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Contents

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Using Roleplaying to Teach the Psychiatric Interview

TIMOTHY K. WOLFF
DEBORAH A. MILLER

ABSTRACT. In this article, we describe a technique in which the instructor uses roleplaying with some psychodrama techniques to help third-year medical students learn the psychiatric interview. The instructor is the director and initially plays the part of a psychiatric patient, and the students perform several roles including those of the interviewers and, eventually, the patient. A survey, distributed to 46 medical students, was returned by 31 students. Through the use of a semantic differential and evaluation of other data from the survey, we concluded that the technique is a helpful and dynamic way for medical students to learn the psychiatric interview.

AN EFFECTIVE INTERVIEW OF A PATIENT provides the clinician with important information and establishes a rapport with the patient. Others have emphasized the importance of teaching medical students how to interview patients (Naji, Maguire, Fairbairn, Goldberg, & Faragher, 1986; Sanson-Fisher & Maguire, 1980). In this article, we will review some of the techniques described in the literature, discuss our use of roleplaying with some psychodramatic modifications to teach the psychiatric interview, and comment on the findings of the survey we used to secure feedback from the medical students.

A number of different techniques have been used by educators to help students gain experience in the psychiatric interview. In one technique, the interview is analogous to the physical exam (Arnold, Calestro, Bates, & Wassermon, 1983). Another technique employs a teaching package that uses hands-on experiences, peer feedback, and group discussion led by a senior psychiatrist (Lovett, Cox, & Abou-Saleh, 1990). Other authors have examined the effectiveness of direct observation by a clinical instructor of the student interviewing a real patient (Links, Colton, &

Norman, 1984) and the value of practice interviews, audiotape replays, and, especially, videotaping as sources of important feedback (Maguire, Roe, Goldberg, Jones, Hyde, & O'Dowd, 1978). Actors have been used as simulated patients and members of the teaching team to help students increase their ability to communicate and understand the patients' perceptions (Whitehouse, Morris, & Marks, 1984). Some students have played the role of emotionally disturbed individuals while other students conducted the interview (Scheffler, 1977).

Having a faculty member simulate a psychiatric patient with another faculty member offering prompting and feedback during the interview has also been used effectively (Goble & Stewart, 1987). Although these different approaches have some similarities, they did not allow for role changes by the participants or use of some specific psychodrama techniques.

Psychodrama, pioneered by J. L. Moreno, MD, in 1921 as a therapeutic modality, is a therapy that integrates verbal and action techniques into a process that produces insight and learning (Heisey, 1982). In psychodrama, the protagonist is the member of the group who works on a problem; the director is the person who is responsible for directing the protagonist through the scenes or events; and the auxiliary egos or doubles are played by other people in the group. The psychodramatic enactment helps the protagonist explore his problem (Blatner, 1973).

On our in-patient unit, third-year medical students (usually 3) doing their clinical psychiatry rotation meet with the ward's attending physician once a week, in addition to having ward supervision and course didactics. During the first or second meeting, the roleplaying technique is used to teach the patient interview. Some of the techniques of psychodrama are used in the roleplaying. After the introduction, the director (the ward's physician) sets the roles and acts as the patient. One student is the patient's double and reports the patient's potential feelings or thoughts freely at any time. Another student is the interviewer, and the last student is the interviewer's double, reporting the interviewer's potential feelings or thoughts freely at any time. The task for the interviewer is to do an initial interview on this newly admitted patient.

Typically, the role of the patient is played as a narcissitic, suicidal, and depressed man who is exploring boundaries, as well as being provocative but vague about his suicidal tendencies. Such a patient role provides plenty of work for the doubles and causes some frustration for the interviewer. At times, the medical director may have to get out of his or her role as a patient to act as the psychodrama director and either prompt or positively reinforce a comment from one of the doubles or the interviewer. In the role of the patient, the doctor has the unique opportunity of being able to experience the interviewer's effectiveness and counter-

transference directly. This aids with subjective feedback. For example, the doctor-as-patient may note that a certain part of the interview felt more like a legal interrogation than a humanistic interview.

After 10 minutes have elapsed, the students change roles. The roles are changed at intervals so that each one of the students has an opportunity to play the patient, and the ward physician may play one of the doubles or become the interviewer.

Following is a sample of the interactions during the roleplaying exercise after approximately 30 minutes have elapsed. In this exercise, the ward physician is the double of the patient, and the patient's role is that of a depressed man.

Interviewer (I): What was it that you were doing yesterday?

Patient Double (PD): This is terrible. . . . I don't know if I want to go into this. It's horrifying to go over it.

Patient (P): I just don't know how to tell you.

I: Well, start out by telling me what happened in the beginning. . . . What happened yesterday?

P: I was going to kill myself.

Interviewer Double (ID): Maybe I should start him out from the very beginning and go step-by-step.

I: What brought you to want to kill yourself? What brought you to that?

P: I have been telling you it's everything . . . in no part of my life have I ever been good to anyone.

ID: Maybe I should start out and ask him how things started in the morning and how things went through the day. (Authors' note: This actually is coaching—not doubling—and less desirable for the exercise.)

I: Why don't you start from the beginning when you woke up and try to go through the day? Maybe that would be easier for you.

PD: I am feeling irritable. This is difficult. He is really pressing me.

P: I just wanted to kill myself, O.K., . . . I just wanted to kill myself.

I: Did you have a plan in mind? Was the plan already laid down?

P: Yes, yes.

I: Could you share with me what that plan was?

PD: How could I talk to him about putting a revolver in my mouth and blowing my brains out and still not have him commit me?

P: Are you going to put me in the hospital?

ID: I can see he is very concerned about being committed. How can I reassure him that my main concern is his safety?

I: If . . . I am here to help you and if I think that you are a danger to yourself or to others, then we are going to have to take the appropriate steps. This is why I am asking you some of these tough questions to find out if you are a danger to yourself or others.

ID: Maybe I can reassure him that . . . being hospitalized might be in his best interest at this time. He seems to have some concern about the stigma of being hospitalized in a psychiatric institution. . . . I must explain that this is in his best interest right now.

I: We may find that you need hospitalization. If we find that that is the most appropriate therapy for you, then we will be able to help you so that you will feel that you won't have this need to hurt yourself. That is what we are trying to avoid. So if we do hospitalize you to make you better, you'll be able to leave and be productive again.

P: I really, yesterday I really, I had a loaded gun and sat there, and looked at it.

I: What were you thinking when you were just sitting there?

P: That I wanted to die, that the pain was too great and I couldn't go along any longer like this, that I would be better off with the pain gone.

PD: I am damned forever, and I don't think he understands this.

P: Right now, I don't feel that there is anything that you or any hospital or anyone can do to make me feel better.

PD: Why did my sister make me come here?

I: How do you know that, if you won't give us a try? What makes you think that?

P: I would already be gone if I hadn't been forced to be here—do you understand that? I don't think that anyone can help. . . . I am so down.

ID: We need to find out exactly what happened and why the attempt did not succeed. Did he change his mind at the last moment? And was there some reason he decided not to do it?

I: Let's get back on track. You said you were sitting there with the gun, thinking; what happened after that?

P: I just didn't want to go to hell.

PD: I can't believe I just said that, I don't know what is going to happen now.

I: Is that the only thing that prevented you from killing yourself?

P: This may sound bizarre, but remember I was telling you that I was Catholic. Well, when I was a kid, I got real scared. Any time that I did anything that was wrong, they said I might go to hell. Suicide was the biggest, only sin . . . just go to hell.

PD: I am feeling bad right now.

P: I am really feeling bad, I am feeling worse than . . . I did when I came here.

PD: It is not his fault . . . I am so down I don't know what's going on.

P: Why are you wasting your time with me?

I: We are not wasting time. It's hard to confront some of those feelings you have.

P: I'm just worthless. I have never done anything good at any time.

ID: Maybe I need just to prove to him or tell him what things have worked in his life—the good things in this life like other accomplishments.

The female medical student proved able at roleplaying the somewhat delusionary, guilty, depressed male patient. The interviewer and his dou-

ble have to deal with an almost irrational, helpless, and frightened patient and grapple with getting the information and being empathic. The intensity of this particular dialogue was punctuated with a sigh by the participants at the conclusion.

Near the end of the meeting, we stopped the interview and discussed the exercise. Issues that were frequently considered included how to deal with personal questions from the patient, negative emotions provoked by the patient, and the patient's suicidal ideas. In addition, we discussed strategies for handling difficult times in the interview. The feedback to the students doing the sample dialogue included some discussion about their tendency to deviate from standard initial information-gathering questions to a quasi-therapy-oriented interaction. Because the students frequently devalue and denigrate the interviewer during the exercise, the faculty members pointed out that the students tended to be hypercritical of themselves and each other, whereas most acutely ill psychiatric patients do not focus on the shortcomings of the interviewer.

