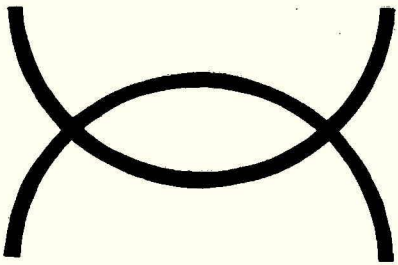
GROUP PSYCHOTHERAPY



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SOCIOMETRIC MEANING IN INTERPERSONAL RELATIONSHIPS

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As with a number of useful ideas which have come to us, it will probably not surprise anyone that Aristotle said it first. Speaking about man, the "political" (social) animal and his relations with others, he said, "Birds of a feather flock together." Empirical and experimental evidence support Aristotle's assertion and further suggest that those "birds" have a "pecking order," and that "flocking together" *makes* "birds of a feather." Social scientific investigations since WW I have revealed that groups are formed and rank their members because of a similarity of norms, standards, and values of the group members. The description and measurement of such interpersonal relationships are the subject of this paper.

Theoretical Considerations

Group formation and ranking might be explained in this way. Shutz (1960) has said that an individual in a group will want to achieve a sense of comfort and balance in three areas, (1) inclusion, (2) affection, and (3) control. That is, the extent to which he personally wants to be included in the group, to show or be shown affection, to control or be controlled by others. The extent to which this individual's comfort exhibits itself in behavior that represents group norms (the group's comfort level) will be a determiner of ranking in the group for that individual.

Another way of explaining group formation and ranking is with the internal-external systems theory of George C. Homans (1950). Homans would say that we rarely determine our goals, norms, standards, or values on an individual basis, but rather, they are determined for us by the groups we are members of. That there is a tremendous pressure to conform exerted by the group. That the groups which exert the strongest pressure are those which have the strongest ties to members, e.g. those where sentiment (affection) is greatest, where there is more frequent interaction, those where activities allow for interpersonal communication.

It might be said then that ranking in groups is determined by how well

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the individual comfort level described by Shutz fits the group system described by Homans. The individual will want to satisfy his sense of balance, harmony, and equilibrium. The group will want to determine its norms, standards, and values. Group structures and ranking will be a function of how well these two systems coincide. It is important to note that according to Homans, sentiment is the major factor in strength of group ties. That one's measure of inclusion is based on reciprocal feelings, and that inclusion and affection are, according to Shutz, two major elements of the individual comfort level. The feeling-affection-sentiment overlap of the two systems is obvious at least on the theoretical level, and is central in the sociometric measurement of group relationships.

Ranking in groups

In nearly all established groups, members are ranked and in turn rank others. The ranking may be implicit or explicit, may be rough or very precise. But one thing is virtually certain. The more a group member represents the norms, standards, and values of the group, the higher he will rank (See summary in Berelson and Steiner, 1964, p. 339 ff.).

Middle status persons are most likely to conform. They have the most to gain by conforming and the most to lose by deviating. They are most likely to be criticized for deviating or ostracized under strict and continuous social control. A high premium of group membership has a direct relationship to conformity. This means that people will tend to go along with the group. I believe that we are all familiar with the autokinetic effect explored by Sherif in 1935 and the Asch experiments done in 1951. The individual will normally resist conforming to group norms only if there are strong countervailing influences from another group to which he is conforming. For instance, highly popular teen-age girls tended to conform closely to neighborhood norms for popular music and disc jockeys. Fad and fashion norms are anchored in small groups of friends (Johnstone and Katz, 1957, p. 563).

However, there is an exception to this rule. Very secure high ranking members do not conform *as strictly* as others and are not subjected to such serious pressure to conform. Tolerance of "eccentricity" is normal in some groups because high status people provide services for the group and have more freedom from control (Riecken and Homans, 1954, p. 793).

High status is more innovative than low or mid status. A responsibility for innovation is assumed with leadership. Innovation brings esteem and authority. Whereas, low status non-conformity is more apathetic and deviant, against the norm rather than setting or extending the norm (Homans, 1961, p. 163).

The closer a person conforms to the norms of a group, the better liked he will be (Affection-Shutz; Sentiment-Homans). The better liked he is, the more he will conform. The less he conforms, the more disliked he will be. "Deviants are rejected while conformists become popular" (Argyle, 1957, p. 155). People want to be liked, so they will engage in actions that will tend to increase the esteem they receive from those around them, i.e. conformity.

