme issues will be published from time to time.

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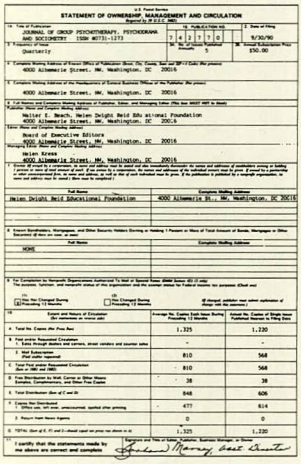

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