Method

A survey was designed and distributed to the 46 students who had taken part in the roleplaying exercise. The survey was distributed after the students had completed their psychiatry clerkship, and they responded anonymously. The initial part of the survey consisted of seven agree/disagree type statements that focused on how this experience helped the students become more aware of the patient's feelings, as well as their own; on the extent of their previous experiences with roleplaying techniques; and on whether this technique could be used on other rotations. Students were then asked to rank each role according to its level of difficulty. Adequate space was given for the students' comments about how they felt while performing the different roles and about whether this experience had had an effect on how they interact with patients.

We then used a variation of a technique known as the semantic differential (Snider, 1969). This technique is based on the idea that the process of judgment can be conceived as the placing of a concept on a continuum that is defined by a pair of polar terms. Eleven pairs of adjectives, which seemed most useful for study, were selected from a list of items that have been used in other studies for measuring the meaning of a concept. Students were asked to rate each role on the continuum of adjective pairs (e.g., calm/agitated, relaxed/tense, healthy/sick). Most of the pairs chosen were adjectives that could be clearly attributable to the student's level of comfort with the role or to how the student imagined the role character may have felt or thought. The most obscure pair was the wide/

narrow continuum. This was used to see if the students would differentiate the range in the scope of focus between roles. Rather than using a factor analysis to determine those pairs of adjectives that rate similar characteristics, we decided to use an analysis of variance (repeated measures). This method was used to establish whether there were any differences among the roles that each student depicted.

Results

A total of 31 (67%) of the surveys were returned. Twenty-two (71%) of the respondents felt that the experience made them more aware of patient feelings, and 28 (90%) indicated that it made them more aware of their own feelings. Only 3 of the students had participated in an experience similar to this prior to or during medical school. Twenty-six (84%) felt that the experience could be used on other medical school rotations. Twenty-nine (94%) felt that they used the skills learned during their psychiatry rotation, and 23 (74%) decided they would use these skills on other rotations.

Eighteen (58%) of the students felt that the interviewer role was the most difficult to portray, and 8 (25%) classified this role as the easiest one. The students were divided on the difficulty of both doubling roles. They rated the patient double role as follows: Four (13%) felt it was the most difficult, 10 (32%) difficult, 9 (29%) easy, and 8 (25%) easiest.

The interviewer double role was ranked in the following manner: Nine (29%) most difficult, 7 (23%) difficult, 12 (39%) easy, and 3 (10%) easiest. This distinction is further identified by the fact that 17 (55%) felt comfortable playing the interviewer double role, and 19 (61%) felt comfortable in the patient double role.

Many students commented that the exercise was a positive one. One student felt that the "experience was an excellent method for teaching how to interview" and described it as "an informal and uniquely informative introduction to interviewing techniques." Many felt somewhat awkward because the exercise was done at the beginning of the rotation and suggested that it would be useful to repeat the exercise at the end of the rotation. Some students expressed concern that having the attending physician participating and the other participating students observing them made for an anxiety-provoking situation.

Mean ratings for each adjective set based on the different roles were calculated and plotted (see Figure 1). A repeated measures analysis of variance was calculated to determine on which sets of adjective pairs a significant difference could be found among the four different roles ($p < .05$). Differences were discovered on the following five adjective pairs: strong/

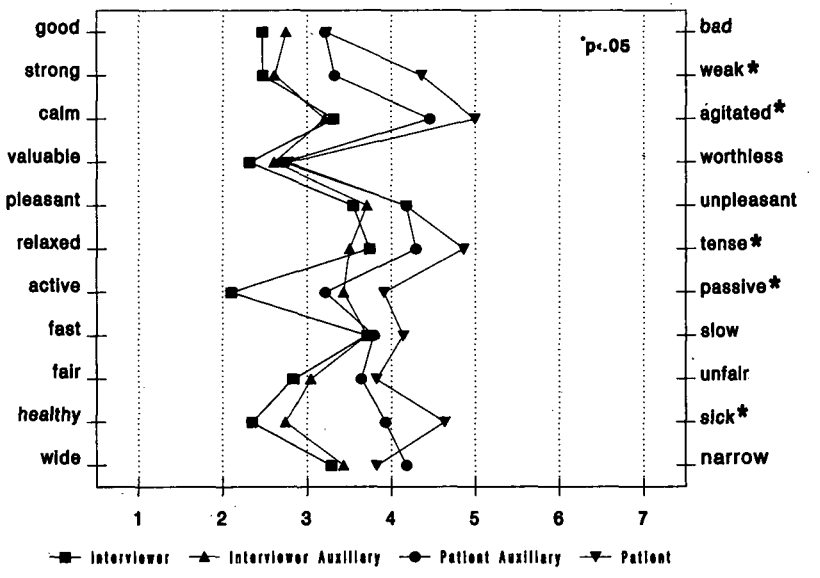

FIGURE 1—Comparison of Four Interview Roles, The University of Texas Southwestern Medical Center, Dallas

weak, calm/agitated, relaxed/tense, active/passive, and healthy/ sick. No significant differences were found on the pairs good/bad, valuable/worthless, pleasant/unpleasant, fast/slow, fair/unfair, or wide/narrow.

Discussion

Several problems are inherent in a survey of this type. One problem is the fact that 15 (33%) of the students surveyed did not respond. It is very possible that those who chose not to respond tended to think less favorably of the exercise. Further, students may not be particularly good at evaluating a technique unless they have a clear alternative learning method, the fact that a control group was not used is another problem. Nevertheless, the results indicate that among those students who answered the survey, the roleplaying technique was deemed helpful. Students were better able to appreciate their own feelings as well as the feelings of the patient. From the survey, we learned that these new skills are being used not only on the psychiatry rotation but also later on the students' other clinical rotations. The results of the semantic differential indicated that the

students were able to discern different emotional states for the varying roles because the difference on five of the adjective pair continua were statistically significant.

Conclusion

Medical educators have a responsibility to examine teaching techniques and explore alternatives to facilitate learning by medical students. The use of roleplaying challenges the student to scrutinize, in a dynamic, unique way, the frustrations of the interviewer and the concerns of the patient. Overcoming their anxieties about the patient interview helps the medical students to be more empathic and more effective in fostering positive doctor-patient relationships.

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REFERENCES

Arnold, L. E., Calestro, K., Bates, W. J., & Wassermon, M. L. (1983). Teaching psychiatric interviewing as a core physician skill. *The Journal of Psychiatric Education, 7,* 102–112.

Blatner, H. A. (1973). *Acting-in: Practical applications of psychodramatic methods.* New York: Springer Publishing.

Goble, L. K., & Stewart, J. T. (1987). The teacher becomes a patient: Teaching interviewing to medical students. *Journal of the Florida Medical Association, 74,* 417–419.

Heisey, M. J. (1982). *Clinical case studies in psychodrama.* Washington, DC: University Press of America.

Links, P. S., Colton, T., & Norman, G. R. (1984). Evaluating a direct observation exercise in a psychiatric clerkship. *Medical Education, 18,* 46–51.

Lovett, L. M., Cox, A., & Abou-Saleh, M. (1990). Teaching psychiatric interview skills to medical students. *Medical Education, 24,* 243–250.

Maguire, P., Roe, P., Goldberg, D., Jones, S., Hyde, C., & O'Dowd, T. (1978). The value of feedback in teaching interviewing skills to medical students. *Psychological Medicine, 8,* 695–704.

Naji, S. A., Maguire, G. P., Fairbairn, S. A., Goldberg, D. P., & Faragher, E. B. (1986). Training clinical teachers in psychiatry to teach interviewing skills to medical students. *Medical Education, 20,* 140–147.

Sanson-Fisher, R., & Maguire, P. (1980). Should skills in communicating with patients be taught in medical schools? *Lancet, ii,* 523–526.

Scheffler, L. W. (1977). Being is believing: Playing the psychiatric patient. *The Journal of Psychiatric Education, 1,* 63–67.

Snider, J. G., & Osgood, C. E. (1969). *Semantic differential technique. A sourcebook.* Chicago: Aldine Publishing.

Whitehouse, C., Morris, P., & Marks, B. (1984). The role of actors in teaching communication. *Medical Education, 18,* 262–268.

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Creative Thinking Abilities of Adolescent Substance Abusers

JAY EDWARDS

ABSTRACT. Using the Torrance Test of Creative Thinking, Figural Form A, I have studied the creative-thinking abilities of 15 substance-abusing hospitalized adolescents and 15 non-substance-abusing hospitalized adolescents. The determination of substance-abusing versus nonsubstance abusing waas made on the basis of psychiatric evaluation and diagnosis. I performed *t* tests to determine differences between groups on the variables of flexibility and overall creativity. The substance-abusing group showed significantly lower scores on both criteria. These findings suggest that substance-abusing adolescents may lack some creative-thinking abilities that, if present, might increase their ability to adapt to environmental changes and remain functional rather than resort to drug abuse. These findings support the need for creativity and spontaneity training as an adjunctive therapy in drug treatment.