Finally, different groups will have different norms and will rank their members differently depending upon group objectives, clarity of goals, member access to information, etc. (Bales, 1959, p. 299). It is clear, however, that groups rank their members based on feelings (affection, sentiment) arising out of the extent to which individuals represent group norms, standards, and values.

Sociometric theory

Social scientists have long been concerned about the problems inherent in man's interpersonal relationships because social relationships have a significant bearing on individual and group effectiveness. Moreno (1960 et al.) has developed sociometric concepts and tools that have yielded new and important understandings of complex social microcosms. (See Gage, 1963, p. 347 ff. and Hare, Borgatta and Bales, 1965, p. 99 ff.). Moreno did not originate the idea that groups had structures. Olson (1929), Loomis (1931) and Challman (1932) all had studied group structures on the basis of observation. However, Moreno, as early as 1931, was the first to develop a sociometric "test" and to structure a group according to expressed preference.

A sociometric "test" is a technique for eliciting responses from members of a defined social group about each other. The responses have direction and are essentially rankings. The results, once obtained, are usually presented in some diagrammatic or sociomatrix form. Moreno is responsible for the systematic development of this method for obtaining verbal choice responses and their subsequent representation. Most reports of the development of the sociometric "test" appeared in *Sociometry*, a journal which was under Moreno's direction until 1956 when it was acquired by the American Sociological Association.

Sociometric theory involves a special vocabulary to specify the way in which it describes interpersonal relationships. Three important terms are *tele transference*, and *social atom*

tele: A fundamental unit of attraction between members of a group and having two dimensions, projective or outgoing and retrojective or returning.

According to Moreno, "The trend toward mutuality of attraction of rejec-

tion many times surpasses chance probability." Moreno described it as being mathematically in direct proportion to the number of pair relationships, and in inverse proportion to the number of unreciprocated relationships.

transference: A "passing over" of tele or "identity." Increases in direct proportion to the number of unreciprocated relationships and in inverse proportion to the number of paired relationships.

A psychiatrist named Sullivan called transference a "parataxic distortion" because it is a "carry-over" from past experience, largely false-to-fact, more misleading than reliable, based on incident, accident, and irrelevancy.

social atom: The smallest living social unit, itself not further divisible (Moreno, 1953, p. 291).

As related to tele, the networks of the social atom are composed of tele (attraction, rejection, flow of feeling). Once a sociometric "test" has been devised and a sociogram or sociomatrix constructed, there are several other terms used to describe the configurations and occurrences within the structures of the social atom. These can be found in any standard reference on sociometry (See bibliography).

Sociometry and psychometry

The word "sociometry" is often confused with "psychometry," but there are fundamental differences between the words and the concepts. Psychometry is individual mental-psychological measurement. Sociometry is a testing of social structure and social sentiment. Psychometry doesn't measure group structure but sociometry does (Crisswell, 1949, p. 288). Sociometric focuses on the individual as part of a group rather than on the individual as an entity (Pepinsky, 1949, p. 39).

Lindzey and Borgatta (1954) say that a sociometric "test" is a rating scale in that members of the group are asked to rate the other members of the group in terms of their social desirability for sharing activities, but there are fundamental differences between sociometric "tests" and rating scales. Sociometric measures are more limited than rating scales in the variables they can be used to assess, and more restricted in the settings in which they can be employed. There is usually no need to train raters to engage in sociometric ratings. The rater is asked to use the same criteria he has been using all of his life to do something he is an expert in. To indicate whom he likes or dislikes, to what degree. To decide those with whom he would wish to interact or avoid. There are differences even in the ratings. Sociometric ratings are not impersonal, but are thought to be the result of rater-ratee interac-

tion. Because of these differences, Crisswell (1949) has suggested that "test" not be used to describe sociometry, but that "technique" be employed instead.

Sociometric validity and reliability

Scientific evaluation carries with it the conventional notions of validity and reliability. There are some limitations of scientific reliability applied to sociometric data. It is difficult to distinguish between the effects of memory and change. If a test-retest interval is long, real changes in group relationships will have taken place and the reliability co-efficient will have been lowered. In this example, "low reliability" is preferred because it distinguishes the modification of group relationships manifested in changed choice patterns. In fact, Lindzey and Borgatta (1954) say that high reliability may mean an insensitive instrument. Crisswell (1949) suggests comparing the instrument scoring to some other criterion and measuring the extent to which error variance is reduced.