CREATIVITY HAS LONG BEEN A FOCUS of interest among those in the field of psychology. Once thought to be a rare attribute associated with artists and great thinkers, creativity is recognized today as an essential element, basic to all individuals and their behavior. A review of the literature on creativity and creative thinking reveals a plethora of theories, from Freud's idea that creativity is essentially a neurotic defense mechanism formed by the sublimation of regressed and aggressive tendencies (Freud, 1959) to Guilford's (1950) more scientific attempts to distinguish between convergent and divergent thinking. Few, however, have viewed creativity as a teachable skill, enhancing one's ability to meet life's unexpected challenges. In this regard, creativity is what allows an individual to adapt and evolve.

Jacob L. Moreno, the originator of psychodrama, began incorporating his creativity theory into his group psychotherapy methods as early as 1921 (Blatner & Blatner, 1988). Moreno believed that spontaneity and creativity are two factors, working in tandem, that allow us to respond to the unique challenges of everyday life. "Spontaneity can be thought of as the readi-

ness for an action, and creativity as the response (act)" (Buchanan, 1984, p. 788). Moreno feared that as society became more and more conserved, that is, relying on past acts of spontaneity and creativity rather than on creating new ways, individuals would follow that trend. He called upon individuals to summon the "godhead" within each of us and become creators rather than be acted upon by others' creations. He believed that this ability could be nurtured and be developed through psychodrama and spontaneity training. The Blatners (p. 48) echoed these concerns with their statement, "Elements of spontaneity are our natural heritage, and they must be reclaimed and reintegrated if we are to utilize the tremendous psychological energies that can serve as resources for helping us to cope with the challenges of an increasingly changing world."

Moreno (1985, p. 117) saw spontaneity and creativity as separate from intelligence: "The intelligence tests have been made after the standard formal interview. But to answer set questions and to meet reality are two different things." As demonstrated by his work at the New York State Training School for Girls, Moreno (p. 133) was able to help the girls, through spontaneity training, "act and look better oriented toward life, more inspired, more real, wiser, and, if perhaps less learned, certainly more intelligent than some pupils in the formal school who are of similar I.Q.'s."

Where Moreno broke ground, others followed. E. Paul Torrance, a student of psychodrama and contributor to early volumes on psychodrama and education (Torrance, 1948), defined creativity

> as a process of becoming sensitive to problems, deficiencies, gaps in knowledge, missing elements, disharmonies, and so on; identifying the difficulty; searching for solutions, making guesses, or formulating hypotheses about the deficiencies; testing and retesting these hypotheses and possibly modifying and retesting them and finally communicating the results. (1974a, p. 8)

Torrance seems to have combined Moreno's ideas of spontanteity–creativity to come up with one comprehensive definition of creativity that has four subcategories: fluency, flexibility, originality, and elaboration. *Fluency* reflects the ability to produce a large number of responses to a situation. *Flexibility* represents a person's ability to produce a variety of kinds of ideas, to shift from one approach to another, or to use a variety of strategies. *Originality* represents the ability to produce ideas that are away from the obvious, common place, banal, or established. *Elaboration* reflects the ability to develop, embroider, embellish, carry out, or otherwise elaborate ideas (Torrance, 1974b, pp. 56–58). Although Torrance based his scoring system on factors developed by Guilford, his intent was to have the tests reflect the natural complexity of the creative process and be applicable to creativity training in the classroom setting (Anastasi, 1988).

Richards (1981), in a study of creativity theory, found two aspects common to all definitions of creativity: "(a) that it involves an unusual or uncommon element; and that (b) the product be appropriate to a context or purpose—i.e., not haphazard, bizarre, or fully idiosyncratic" (p. 266).

In an article entitled "Creativity and Personal Growth," Sarnoff and Cole (1983) discussed, in detail, the need for an individual to maintain levels of creative ability in order to adapt to one's environment. They concluded:

> For these reasons, the most basic form of creativity is that concerned with personal growth and integration. . . . In short, these studies reveal an inability to deal with change, and a desire to regress which results in illogical cognitive and interpersonal functioning in many areas. (p. 99)

They discussed two forms of creativity that must remain in balance in order for an individual to remain healthy. Level one is concerned with the process of personality growth and development. Level two is concerned with the application of these newly developed skills to the environment in terms of tools, concepts, systems, and behaviors across all disciplines.

Chronic Substance Abusers

When persons lack creative abilities, their dysfunctional behavior may be manifested in many ways. Current theories on personality traits of substance abusers suggest evidence of this phenomenon. It is easy to draw parallels between the language used to describe addicted personalities and the language used to describe the creative process.

Chein (1980, p. 80), in a discussion of personality disorders among substance abusers, stated, "These disorders were evident either in overt adjustment problems or in serious intrapsychic conflicts, usually both, prior to their involvement in drugs. . . ."

Gorusch found a lack of an internal motivating factor at work in these individuals. "If more creative means were available, then novelty seeking, curiosity, or relief from boredom" would not be sought by individuals through drug use (1980, p. 23).

Greaves (1980) hypothesized:

> [P]ersons who become drug dependent are those who are markedly lacking in pleasurable sensory awareness, who have lost the childlike ability to create natural euphoria through active play, including recreational sex, and who, upon experimentation with drugs, tend to employ these agents in large quantities as a passive means of euphoria or least as a means of removing some of the pain and anxiety attending a humorless, dysphoric lifestyle. (p. 27)

Milkman and Frosch (1980) discovered similarities between ampheta-

mine and narcotics users that seem to coincide with Sarnoff and Cole's findings regarding coping skills. They emphasized the following:

> The drug state helps to ward off feelings of helplessness in the face of the threatening environment. The pharmacologic effect bolsters the characteristic defenses deployed to reduce anxiety. Drugged consciousness appears to be a regressive state which is reminiscent of and may recapture specific phases of early child development. (p. 44)

Insufficiency of coping mechanisms also was discussed by Peele: "Persons who are faced with persistent difficulties and anxieties in their lives and who are not prepared to cope with them realistically resort to analgesic drugs for comfort" (1980, p. 143).

Khantzian (1980, p. 29) suggested that drug dependence is intimately tied to individual attempts to cope with their internal emotional and external social and physical environment. If drug dependency is viewed from a contemporary psychoanalytic perspective, it can "best be understood by examining how such a person's ego organization and sense of self serve or fail the individual's attempts to cope and how the specific effects of various substances facilitate or impede such attempts."

A team of researchers at Tel-Aviv University studied the relationship between personality types and the drug of choice among substance abusers. They asserted, "Our central claim is that the use of drugs is one of the ways by which individuals try to cope with their intra-psychic imbalance. Other possible avenues to achieve balance would be creativity, revelation, and love" (Shoham, Baruch, Rahav, Markowski, Chard, & Ben-Haim, 1984, p. 303).

Statement of the Problem and Hypotheses

It has been postulated that one of the more significant factors contributing to the use and continued abuse of drugs and alcohol is the inability of the individual to adapt to changes in the environment, or stated differently, the individual's lack of sufficient coping mechanisms. Creativity may be, among other things, an ability within the individual to adapt to the environment in order to continue to grow and develop into a healthy being.

Torrance has claimed, and research has been conducted that supports his contentions, that if the potential for creative thinking can be identified at an early age, those individuals who show creative potential can be taught in such a way that they use their creative abilities to strengthen areas where deficiencies exist (Torrance 1965; 1967; 1968).

Until very recently, the creative potential of those identified as behaviorally or emotionally disordered or delinquent has not been explored. Under the heading of delinquent behavior, there exists a population that may be

using and abusing chemicals as a sort of cultural conserve, possibly because of their inability to respond spontaneously and creatively to challenges in their environment. If a deficiency in creative-thinking abilities can be identified within the substance-abusing population, then steps can be taken to work with these individuals in a new way. It seems likely that programs to help develop creative abilities could be as successful within this population as they have been with other populations (Torrance, 1967). Two hypotheses were explored: (a) The substance-abusing subjects would be less creative, as measured in terms of their mean composite scores on the Torrance Tests of Creative Thinking (TTCT), Figural Form A, than on the non-substance-abusing group. (b) The substance-abusing group would score lower on the measurement for flexibility as measured by the TTCT, Figural Form A, than the non-substance-abusing group.

Methodology

Subjects

The subjects consisted of 30 adolescents, ages 14 to 17 years old, with a mean age of of 14.9 years, who had been hospitalized at a private psychiatric hospital for the purpose of assessing and treating their chemical dependencies and psychiatric illness. Each group consisted of 6 females and 9 males. The subjects were evaluated by an intake psychiatrist, a social worker, and a nursing-staff member, assigned by the hospital, to determine their appropriateness for treatment. In addition, the subjects were interviewed by a staff substance-abuse counselor to obtain a drug-use history. Involvement was voluntary, and all patients were eligible to serve as subjects with the following exceptions. Subjects were not to be actively psychotic, that is, experiencing auditory or visual hallucinations, or suffering from delusions or rapid changes in mood that might affect test performance. Subjects were not to be suffering from drug or alcohol withdrawal, as determined by the nursing staff. Subjects were given time to become oriented to the unit, also determined by the nursing staff.