Sociometric validity is also difficult. In most psychometric tests a trait is measured by eliciting related responses. For example, attitude is measured by asking opinions and answers can be compared to data gathered by psychological testing. But in a sociometric test, the sample is drawn *from the behavior studied.* Under such conditions, the predictor is the same as the criterion. However, once sociometric choice behavior is used to describe more general traits, it becomes, for scientific purposes, the same as a psychometric test, and can be subjected to validation against a suitable criterion.

Pepinsky (1949) says that sociometric validity finally rests on being sure that the responses obtained are not falsified. This would mean that the test have face (appearance) validity, that there be rapport between the experimenter and Ss., that Moreno's criteria of actual reorganization (for "built-in" validity) actually take place.

Gronlund (1959) reviewed literature on sociometric validity and reliability. He reported that he found the internal consistency of sociometric tests to be high and stability over time to be high also, varying with time interval. As to validity, Gronlund found that sociometric tests have been found to be sufficiently related to Ss behavior outside the testing situation. He said he found it to be more related to social adjustment than to personal adjustment.

Sociometric-semantic synthesis

At the cost of oversimplifying, it would appear that Korzybski (1950, 1958) was essentially concerned about two things: (1) that people behaved as if words were things, and (2) that people assumed that their abstractings

and meanings were the same as everybody else's. It is important to note that instead of talking about "meanings," Korzybski referred to "semantic reactions." He suggested that a great number of the ills of the world were traceable to a lack of correspondence between the perceivable world and the "semantic reaction" inside. He further suggested that a greater harmony in interpersonal relations might be achieved if the world were more "scientific" and hence more "sane." That is, if people observed objectively, defined operationally, and judged rationally. He held that science was sane, and that the applicability of the scientific method to social ills was bound to improve the *status quo*. Korzybski's suggestion was largely ignored, and the *status quo* has sadly degenerated from chaos to catastrophy.

It would appear that there is considerable overlap between the methodologies of Moreno and Korzybski. That which Korzybski advocated is what Moreno accomplished. In very simple terms, Moreno made objective, scientific, and measurable—that which was subjective, personal, and emotional. He opened the door on the science of interpersonal relationships by describing interpersonal "meaning," by measuring "semantic reactions" of attraction and rejection that people have toward each other.

Obviously, we don't only react to words; we react to people depending upon what we abstract about them. Let me specify. Tele is a semantic reaction based on a factual relationship. Let me remind you of the importance both Shutz (1960) and Homans (1950) ascribed to feelings-affection-sentiment, and say that tele is that relationship scientifically defined and measurable. Transference is, again, a semantic reaction, but one which is non-scientific, based not on Korzybskian fact-territory abstractings, but upon faulty abstractings of an un-indexed and un-dated variety. I believe that transference is what Korzybski called "identification." Clearly, training in general semantics holds considerable promise for reducing transference in interpersonal relations, for making them more "sane."

Secondly, it seems to me that the presentation of sociometric data in sociogram or sociomatrix form is again an example of making objective and scientific, that which is subjective and emotional. Changes in time and changes in relationships (dating and indexing) can be rendered in elaborate overlays, three dimensional models, or with matrixalgebra. It seems rational to want to understand relationships before tampering with them. These display techniques describe the relationships so they then can be experimented with.

Which leads to a third point. Sociometry is not only a research method-

ology, but an action methodology. Once the relationship is exposed, it can (if deemed appropriate) be changed. The methodology has direct application to daily living in the world around us because it tells us:

1. How to organize large aggregates into small face-to-face groups.
2. How to develop compatible groups.
3. How to organize efficient groups with members who get along with one another.
4. How to adapt a group to a specific task.
5. How to identify group leaders, followers, etc.

But there is a reciprocity apparent in the works of the two men, Moreno and Korzybski. For all of the scientific promise sociometry has for objectifying the "semantic reactions" of interpersonal relations, there is also the potentiality of the application of general semantics to sociometry. An obvious example would be the tendency of a researcher to identify his symbols on a chart or numbers on a line as if they were more than high order abstractions.

It would also appear that the two methodologies could be used conjointly, and that such a usage could be productive. Both men were concerned about the problems and ills of the world. Such problems, so far as I see, tend not to be content problems, but to be "people problems." It is apparent that sociometry can describe aspects of interpersonal relationships essential to group structure and that this "meaning in people" is one of the provinces of general semantics. The relationships as well as the "reactions" can be understood, and hopefully, can be remedied.

But there is still much to know. Both methodologies are in their infancies and need development. Apart from the critical synthesis already implied here, I would also suggest factor analyses of the relationships between sociometric choice and psychological profiles. I suggest investigation into the relationships between sentiment-affection-liking and conformity. I suggest the investigation of transference as a semantic disorder. I suggest correlation investigation between sociometric choice and sociological attitude data. I suggest that new instruments for measuring meanings be developed and that instructional instruments be developed for moving the findings from the academic world to the streets. The infinite variety of social ills are too enormous to undertake totally, but a semantic-psychometric-sociometric investigation of *conflict* looms before us so importantly on the local, national, and international scene that it can hardly be ignored. It appears to me that general

semantics has long overlooked the potentiality of sociometry for accomplishing its (general semantics') ends. It can only overlook the potential now at a tremendous cost in time and effort.

Such research as I've suggested should yield insights into who ought to communicate what, and when, and to whom to alter Aristotle's "birds of a feather" from "hawk" or "dove" into man, the social animal who is able to see the grey between the black and white, and cope with his feelings about it.

References

ARGYLE, MICHAEL. *The Scientific Study of Social Behavior,* New York: The Free Press, 1957.

BALES, ROBERT F. "Small Group Theory and Research" in Robert K. Merton, et al. (eds.), *Sociology Today: Problems and Prespects,* New York: Basic Books, 1959.

BARBOUR, ALTON. "Making Uncommon Sense" in Louis E. Glorfeld, *A Short Unit on General Semantics,* Beverly Hills, Cal.: Glencoe Press: 1969.

BERELSON, BERNARD, & GARY A. STEINER. *Human Behavior, An Inventory of Scientific Findings,* New York: Harcourt, Brace and World, Inc., 1964.

CHALLMAN, R. C. "Factors Influencing Friendships among Pre-school Children," *Child Devel.,* 1932, 3, 46-158.

CRISWELL, J. H. "Sociometric Concepts in Personnel Administration," *Sociometry,* 1949, 12, 287-300.

GAGE, N. L. (Ed.) *Handbook of Research in Teaching,* Chicago: Rand-McNally, 1963.

GRONLUND, N. E. *Sociometry in the Classroom,* New York: Harper, 1959.

HARE, A. PAUL, EDGAR F. BORGATTA, & ROBERT F. BALES. *Small Groups: Studies in Social Interaction,* New York: Knopf, 1965.

HOMANS, GEORGE C. *The Human Group,* New York: Harcourt, Brace Inc., 1950.

HORST, P. "A Generalized Impression of the Reliability of Measures," *Psychometrika,* 1949, 14, 21-32.

JENNINGS, H. H. *Leadership and Isolation,* New York: Longmans, Green, 1943, 1950.

JOHNSTONE, JOHN, & ELIHU KATZ. "Youth and Popular Music: A Study in the Sociology of Taste," *Amer. J. Sociol.,* 62, 1957, pp. 563-68.

KORZYBSKI, ALFRED. *Science and Sanity,* Lakeville, Conn.: International Non-Aristotelian Library Publishing Co., 4th Ed., 1958.

LINDZEY, G., & E. F. BORGATTA. "Sociometric Measurement" in G. Lindzey (ed.), *Handbook of Social Psychology,* Cambridge, Mass.: Addison-Wesley, 1954, pp. 405-448.

LOOMIS, A. M. "A Technique for Observing the Social Behavior of Nursery School Children," *Child Develop.,* Monograph, 1931, No. 5.

MORENO, J. L. "Sociometry in Action," *Sociometry,* 1942, 5, 298-315.

MORENO, J. L. "Sociogram and Sociomatrix," *Sociometry,* 1946, 9, 348-349.

MORENO, J. L. "The Three Branches of Sociometry, A Postscript," *Sociometry,* 1948, 11, 212-128.