The subjects were divided into two groups according to the individual patient's diagnosis. Patients with a substance-abuse diagnosis made by the admitting physician using DSM-III-R criteria formed one group, and patients hospitalized without a substance-abuse disorder were in the second group. Research conducted on the interrater reliability of the DSM-III diagnostic classes for children's and adolescents' substance-abuse disorders showed a reliability score, using a kappa statistic, (.7 or above indicated good agreement) of 1.0 in phase one of the research and .56 for phase two (Williams & Spitzer, 1979).

Tests

Within the TTCT, Figural Form A was chosen to allow for more representative scores from subjects who might be restricted by poor reading or writing skills. Intra- and interscorer reliability has been shown consistently to correlate above the .90 level (Torrance, 1974b). Test–retest reliability studies (Goralski, 1974; Hagender, 1974) have shown reliability coefficients consistently rated at .70 or higher. Other studies have demonstrated significant content and construct validity (Lieberman, 1965; Long, Henderson, & Ziller, 1974; Torrance, 1962).

Intelligence test scores were taken from archival data on the subjects. All subjects in this study had completed psychological evaluations that included intelligence testing.

Results

The non-substance-abusing group of 15 subjects had the following characteristics: a mean age of 14.9 years, with an age range from 13 to 17 years, and a mean grade level of 9.3, with a range from the 7th to the 12th grades. The substance-abusing group of 15 subjects had the following characteristics: a mean age of 15.5, with a range of 13 to 17 years, and a mean grade level of 9.6, with a range from 7th to 12th grades. Each group consisted of 6 females and 9 males. A comparison of the mean ages of the two groups showed no significant difference, $t(28) = 1.18$.

The non-substance-abusing group scored significantly higher than the substance-abusing group on the overall composite creativity score $t(28) = 1.94$, $p < .05$, as well as on the measure of flexibility, $t(28) = 1.79$, $p < .05$ (see Table 1). Intelligence scores were not significantly different between the groups.

TABLE 1
Flexibility, Creativity, and Intelligence Test Scores of Substance- and Non-Substance-Abusing Adolescents

	Group				
	Substance-abusing		Non-substance-abusing		
Test	*M*	*SD*	*M*	*SD*	*t*
Flexibility	93.53	21.06	105.80	16.17	1.79*
Creativity	97.60	17.34	108.40	12.78	1.94*
Intelligence	106.33	11.31	110.4	11.04	.99

*$p < .05$.

Discussion

The results of this study indicate that there were significant differences between the substance-abusing group and the non-substance-abusing group in terms of flexibility and overall creativity, with the latter group scoring higher on both criteria. Therefore, both the first and second hypotheses were supported. Although there has not been any quantitative information regarding these comparisons in the past, these findings support theories of creativity developed by Paul Torrance (1965) and J. L. Moreno (1985). According to both these theorists, dysfunctional behavior, such as chemical dependency, may be related to an inability to adapt to environmental changes, the operational definition of creativity, and, more specifically, flexibility.

There is no basis to compare this research with past studies because this study was unique in its investigation of substance abusers' creative-thinking abilities. Finch (1977) and Kandil and Torrance (1979) did not find that socially or emotionally maladjusted youth differed significantly in their creative-thinking ability from socially and emotionally adjusted children. Harvey and Seeley (1984) found that antisocial youth also exhibited creative potential similar to that of nondelinquent children. Thus, it may be possible that among all persons with dysfunctional behaviors, substance abusers have a unique deficiency, one involving their creative-thinking abilities. Specifically, as compared with other hospitalized adolescents, their deficiency in this area is significantly greater and may contribute to their current dysfunctional status.

Although it is unclear whether the deficiency predated the chemical addiction and initially led the subjects to abuse drugs or the drug dependency brought about the deficiency, these findings have implications for treatment and prevention. Torrance (1965) developed courses that facilitate the ability to think creatively, and these have been used successfully with gifted and talented students. Similarly, Moreno proposed spontaneity training as an aid to help individuals reclaim their ability to respond to the moment in ways that help them create viable new roles. In *Psychodrama: Volume 1*, he outlined courses in spontaneity training for children and adults and recommended that they become a part of mainstream education (1985). I suggest that further research efforts be directed toward examining the phenomena of spontaneity and creativity and their place in substance-abuse treatment and prevention.

REFERENCES

Anastati, A. (1988). *Psychological testing* (6th ed.). New York: Macmillan.
Anderson, C. M., & Stoffer, G. R. (1977). Creative thinking and juvenile delin-

quency: A study of delinquent youth on the Torrance Tests of Creative Thinking. *Journal of Creative Behavior, 11*(3), 207.

Blatner, A., & Blatner, A. (1988). *Foundations of psychodrma: History, theory, and practice* (3rd ed.). New York: Springer.

Buchanan, D. R. (1984). Psychodrama. In T. B. Karasu (Ed.), *The psychosocial therapies* (pp. 783–799). Washington, DC: The American Psychiatric Association.

Chein, I. (1980). Psychological, social, and epidemilogical factors in juvenile drug use. In D. J. Lettieri, M. Sayers, & H. W. Pearson, (Eds.), *Theories on drug abuse* (Research Monograph Series 30, pp. 76–82). Rockville, MD: National Institute on Drug Abuse.

Finch, J. M. (1977). A comparison of creativity in disturbed, delinquent, accelerated, and normal children. *The Journal of Creative Behavior, 11*(3), 207.

Freud, S. (1959). Creative writers and daydreaming. In J. Strachey (Ed. and Trans.), *The Complete psychological works of Sigmund Freud*, (Vol. 9). London: Hogarth Press. (Original work published 1908)

Goralski, P. S. (1974). Creativity: Student teachers' perceptions of approaches to classroom teaching. In E. P. Torrance (Ed.), *Torrance Tests of Creative Thinking: Norms-technical manual* (p. 20). Lexington, MA: Ginn.

Gorusch, R. L. (1980). Interactive models of non-medical drug use. In D. J. Lettieri, M. Sayers, & H. W. Pearson (Eds.), *Theories on drug abuse* (Research Monograph Series 30, pp. 18–23). Rockville, MD: National Institute on Drug Abuse.

Guilford, J. P. (1950). Creativity. *American Psychologist, 5*, 444–454.

Hagender, H. (1974). Influence of creative writing experiences on general creative development. In E. P. Torrance (Ed.), *Torrance Test of Creative Thinking: Norms-technical manual* (p. 19) Lexington, MA: Ginn.

Harvey, S., & Seeley, K. R. (1984). An investigation of the relationship among intellectual and creative abilities, extra curricular activities, achievement, and giftedness in a delinquent population. *Gifted Child Quarterly, 28*(2), 73–79.

Kandil, S. A., & Torrance, E. P. (1979). Further verification of creative potential among emotionally disturbed and behavior disordered children. *The Journal of Creative Behavior, 17*(2), 95–102.

Khantzian, E. J. (1980). An ego/self theory of substance dependence: A contemporary psychoanalytic perspective. In D. J. Lettieri, M. Sayers, & H. W. Pearson (Eds.), *Theories on drug abuse* (Research Monographs Series 30, pp. 29–33). Rockville, MD: National Institute on Drug Abuse.

Lieberman, J. N. (1965). Playfulness and divergent thinking: An investigation of their relationships at the kindergarten level. *Journal of Genetic Psychology, 107*, 217–224.

Long, B. H., Henderson, E. H., & Zitler, R. C. (1974). Self-social correlates of originality in children. In E. P. Torrance (Ed.), *Torrance Test of Creative Thinking: Norms-technical manual* (p. 23). Lexington, MA: Ginn.

Milkman, H., & Frosch, W. (1980). Theory of drug use. In D. J. Lettieri, M. Sayers, & H. W. Pearson (Eds.), *Theories on drug abuse* (Research Monograph Series 30, pp. 38–45). Rockville, MD: National Institute on Drug Abuse.

Moreno, J. L. (1985). *Psychodrama: Volume 1* (7th ed.). Ambler, PA: Beacon House, (original work published 1946).

Peele, S. (1980). Addiction to an experience: A social-psychological-pharmacological theory of addiction. In D. J. Lettieri, M. Sayers, & H. W.

Pearson (Eds.), *Theories on drug abuse* (Research Monograph Series 30, pp. 142–146). Rockville, MD: National Institute on Drug Abuse.

Richards, R. (1981). Relationships between creativity and psychopathology: An evaluation and interpretation of the evidence. *Genetic Psychology Monograph, 103*, 261–324.

Sarnoff, D. P., & Cole, H. P. (1983). Creativity and personal growth. *The Journal of Creative Behavior, 17*(2), 95–102.

Shoham, S. G., Baruch, I., Rahav, G., Markowski, R., Chard, F., & Ben-Haim, M. (1984). Personality core dynamics and drug preference. *Drug and Alcohol Dependence, 13*, 197–303.

Torrance, E. P. (1948). Psychodramatic methods in the college student personnel program. In R. B. Haas (Ed.) *Psychodrama and Sociodrama in American Education* (pp. 368–375). New York: Beacon House.