MORENO, J. L. *Sociometry, Experimental Method and the Science of Society,* New York: Beacon House, 1951.

MORENO, J. L. *Who Shall Survive* (Rev. Ed.) New York: Beacon House, 1953.

MORENO, J. L., & H. H. JENNINGS. "Statistics of Social Configurations," *Sociometry,* 1938, 1, 342-374.

MORENO, J. L., H. H. JENNINGS, & J. SARGENT. "Time as a Quantitative Index of Interpersonal Relations," *Sociometry,* 1940, 3, 62-80.

MORENO, J. L., H. H. JENNINGS, & J. SARGENT. "Time as a Measure of Interpersonal Relations," *Sociom. Monograph,* 1947, No. 13.

MORENO, J. L., et al. (eds.) *The Sociometry Reader,* Glencoe, Ill.: The Free Press, 1960.

OLSON, W. C. "The Measurement of Nervous Habits in Normal Children," *Univ. of Minnesota Inst. Child Welf. Monograph,* 1929, No. 3

PEPINSKY, P. N. "The Meaning of 'Validity' and 'Reliability' as Applied to Sociometric Tests," *Ed. Psych. Meas.,* 1949, 9, 39-49.

RIECKEN, HENRY, & G. C. HOMANS. "Psychology Aspects of Social Structure," in Gardner Lindzey (ed.) *Handbook of Social Psychology,* Cambridge, Mass.: Addison-Wesley, 1954. Vol. II.

SHUTZ, WILLIAM. *The Interpersonal Underworld,* Palo Alto, Cal.: Science and Behavior Books, Inc., 1960.

THE DEATH SCENE IN PSYCHODRAMA

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INTRODUCTION

> How do we react if we become aware of the inescapable end contained in our future? Are we able to take it, to make its anxiety into a courage that faces ultimate darkness? Or are we thrown into utter hopelessness? Do we hope against hope, or do we repress our awareness of the end because we cannot stand it? (Tillich, 1951)

No matter how bright a man's existence, his life is cast in the shadow of tragedy. He must experience in his particular being the cosmic law that all who are born must die. Yet against this linear progress are natural events which serve as metaphors of hope. The cycles of day and night, of summer and winter, all suggest a return, an eternal return, a process in which death is followed by rebirth. The reconciliation of life to death and the promise that death is the gateway to a new life is the source from which fertility myths, and the great religions of East and West draw much of their power.

Much of contemporary society, however, treats the tragedy as if it were an obscene farce, shrouding its reality by keeping it from public view and burying its implications in guarding euphemisms. A notable exception to this trend has been the Existential emphasis on the significance of death, experienced both psychologically and biologically, as the means which the individual defines himself. Unless a man takes his own life, he has no control over his own death. Every choice he makes becomes meaningful, becomes heroic, becomes a responsible commitment when the individual makes that choice with the knowledge of its potential irrevocability. Therefore, each choice represents a confrontation with death and an affirmation of his own existence, an affirmation of life.

Psychodrama too is a matter of life and death, but it creates an immediacy, a sense of *hic* and *nunc*, which takes it beyond Existentialism, at least as expressed by Heidegger and Sartre (Moreno, 1959a). In psychodrama, death becomes psychological reality, not intellectual choice. For the protago-

nist, the simile—as if facing death—is transformed into the experience of being dead. Further, having experienced death of his old life, the protagonist can use the experience to achieve a meaningful new one.

While the thrust of psychodrama is toward reaffirmation of life, the death scene acts as something of a play within the play. In the death scene, the protagonist is moved toward death, confronts it and judges the meaning of his life. Having encountered death, he is then in *tele* with the audience (Moreno, 1950). He is made aware that his experience is his alone, yet that of everyman. Unlike the everyman of the medieval morality play, however, he is reborn. It then becomes his choice whether his will be a rebirth or a still birth.

Before discussing the structure of the death scene and the techniques used in its various movements, a note of qualification must be strongly sounded. The brief analysis to follow represents a synthesis of individual observations, not a rigid prescription for how a death scene should be done. In keeping with psychodramatic tradition, the structure emerges from the individual's needs; the decision to use a particular technique at a particular point arising spontaneously from the situation.