Torrance, E. P. (1962). *Guiding creative talent*. Englewood Cliffs, NJ: Prentice-Hall.

Torrance, E. P., (1965). Scientific views of creativity and factors affecting its growth. *Daedalus, 94*, 663–681.

Torrance, E. P. (1967). The Minnesota studies of creative behavior: National and international extensions. *The Journal of Creative Behavior, 1*(2), 137–178.

Torrance, E. P. (1968). Examples and rationales of test tasks for assessing creative abilities. *The Journal of Creative Behavior, 2*(3), 165–178.

Torrance, E. P. (1974a). *Torrance Tests of Creative Thinking: Directions manual and scoring guide (verbal test booklet A)*. Bensenville, IL.: Scholastic Testing Service.

Torrance, E. P. (1974b). *Torrance Tests of Creative Thinking: Norms-technical manual*. Bensenville, IL.: Scholastic Testing Service.

Wallach, M. A. (1970). Creativity. In P. H. Mussen (ed.), *Carmichael's manual of child psychology* (3rd ed., Vol 1, pp. 1211–1272). New York: Wiley.

Williams, J., & Spitzer, R. L. (1982). DSM-III field trials: Interrater reliability and list of project staff and participants. In J. Williams (Ed.), *Diagnostic and statistical manual of mental disorders*, (3rd ed., pp. 467–472). Washington, DC: American Psychiatric Association.

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From Small-Group Members to Leaders: Conflicting Changes in Behavioral Ratings Given and Received

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ABSTRACT. After about 45 interaction hr in initial small groups, 37 individuals rated each same-group participant's within-group behavior for self-acceptance and acceptance of others. After 10 intervening weeks of leadership training, both measures were repeated in new groups that were co-led by these former members. As novice leaders, they received higher ratings from others and themselves than in their initial groups, although their ratings showed substantial cross-role and inter-group consistency on each measure. However, new leaders also rated their new groups' participants lower on both scales than they had rated those in their initial groups, confirming the mixed pattern noted in their subsequent groups (Hurley, Feintuch, & Mandell, 1991). Whether this blend of rising ratings received and falling ratings given to others reflects the new leaders' increased comprehension of interpersonal operations, their increased risk of shifting toward a less constructive interpersonal stance, or other considerations requires further study.

NEARLY ALL CANADIAN AND NORTH AMERICAN mental health facilities offer clients the option of participating in small interpersonal groups (Butler & Fuhriman, 1986), but the preparation of leaders for such groups has received little research attention. One relevant study addressed how leaders of interpersonal groups rated, and were rated by, the members of their first three groups (Hurley, Feintuch, & Mandell, 1991). On separate measures of self-acceptance and acceptance of others, representing the two most central dimensions of interpersonal behavior (Hurley, 1976, 1989b), the new leaders were rated progressively higher, but they rated the members of their successive groups increasingly lower, on

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each scale. This mix of leaders' increasingly favorable ratings with the declining favorability of their ratings of group members seems problematic because it appears to move group leaders toward a less constructive interpersonal stance. Hurley et al. also found substantial intergroup consistency in ratings of these new leaders for self-acceptance and other-acceptance by members of successive groups, sharply conflicting with Smith's (1980) characterization of the small-group leader as a "prisoner of circumstance" (p. 74).

In the present study, we sought to determine if earlier ratings of these new leaders, as members of their initial small group, would be consistent with their later ratings as novice leaders. We also sought to determine whether changes in the ratings that they received and gave others as members, when compared with their later ratings as novice leaders, would confirm the shift toward rising self-ratings but falling ratings of others.

Method

Setting and Participants

For 20 years, small groups have been the central feature of an elective undergraduate course for enhancing interpersonal communication skills at Michigan State University. The typical group in past courses comprised eight male and female upper level undergraduates, with male and female coleaders. Each group convened for about 50 hr, including two 90-min meetings per week and two 12-hr "marathon" sessions near the third and seventh weekends of 10-week academic terms. Oversight was provided by the first author, an elected Fellow of the American Psychological Association's Division of Clinical Psychology and also of the American Group Psychotherapy Association, who has nearly 20 years of experience in leading small groups.

More direct guidance was given in 2-hr weekly staff meetings, in which each group's problems and progress were reviewed. Also examined at these meetings were postsession ratings that had been routinely collected near the end of each group session. To this postsession questionnaire's last item, "I gained something of value from today's [small group] session," the mean member-based response in 103 such groups (1981–1991) was 4.41, between *quite a bit* and *a great deal*, on a 7-point scale that ranged from *not at all* (0) to *extremely* (6). Separated from the individual's within-group conduct, course grades were based primarily on the quality of the student's postsession journal entries and secondarily on attendance and textbook-based examinations. Dropouts were uncommon, occurring at a 5% rate in the 103 groups, compared with a 14.8% rate in

Lieberman, Yalom, and Miles's (1973) Stanford encounter groups. Also infrequent were small-group absences, which occurred at a 3.4% rate (Hurley, 1989a).

As in most contemporary undergraduate psychology courses, enrollment was about 60% women. Group assignments were largely determined by the student's class schedule. However, because candor and the minimization of cliquishness were important, students were discouraged from participating in groups with their friends, roommates, close acquaintances, relatives, and so forth. Broad guidelines were provided by the course textbook, Egan's (1976) *Interpersonal Living.* Within a here-and-now orientation, these groups informally addressed such topics as appropriate self-disclosure, empathetic listening and responding, genuineness, mutual respect, and constructive approaches to confronting oneself and others.

Leadership training was limited to volunteers who had shown promising interpersonal skills as group members and met with the first author's approval. This 10-week program, which was concerned with group dynamics and leadership, included a weekly 90-min didactic meeting focused on the discussion of selected readings, weekly direct but nonparticipatory observation of a regular group from this program, maintaining related notes, discussions of observations with experienced leaders, participation in a 90-min weekly advanced experiential group restricted to other leader trainees conducted by a seasoned leader, and writing a related term paper. After completion of this program, new leaders were usually paired with a more experienced partner.

The average age of the 14 male and 23 female students analyzed for the present study was 23 years. All eventually co-led or led at least three small groups and had also participated in the prior study of novice leaders (Hurley et al., 1991).

Measures

There seems abundant evidence that the two principal dimensions of the interpersonal circle (Kiesler, 1983; Merenda, 1987; Wiggens & Pincus, 1989) meaningfully address many forms of human social behavior. After reviewing selections from the pertinent literature, Conte and Plutchik (1982) concluded that "for interpersonal personality data, however, any factors after the first two account for very little of the total variance" (p. 707). Despite this basic agreement, a variety of labels have been applied to these two central dimensions. Plainly dealing with friendliness, the first dimension has often been denoted *affiliativeness* (Wiggens, 1982) but has also been termed *nurturance versus hostility* (Pincus & Wiggens, 1990) and *acceptance versus rejection of others* (Adams,

1964; Foa, 1961; Hurley, 1976). The second dimension, which concerns status, has often been denoted *dominance versus submission*, although *acceptance versus rejection of self* seems a suitable alternative (Hurley, 1976). A notable advantage of the constructs of self-acceptance and acceptance of others is the crucial role each plays in the important theories of personality and psychotherapy formulated by Sullivan (1953) and Rogers (1959).

Relatively simple measures of these two dimensions have been developed for use with small groups. The construct validity of these distinct measures of self-acceptance and acceptance of others is firmly supported by evidence (Hurley, 1989b) that each has convergent and discriminant validity with parallel measures from such prototypical interpersonal instruments as the Interpersonal Checklist (LaForge & Suczek, 1955), the Interpersonal Behavior Inventory (Lorr & McNair, 1965), and the System for the Multiple Level Observation of Small Groups (SYMLOG; Bales, Cohen, & Williamson, 1979). Especially for peers' ratings of the individual, Hurley (1991) found that the acceptance of others measure was nearly equivalent to SYMLOG's Friendliness scale (r = .85) and that the self-acceptance index was similarly correlated (.83) with SYMLOG's dominance (vs. submission) dimension. Using peer-based ratings, neither acceptance scale correlated appreciably with the other SYMLOG index or with SYMLOG's more problematic task-orientedness dimension (Polley, 1986). In prior groups from this program, May (1991) reported that these self-acceptance and other-acceptance scales had high internal consistency regardless of the source or occasion of ratings.

These behaviorally oriented acceptance ratings are a traditional and required feature of this small-group course. Instructions request raters to describe each same-group participant's (including self and leaders) within-group conduct on each subscale, while also advising that all such ratings will later be fully shared among all same-group members. Preceeded by a *liked-disliked* scale intended to provide an outlet for strong feelings, bipolar items from quartets of subscales addressing self-acceptance (*shows feelings—hides feelings, expressive-guarded, active-passive,* and *dominant-submissive*) and acceptance of others (*warm-cold, helps others-harms others, gentle-harsh,* and *accepts others-rejects others*) were alternated. Each pair of anchors, staggered for favorableness to reduce response biases, was separated by 10 equally spaced marks in a semantic differential format. Ratings on each subscale were translated into numbers (0 to 9), yielding potential total scores ranging from 0 to 36 on each acceptance scale. These ratings were routinely administered twice in all groups after the first 90-min regular postmarathon session—or after groups had convened for about 23 hr (seven 90-min sessions + 12 hr)—and again

near 45 hr (fourteen 90-min sessions + 24 hr). About a week later, for review and discussion at that group's next regular session, each individual received a detailed report plus a chart showing each rating that she or he had assigned to and received from each other same-group participant. Only the 45-hr ratings were used for this study because they were based on a greater amount of shared group experience and were probably more valid than the 23-hr ratings.

Consisting of the mean ratings that individuals received from others, their mean ratings of these others, and self-ratings on each acceptance scale (when they were group members and when they were novice coleaders), these data represent 444 (37 × 12 [3 rating indices × 2 scales × 2 groups]) possible data points. Records of two participants' mean ratings of others for self-acceptance and acceptance of others when they had been group members were lost. This limited the analyses of the mean ratings given to others to a sample of 35; otherwise, the data file was complete. Gender did not correlate significantly with any of the 12 rating measures.

Results

Table 1 contains all descriptive statistics and the results of *t* tests for shifts between ratings given and received as group members and as lead-

TABLE 1
Descriptive Statistics and Mean Shifts in 37 Individuals' Ratings as Group Members to Their Ratings as Leaders

Scale	Self-ratings		Ratings received from others		Ratings of others	
	M	*SD*	*M*	*SD*	*M*	*SD*
Self-acceptance						
Leader (L)	29.81	4.2	28.95	3.3	24.02	3.7
Member (M)	29.03	4.3	27.38	4.2	25.19	4.1
Shift (L–M)	0.78	4.5	1.57*	3.6	−1.17*	3.0
Acceptance of others						
Leader (L)	28.62	4.6	28.63	3.4	26.39	3.0
Member (M)	27.22	5.2	27.48	4.4	27.71	3.9
Shift (L–M)	1.41*	4.0	1.15*	3.3	−1.32*	3.2

Note. Shift *t* test $df = 36$ except for ratings of others, for which $df = 34$.
*$p < .05$ (two-tailed test).

ers. New leaders' change in role was associated with rising ratings from group members and from themselves. Only the gain in self-rated self-acceptance ($p < .30$) did not reach statistical significance. A contrasting decline on each acceptance scale marked these novices' ratings of their new groups' members.

The member-to-leader shift was also accompanied by diminishing differences between self-ratings and mean ratings from others. As group members, the novices rated themselves above how others rated them for self-acceptance (mean difference = 1.65, $p < .01$) but not for acceptance of others (mean difference = −0.26). As leaders, the parallel mean differences were 0.86 and −0.01. Yet this role change was accompanied by increased differences between how these new leaders rated themselves and others and how they had rated themselves and others when they were group members: for self-acceptance, $t(34) = 2.11$, $p < .05$; for acceptance of others, $t(34) = 3.86$, $p < .001$. Nevertheless, the novice leaders' mean ratings from members of their new groups and their self-ratings correlated appreciably for self-acceptance ($r = .59$) and for acceptance of others ($r = .60$).

Furthermore, all correlations between novices' ratings as group members and later as leaders were statistically significant ($p < .05$, two-tailed test). The intergroup, cross-role stability of Pearson correlations for self-ratings were similar in magnitude (self-acceptance = .45; acceptance of others = .67) to the mean ratings new leaders received from others (self-acceptance = .57; acceptance of others = .68) and also to their average rating of these others (self-acceptance = .71; acceptance of others = .59). Despite their shifts from group member to coleader, substantial consistency remained in how these persons rated, and were rated by, themselves and others.

Discussion

This study identified significant declines in how novice leaders rated members of their new groups for self-acceptance and acceptance of others. These decrements contrast both with the novices' rising ratings from group members on each scale and with rises in their self-ratings. Similar contrasts were previously noted (Hurley et al., 1991) in the first three groups led by these novices. Their ratings from group members continued to rise, especially for self-acceptance, whereas their ratings of group members continued to decline, especially for acceptance of others.

Two tentative explanations of this pattern seem apparent. One holds that the novice leaders' increasing experience with these groups and related readings enriched their understanding of the situation, enabling

them to show greater acceptance of both self and others while also facilitating a more informed and critical awareness of the behavior of other group participants. This perspective partially fits Gibb's (1964) view of psychological development, in which "a person learns to grow through his increasing acceptance of himself and others" (p. 279), although this formulation offers no explanation for the novice leaders' declining ratings of others. The new leaders' increased awareness of small-group processes may well have helped them to develop cognitive schemas that facilitated the more effective identification of interpersonal behaviors having constructive and unconstructive consequences.

Another view is that their new status as leaders may have led them to overvalue their own interpersonal skills and to downgrade those of beginning group members. Although the available evidence is inconclusive, it does not support this view. The self-acceptance gains of new leaders did not correlate significantly with shifts in their mean ratings of others on either acceptance scale (self, $r = .15$; others, $r = -.17$). Nor did advances in the novices' self-rated acceptance of others correlate significantly with changes in how they rated these others on each scale (self-acceptance, $r = .31$; acceptance of others, $r = .19$). Despite this lack of evidence, the danger to group members of a negative shift in the interpersonal stance of group leaders seems sufficient to take precautions against it. This hazard could be monitored by regular use of the present scales, SYMLOG (Bales et al., 1979), or related measures.

Although the pattern of rising ratings of leaders and their falling ratings of others seems clear, its satisfactory explanation requires further study. Because similar changes might hold in the ratings of members of successive groups who did not shift roles, the relevance of the present shift from member to leader is uncertain. Comparing these findings with the shifts of members of successive groups is a critical next step.

The substantial correlations between how separate sets of group members rated these novices as peer members and subsequently as group coleaders for self-acceptance ($r = .57$, $p < .001$) and acceptance of others ($r = .68$) also deserve comment. This consistency in the behavior of individuals across groups while shifting in role from member to leader is further evidence against Smith's (1980) view of the small-group leader as a prisoner of circumstance. The present leaders' behavior appears to have been influenced more by their personal attributes than by the small-group context.

These 37 persons were not a random subset of the initial group members. They averaged about half a standard deviation above these peers in the mean ratings that they received from others for both self-acceptance and acceptance of others. They were also more academically and intellec-

tually ambitious than their peers; nearly 30 subsequently completed master's degrees in professional sectors associated with mental health, including 9 who entered or completed PsyD or PhD programs in psychology. Although this sample's relatively open nature and 20-year time span enhance confidence in the present findings, caution in generalizing from these results seems necessary in view of evidence that self-construal may take widely divergent forms in Eastern and Western cultures (Markus & Kitayama, 1991).

REFERENCES

Adams, H. B. (1964). "Mental illness" or interpersonal behavior? *American Psychologist, 14,* 191–197.

Bales, R. F., Cohen, S. P., & Williamson, S. A. (1979). *SYMLOG: A system for the multiple level observation of small groups.* New York: Free Press.

Butler, T., & Fuhriman, A. (1986). Professional psychologists as group treatment providers: Utilization, training, and trends. *Professional Psychology: Research and Practice, 17,* 273–275.

Conte, H. R., & Plutchik, R. (1981). A circumplex model for interpersonal personality traits. *Journal of Personality and Social Psychology, 40,* 701–711.

Egan, G. (1976). *Interpersonal living: A skills/contract approach to human relations training in groups.* Monterey, CA: Brooks/Cole.

Foa, U. G. (1961). Convergences in the analysis of the structure of social behavior. *Psychological Review, 68,* 341–353.

Gibb, J. R. (1964). Climate for trust formation. In L. P. Bradford, J. R. Gibb, & K. D. Benne (Eds.), *T-group theory and laboratory method* (pp. 279–303). New York: Wiley.

Hurley, J. R. (1976). Two prepotent interpersonal dimensions and the effects of trainers on T-groups. *Small Group Behavior, 7,* 77–98.

Hurley, J. R. (1989a). Affiliativeness and outcome in interpersonal groups: Member and leader perspectives. *Psychotherapy, 26,* 520–523.

Hurley, J. R. (1989b). Self-acceptance and other-acceptance scales for small groups. *Genetic, General, and Social Psychology Monographs, 115,* 483–503.

Hurley, J. R. (1991). Self-acceptance, acceptance of others, and SYMLOG: Equivalent measures of the two central interpersonal dimensions? *Journal of Clinical Psychology, 57,* 576–582.

Hurley, J. R., Feintuch, B., & Mandell, M. J. (1991). Novice leaders' first three groups: Change and consistency in acceptance of self and others. *Journal of Social Psychology, 131,* 233–245.

Kiesler, D. L. (1983). The 1982 interpersonal circle: A taxonomy for complementarity in human transactions. *Psychological Review, 90,* 185–214.

LaForge, R. R., & Suczek, R. F. (1955). The interpersonal dimension of personality: III. An interpersonal checklist. *Journal of Personality, 24,* 94–112.