The Confrontation

> Shape without form, shade without color,
> Paralysed force, gesture without motion;
> Those who have crossed
> With direct eyes, to death's other kingdom
> Remember us—if at all—not as lost
> As the hollow men (Eliot, 1948)

During the early part of psychodrama, the protaganist's problems have been explored. The patterns of his personality and sources of his anguish have emerged. Now the director moves the protagonist to a confrontation with death.

The lights are dimmed, the stage is cleared, silence is maintained. The protagonist is asked to speak, to tell what it felt like to die, what it feels like to be dead. He usually reports feelings of fear and often despair. He can no longer undo anything which has been done, or do anything that remained undone. The time for choice seems over. All that is left is reflection, a re-examination, a re-evaluation of a life already lived.

The protagonist, however, is not allowed to remain in this state. If he has displayed great rage or hostility he is introduced to a Mephistopheles, who tells him that he has power and inclination to give the protagonist what

he desires—revenge. If the protagonist agrees to bargain with Mephisto, he is allowed to act out his revenge. The Catharsis of his pent up hostility permits him to experience the positive feelings which his rage has blocked. Sometimes the protagonist, in the midst of extracting his revenge, finds what he wants is not revenge at all, but love from the other. This too then finds expression.

If the protagonist is self-involved, unable to relate to others or unsure of his identity, he is introduced to St. Peter, a kindly, elderly, gentleman who expresses surprise at the protagonist's being there and begins to interview him. Starting innocuously, St. Peter moves to questions concerning the protagonist's ability to take responsibility, to act meaningfully and to form close relationships. After the protagonist defends himself, the director asks him to call up a person he is sure he can rely on to corroborate his statements. The two reverse roles and the protagonist, speaking as his friend, is asked to describe the protagonist's failings. The two reverse back and St. Peter asks the protagonist, as himself, to state how he might have changed things had he still been alive.

The Judgment

> "Maybe I did not live as I ought to have done," it suddenly occurred to him. "But how could that be, when I did everything properly?" he replied, and immediately dismissed from his mind this, the sole solution of all the riddles of life and death, as something quite impossible. "Then what do you want now? To live? Live how? Live as you lived in the law courts when the usher proclaimed 'The judge is coming.' The judge is coming, the judge," he repeated to himself. "Here he is, the judge. But I am not guilty!" he exclaimed angrily. "What is it for?" (Tolstoy, 1958)

A judge enters and instructs the protagonist to choose members of the audience to act as jurors. The protagonist is appointed counsel for both the defense and the prosecution. Because he is advocate for both sides, he can articulate much of his inner conflict, stating the case for and against himself as pointedly as possible.

While the protagonist is addressing the jury, the jury represents both the externalization of his own conscience and the collective conscience of the group. They will weigh the evidence and reach a verdict. However, when the protagonist finishes his presentation, the jurors are instructed not to judge him, but to share with him their own feelings and experiences related to his own. His self exposure, instead of bringing condemnation and isolation, has brought reaffirmation of his humanity and his place among men (Moreno, 1959b).

But the trial is not over. The judge gives his office to the protagonist. No one is allowed to judge the protagonist except himself, but this he must do. *He* is responsible. The stage is cleared. The protagonist stands, once again, alone. He alone delivers the verdict.

The Rebirth

> He could move if he wanted: he knew that. But he had no want. Who would want to come back from the dead? A deep, deep nausea stirred in him, at the premonition of movement. He resented already the fact of the strange, incalculable moving that had already taken place in him: the moving back into consciousness. He had not wished it. . . . (Lawrence, 1928)

How will the protagonist use his insights? Like Dante, he returns to life, having seen what death has in store. But the protagonist's Virgil, the director, has brought him to a confrontation with death in all its immediacy, not in a dream. He must now make a choice. He may return to the same situations which he transcended briefly on the psychodrama stage and fall into the same pattern which had originally held him captive. Or he can move back into the world, not as an observer or a victum, but as a protagonist, taking the leading part and responsibility for his own life.

REFERENCE:

1. ELIOT, T. S. *Selected Poems* London: Faber & Faber, 1948.
2. LAWRENCE, D. H. *The Man Who Died.* N.Y.: Knopf, 1928.
3. MORENO, L. J. "Existentialism, Daseinsanalyse & Psychodrama," *Psychodrama*, Vol. II, Beacon, N.Y.: 1959(a), 207-218.
4. Moreno, J. L. "Hypnodrama & Psychodrama" Group Psychotherapy. 3,1:1-10. April, 1950.
5. MORENO, J. L. "Tele & Transference," *Psychodrama*, Vol. II, Beacon, N.Y.: 1959(b), 84-86.
6. TILLICH, P. "The Eternal Now," in *The Meaning of Death*, Herman Feifel (ed), N.Y.: McGraw Hill, 1959.
7. TOLSTOY, L. "The Death of Ivan Illich," in *Ten Short Novels*, L. Hamalian & E. Volpe (ed.), N.Y.: Putnam's, 1958

SOCIODRAMA AND PSYCHODRAMA WITH URBAN DISADVANTAGED YOUTH

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"Upward Bound" is a program developed by the United States government in conjunction with various colleges and universities throughout the country. It is an educational experience used as a tool to motivate urban disadvantaged youth to attend college or some additional training beyond the high school level. As part of the War on Poverty, administered by the federal Office of Economic Opportunity, Upward Bound attempts to involve the youngster's total environment—their homes, communities, schools, and, their biggest deterrent, their own self-confidence.

High school students from poverty backgrounds, mostly in the 10th and 11th grades, are selected by the directors of the Upward Bound projects on the basis of recommendations obtained from teachers, counselors, local anti-poverty agencies, welfare workers, or others who know the student. It is not necessarily the "A" student who is sought, but rather the youth whose ability may be lost to society unless he can be properly motivated. Thus, directors search for teenagers who have been denied the access, the broad vision, and the opportunity to develop their own talents and brains commensurate with their natural potentials.

The program consists of a full-time summer residential phase, during which the students live on the college campus for six to eight weeks, and take courses in English, history, chemistry, math, and reading. This is then followed up with tutoring, counseling, and various activities planned for the students throughout the normal academic school year. Students remain in the program, while attending their regular high schools, until they graduate. The summer directly following high school graduation, the student remains with Upward Bound in a bridge program which prepares him for independent college study and life.

Colleges and universities with residential facilities run the Upward Bound projects and are staffed with both university and high-school teachers, experts with skills in specific fields, and undergraduate students who serve as tutor-counselors. In addition, trained counselors and social workers are employed to help both the students and their families with any individual problems that may arise.

Mundelein College, a Catholic women's college in Chicago, Illinois,

which is administered by a community of nuns of the B.V.M. order, began their Upward Bound project at the inception of the federal program in the summer of 1966, and each year since, has worked with a group of 55 disadvantaged girls, predominantly Negro, from the inner city of Chicago.

During the first term of the program, there were discipline problems, stealing among the girls, in-group and out-group problems, covert racial conflicts, and other implicit problems that the staff was unable to deal with effectively in their regular one-to-one counseling sessions. The second summer, in an attempt to avoid these destructive operations and to achieve a more cohesive group, the directors hired my assistant and me to conduct psychodrama and sociodrama sessions, in the hope that these methods would help to bridge the gaps needed to prepare these economically, culturally, and educacationally disadvantaged teenagers for college and for society. At this time Mundelein College was the only school in the country to add a psychodramatist to their staff and to incorporate psychodrama sessions as a regular part of the program's curriculum both during the summer residential phases as well as in the continuing activities during the school year.

Before beginning work the summer of 1967 an orientation was held for all the staff members. During this orientation various experts in the areas of urban problems, the inner-city youth, and the black student in a white world lectured on the educational, socio-economic, and cultural differences between the Upward Bound student and the typical middle-class high school student. It was through the psychodrama sessions, however, that all participants in the program became acutely aware that the innate human problems that prevent the realization of potentials are the same for everyone, regardless of whether they are black or white, rich or poor, or come from the suburbs or the slums.

Sociodrama and psychodrama were added as a non-academic element into the Upward Bound program in an attempt to help the girls explore some of the problems of growing up, to help them expand their perceptions, and to learn to live creatively.

Our work began slowly as the students and staff were anxious, hesitant, frightened, and some were far from convinced that the method would be effective. We began by gaining the trust of the participants through spontaneity exercises and sociodrama, and the group slowly moved from one of nervousness and hesitancy into one filled with spontaneous and creative individuals.