Lieberman, M. A., Yalom, I. D., & Miles, M. B. (1973). *Encounter groups: First facts.* New York: Basic Books.

Lorr, M., & McNair, D. M. (1965). Expansion of the interpersonal behavior circle. *Journal of Social and Personality Psychology, 2,* 823–830.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98,* 224–253.

May, B. A. (1991). The interaction between ratings of self, peers' perceptions, and reflexive self-ratings. *Journal of Social Psychology, 131,* 483-493.
Merenda, P. F. (1987). Toward a four-factor theory of temperament and personality. *Journal of Personality Assessment, 51,* 367-374.
Pincus, A. L., & Wiggens, J. S. (1990). Interpersonal problems and conceptions of personality disorders. *Journal of Personality Disorders, 4,* 342-352.
Polley, R. B. (1986). Rethinking the third dimension. *International Journal of Small Group Research, 2,* 134-140.
Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science: Vol. 3. Formulations of the person and the social context* (pp. 184-256). New York: McGraw-Hill.
Smith, P. B. (1980). The T-group trainer: Group facilitator or prisoner of circumstance? *Journal of Applied Behavioral Science, 16,* 63-77.
Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.
Wiggens, J. S. (1982). Circumplex models of interpersonal behavior in clinical psychology. In P. C. Kendall & J. N. Butcher (Eds.), *Handbook of research methods in clinical psychology* (pp. 183-221). New York: Wiley.
Wiggens, J. S., & Pincus, A. L. (1989). Conceptions of personality disorders and dimensions of personality. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1,* 305-316.

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Research Report: Dyadic Loneliness in Marriage

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For years, a professor in Colorado has asked his first-year students, many of whom are away from home and family for the first time, to write a paper on loneliness, as he too was required to do when he was an undergraduate in California. Those papers have accumulated now for decades, slowly filling drawers and finally file cases with the weight of student descriptions of their despair. One student who was asked to do that was Raymond Ross, and the memory of those file cases inspired his graduate research into parental loneliness.

His point of departure was that because of the changes that have occurred in the family during the past 30 years, basic social and emotional needs of the family members were not being met and that home environments were often punctuated with discord, abuse, and neglect. He reasoned that parents and children alike might experience loneliness within the family unit as a consequence of stresses on the family. The most common form of loneliness is to be without a companion or partner. There is a wealth of information in the literature concerning loneliness resulting from separation (people separated from relatives, divorced or widowed persons, old persons in hospitals or nursing homes) but little that addressed the expression and consequences of loneliness in ordinary, everyday life.

The researcher drew 934 parent subjects (467 marital dyads) from Academy School District Twenty in El Paso County in Colorado, which consists of mixed ethnic and occupational populations in urban and suburban households. Subjects were married parents who lived together and had a child or children attending third, fourth, or fifth grade in the district. The measure of the experience of loneliness was obtained with the UCLA Loneliness Scale, Version 3, constructed by Russell and Catrona in 1987, and compared with several dimensions of family functioning (cohesion, adaptability, emotional intimacy, social intimacy, sexual intimacy, intellectual intimacy, recreational intimacy, family satisfaction, quality of life, and family strength), using 10 different scales, all con-

structed and validated by Olson, Portner, Schaefer, Wilson, Barnes, and Lavee in the early 1980s. Pearson product-moment coefficients were used on all correlations; Tukey's test (.05 level) was used for one-way post hoc tests of analysis of variance. Demographic data were also gathered.

There is a tendency to believe that the marital state fends off loneliness irrespective of the extent to which the marriage is satisfying because there is always a potential companion around; however, the results of the investigation showed that 20% of the wives and 24% of the husbands were significantly lonely. Consistently, men were more lonely than women. Moreover, the experience of loneliness reported by respondents in the study was found to have a significant inverse correlation with every variable of effective family functioning measured in the research. In other words, as the degree of the person's perception of his or her quality of life diverged from the ideal, the intensity of his or her loneliness increased.

Loneliness was significantly and negatively correlated with every measure of intimacy in the marital relationship as well. As with the variables of family functioning, as the level of satisfaction with the intimate expressions of marriage diverged from the ideal, the intensity of loneliness reported by the parents increased. And as expected, there was a strong link between the experience of loneliness and depression. Some researchers claim that loneliness and depression have common origins.

Because poor parent-child relations or a disharmonious home life are thought to influence the behavior and academic success of children, one of the purposes of the study was to determine whether children with school-related difficulties were in families in which the parents were lonely, but there was no support for this hypothesis. Children with difficulties in school come from lonely and nonlonely families alike.

A sociometric isolate is usually assumed to be a lonely person. He or she does not choose and is not chosen by other group members. Moreno spoke of the group as being a microcosm of the larger world, so an isolate in a small group is usually thought to be an isolate or underchosen in the world outside the group. Psychodramatists who speak from their clinical experience will often tell you that an isolate in a group is likely to be a source of difficulty for the group until that person is paid attention to and integrated into the group in some way. Sociometrists usually assume that isolates are lacking in ways to connect with other people and somehow need to be connected in order to function in the group and in the world outside the group.

One reason that the findings of this investigation may be interesting to sociometrists is that the investigation differentiated between the experience of loneliness that results from the mere absence of a *companion* and the

loneliness that results from the absence of the *qualities* people seek in the relationship. It is not just the existence of the companion or partner that matters, it is the quality of the relationship that matters. Any warm body will not do, even if he or she is the marital partner. In this study, loneliness was associated significantly with the social and personal aspects of the lives of the respondents, such as intimacy and family functioning. If the quality of the marital relationship was unsatisfactory and the quality of family life was as well, partners in the marital dyad were likely to experience loneliness. The study provides explanations for that oft-heard expression about feelings of loneliness in the midst of others.

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BRIEF REPORTS

These brief reports were written by psychodrama trainees who have been working with Antonina Garcia, an executive editor of this journal.

Using the Role-Reversal Technique in an Industrial Setting

In the spring of 1991, the manufacturing division of our company reorganized into a series of semi-autonomous or self-managed work teams. My job responsibilities included providing instruction to team members concerning the skills necessary for effective team work. At a series of skill-training sessions, the topics included developing the teams' missions and goals; clarifying individual, team, and managerial roles and responsibilities; and developing adequate processes and procedures to ensure that goals could be met.

Early in the transition from work groups to self-managed teams, I was conducting a team-training event with members of the newly formed shipping team. The training was focused on clarifying team member versus manager responsibilities. In this particular meeting, participants were sitting around a conference table looking glum. They did little interacting among themselves or with me. After I had made a point about how important it was for them to work together cooperatively, one female team member posed a question that ricocheted around the room: "Why are they making us do this?" (By "this" she meant, work in the self-managed team.)

All 11 pairs of eyes focused intently on me, hungrily awaiting the answer that would explain why they were having to endure so much uncertainty and interpersonal pain. Because I had been asked this same question on several occasions by this group, I sensed that the individual who asked the question was posing a central concern of the group. Clearly, none of the previous answers satisfied the team members. I decided to try a different approach this time. I said, "Okay, let's find out. You be the president of this company, and I'll be you. I'm going to go around the room and ask each of you, in turn, 'Why are you making us do this?' I want you to answer as if you were president of the company. Are you

willing to try this approach?" After looking at each other for a brief second or so, each person nodded his or her head in agreement.

I then did a role reversal with each person, and I moved from one to the other, posing the question and listening intently as each responded from the role of the company president. Remarkably, each person's response was exactly what I might have said, except that coming from them, it felt more authentic and believable. Their list of reasons was impressive: "So that we can remain competitive, . . . to give the company more flexibility in managing the work, . . . to make it easier for the worker to do the job." I noticed that as I approached each person and indicated that it was time to be in the role of the president, each one sat up a little straighter and seemed to become, for a moment, the president of the company.

At the end of the role reversal, the climate in the room had changed perceptibly. The participants were nodding in agreement with what had been said, and the atmosphere was relaxed and pleasant. The classes continued, but the question of purpose never came up again.

UNEEDA BREWER

A Group Singing Warmup With the Chronic Mentally Ill

Difficulties with spontaneous interaction and experiencing deep feelings of isolation and of not being understood are among the many challenges that face persons with mental illness. These challenges are compounded by an awareness of societal stigma and prejudice against persons with psychiatric problems. For the mentally ill, the therapy group can become a safe place to risk sharing with and connecting with others who have similar problems.

Group singing can be one means through which clients identify and share common issues. Because many musicians and composers suffer from mental illness and/or substance abuse, their popular songs often express feelings and struggles to which people with mental illness can relate. When, for example, songs such as "Nowhere Man" (Beatles), "Candle in the Wind" (Elton John), or "Desperado" (Eagles) are sung in a group, a client's feelings of aloneness and struggle are validated, and a sense of empathy between songwriter and client can be felt. In the "role" of the songwriter or the song's character, clients can more safely experience and express feelings that often remain untapped and unheard.

After group members have had an opportunity to discuss the emotional content of a song from the perspective of the songwriter or the song's character, they seem to feel safer in sharing similar feelings of their own. Because many emotional themes are often present within the same song, clients are able to identify with and warm up to those feelings that relate most closely to their own issues on a given day.

For example, a client singing "Candle in the Wind" might identify loneliness as one of the themes for the song character Marilyn Monroe, quoting the line "Loneliness was tough, the toughest role you ever played." The client may then state, "That sounds just like me. I don't like to feel lonely." Another person might choose trust as a theme, citing the line "Never knowing who to cling to when the rain set in." To personalize the statement, he or she might add, "I also have a hard time knowing who to trust when I need help."

Once several themes have been identified, the therapist can ask clients to volunteer to be the protagonist. They may feel ready to describe their own loneliness or their own lack of trust. The group would then be ready to work within a psychodramatic framework.

If clients are not ready for psychodramatic work, a sociodrama could be constructed in which a client plays the role of Marilyn Monroe in a scene where Marilyn is feeling lonely or not sure whom to trust. Through the song lyrics, the group has already had the opportunity to warm up to her character. Group members may have questions or "advice" or empathy to share with Marilyn Monroe through the modality of sociodrama. Clients may also take the risk, in the role of Marilyn Monroe, to express feelings that they have been unable to share as themselves.

Whether used in a psychodrama or a sociodrama, thematic songs can be an effective means to validate shared struggles and a catalyst for the identification and expression of feeling. Songwriters and characters in songs, in a sense, give permission for clients to feel the way they do and to risk opening themselves up to interaction within a group setting.

AMY KNIGHT

Psychodrama by Remote Control

A wealth of wonderful techniques exist for facilitating psychodrama. For example, an invisible screen can be pulled down to allow one to say what one wants without "being heard." As our modern world develops, more new tools become available that therapist can use. One handy tool

—the remote control—offers possibilities for a variety of uses. I will describe how I use some of them.

I give the protagonist an invisible remote control or an actual one, as a prop. The protagonist, calling out the commands, presses the imaginary buttons. Remote control commands, as applied to a psychodrama, bring about these results.

Mute: The sound stops while the action continues. For example, a nagging auxiliary can continue quietly mouthing complaints and shaking a finger or using other appropriate body language. The protagonist is empowered by not having to listen and might be able to laugh at what has been an otherwise damaging experience.

Pause: All sound and action freezes. The protagonist can examine the picture closely to maximize its effects, plan scene changes, or take a break.

Rewind: The protagonist can return to a previous scene and review it. This is especially beneficial after a successful exchange to reinforce the positive experience. If the protagonist rewinds to an earlier event (high school graduation, perhaps) only to realize that the work really needs to be conducted in an earlier time (a 16th birthday), he or she can continue to rewind to the appropriate time. Rewind can take the protagonist from present day to prebirth.

Fast forward: The protagonist can skip forward as much as desired to arrive at significant and meaningful scenes, which could include projected future scenes and even postdeath scenes. For example, the protagonist could play out the "successful" end to a future event, such as obtaining certain credentials, and skip over irrelevant material. The benefit of this projection is that it helps the protagonist figure out what steps need to be taken to achieve the goal.

Volume: The protagonist can turn the volume up or down to achieve a satisfactory level. Messages that are hard to hear or are unwanted can be projected in a very quiet tone, whereas the volume can be turned up to hear the positive messages loud and clear. For example, protagonists can rewind and replay a scene, raising the volume each time, consistent with their level of tolerance, to hear the stand-in say louder and louder, "Leave me alone," to an abuser.

Having a remote control to use in a drama gives protagonists a stronger sense of being in control, empowering them to go at the speed they can handle and to experience as much or as little of particular scenes as they can tolerate. A protagonist can play and replay a scene as many times as needed to further a healing process. This is a technique worth trying.

LINDA COMBS

Poetry in Psychodrama

Inherent in psychodrama is the evocation of images designed to lead the client to a new level of self-understanding and positive change. Directors use many avenues to warm up their group to begin the psychodramatic action. Occasionally, the action may lead to an expression that is the culmination of an individual's work as well as the stepping off place for new work. My own experience in an intensive psychodrama-training workshop culminated in an explosion of poetic expression, hitherto unknown to me, in which I dealt with an awareness of long-dormant feelings and emotions. The two poems presented here are the result of psychodramatic work and may be of use to the reader as warmups for future group work.

When I Was Ten

When I was ten, I was such a sensitive child.
  Every nuance of another was indelibly filed.
In my mind's eye, I saw rejection everywhere
  And thus walked about in pain and despair.
Whether or not a slight was meant,
  To my child's view—the twig was bent.
Perfection, too, was part of the game.
  Look good, do right, stay away from shame—
Such a sensitive child, so easily hurt,
  Always so fearful of walking in dirt.

A life filled with pain, that was me at ten.
  The grown-up me has memories of when
She was filled with joy, reaching out to another,
  But was not accepted, so she went under cover,
The cover of loss, emptiness, and pain,
  Heart hidden so long with nothing to gain.
The child in me has wallowed this way.
  Can I give her a voice, call her out now to play?
She's a part of my life—yes, that's for sure.
  If I acknowledge her now, I may find the cure.

She was sensitive, aware, thoughtful, and kind—
  Such wonderful traits in a woman to find.
Hidden away, she's my life filled with sorrow.
  Hidden away, she's an empty tomorrow.
Bring her to life, let her know she's okay.
  She's special, love and accept the part she can play.
Dear little girl, let me talk to you now.
  You are important; you must live, let me show you how.

Your feelings were real; you felt hurt—yes, that's true.
Rejections . . . perfections . . . much was heaped upon you.

Yet your sensitive soul and deep caring heart
Are needed by me as a new path I chart.
Dear little girl—so lost, so alone—
Wanting to laugh but so somber in tone—
All that was in you is now part of me.
Let me own your projections so I can be free.
So much of you was hid in a jar
Come with me now to a place that is far
From the poor self-image that was your world view
To see your real self—so valued, so true.

Little girl, little girl, wake up from your sleep.
Your unique qualities I really must keep.
Don't keep them hidden and buried away.
Come, little girl, I do want to play.
Can we laugh and let go of those feelings of yore?
Life now with you won't be a bore.
You need to speak up, give your feelings a voice.
Little girl of mine, you do have a choice.
Ten-year-old child, let go of your pain.
We've little to lose, but oh—so much to gain.

The Place Where I Stay

Life on the edge, it's the place where I stay
I don't really fit in, yet being out just isn't okay.
I walk around life as two people, it seems.
I must live in reality; there's no room for dreams.
But the Oz land is there when my heart can be heard.
The head message is different . . . I can't change a word.
So I'm stuck with what is, not with what could be.
My heart cries out for life. Little child, where is she?
Oh, she's safe, locked in the closet. Don't worry, my dear.
All her feelings are safe; they've been tightly locked there.
So I live on the outside, being strong, brave, and sure.
I'm okay. It's okay. Everything's fine. That's the cure.
Another me speaks from that tight, locked-up place.
Life is too busy to notice her cry; so I just stuff my face.
Two messages come—only one can be heard.
That poor little girl, she can't say a word.

These poems were an outgrowth of the process of participation in psychodrama from the perspective of protagonist, auxiliary, double, and observer participant. Often, individuals who find it difficult to reach feelings directly can be gently led to experience their own images by way

of this medium. Psychotherapeutically, this approach can encourage spontaneous poetry as an individual warmup. The approach can also be used during a reflective time after a deeply moving experience during an all-day or a weekend workshop when time for this can be allotted. People who have never written poetry or those who never thought they could might be led to experience not only giftedness within themselves but also insight and freedom.

JOAN M. JENNINGS

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.

The journal welcomes practitioners' short reports of approximately 500 words. This brief section is devoted to descriptions of new techniques, clinical observations, and results of small surveys and short studies.

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2. Each manuscript must be accompanied by an abstract of about 100 words. This should precede the text and include brief statements of the problem, the method, the data, and conclusions. In the case of a manuscript commenting on an article previously published in the *Journal of Group Psychotherapy, Psychodrama and Sociometry*, the abstract should state the topics covered and the central thesis, as well as identifying the date of the issue in which the article appeared.

3. The *Publication Manual of the American Psychological Association*, 3rd edition, the American Psychological Association, 1983, should be used as a style guide in the preparation of manuscripts. Special attention should be directed to references. Only articles and books specifically cited in the text of the article should be listed in the references.

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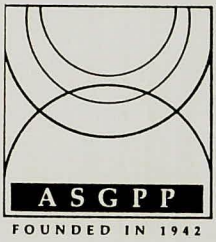

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The pioneering membership organization in group psychotherapy, the American Society of Group Psychotherapy and Psychodrama, founded by J. L. Moreno, MD, in April 1942 has been the source and inspiration of the later developments in this field. It sponsored and made possible the organization of the International Association on Group Psychotherapy. It also made possible a number of international congresses of group psychotherapy. Membership includes subscription to *The Journal of Group Psychotherapy, Psychodrama & Sociometry,* founded in 1947 by J. L. Moreno as the first journal devoted to group psychotherapy in all its forms.