Three main areas of relationships were worked on that summer, primarily through the method of sociodrama: student-teacher relationships, parent-child relationship, and peer relationships. In the first week of the program,

after discovering that a particular class was having discipline problems, we called upon faculty members to play the teachers, and troublesome students to replay their classroom behavior during a sociodrama session. The results of the session were revealing for both sides. In role reversal, the teachers cast as students concluded that "This material is pretty dull," and the students, playing the roles of teachers facing a rebellious class, were terribly frustrated. The session led to an actual confrontation between the students and the teacher in which the issues were brought out and settled. The class was then able to function without further difficulty for the remainder of the summer.

In another session, dealing with the upcoming prospect of meeting a new roommate at college, a student who showed extreme nervousness and fear at having to meet and live with a virtual stranger, handled herself with poise and confidence when faced with the actual situation a week later.

The students' relationships with their parents was another area on which we spent many sessions trying to alleviate some of the problems. Besides the inevitable "generation gap," the Upward Bound students are faced with trying to explain to their parents, most of whom have limited educational backgrounds, what they are learning and why they want so desperately to be able to continue their educational training.

As the program developed through the summer and into the fall, the sessions progressed into personal psychodramas, sensitivity training, concepts of trust and risk, and self-confidence. The work became a two-edged sword and we discovered that we must not only train and motivate these young people toward college and beyond that for a better life, but that each of them must also learn to cope with his immediate local environment—the ghetto, the slum, the fatherless home—as hostile as it is. The students came to learn that things could in fact be changed, and that they could break the seemingly endless cycle into which they had been born.

Although many new girls entered the Upward Bound program in the summer of 1968 there was no difficulty in introducing the newcomers to the method. The summer was spent working further on the ever-present problems of youth: lack of self-confidence, in-group and out-group conflict, fear of meeting new people and new situations, inability to communicate with parents, and trouble in coping with a world involved in a gruesome war overseas, and involved in a great racial turmoil in their own backyards.

It is difficult to present a completely scientific and objective evaluation of the uses of sociodrama and psychodrama with this particular group of Upward Bound students. As mentioned earlier, Mundelein College was the only participating school to use a psychodramatist on the staff. Also, the en-

tire group of girls and staff, including nuns, lay teachers, and counselors, participated in the sessions, so we can make no comparisons between control and experimental groups. Thus, all we can offer is our own observations, those of the staff, and the comments made by the Upward Bound students themselves in terms of the value of these methods in conjunction with the standard Upward Bound program.

Both the students and the staff of the Upward Bound program benefited and gained insights from the sessions. The techniques of psychodrama, such as role reversal and doubling, helped the girls to see the reasons behind their own feelings and behaviors, and to view other peoples feelings in a new light. The sessions enabled both the students and the staff to look at people and situations without the traditional stereotypes as blinders, and to see that their own doubts and fears are not exclusive, but are rather, part of being human.

The use of sociodrama and psychodrama helped to establish the bonds which linked the Upward Bound students to the faculty and the tutor-counselors by instituting a cohesion between the academic phase of the program and the day to day personal living. Staff members reported that the sessions enabled them to better see what was going on inside of the students, and thus helped them to gear their teaching programs more effectively. In a written evaluation of the sessions one staff member said, "The orientation meetings and staff discussions about the girls and their problems were clarified during the psychodrama sessions with an immediacy that cannot be achieved with mere verbal discussion. The sessions touched me deeply and were the best experience I had in the program."

The students were also invited to anonymously comment and evaluate the sessions in terms of both personal feelings and how the group as a unit was affected. Out of this came such statements as:

"I was helped to find solutions I had never thought of before."
"I overcame shyness and learned I can communicate with self-confidence."
"The sessions helped the group get along together."
"The sessions showed our common problems and helped to work them out."
"The sessions enabled us to let off steam in a safe way."

Most significant to us, however, were these evaluations given by the program directors:

> Through the sessions many problems were aired early, thus preventing possible serious and destructive occurrences. The sessions allowed the students to break out of old patterns and expectations, and to rework

heretofore unsuccessful situations. In addition, the experience helped them to see that the future can be anticipated, planned for, and is not as terrifying as they had previously thought.

The sessions put many of our students in touch with their inner feelings for the first time in their lives. We feel the rare opportunity to participate in a situation where trusting is built into the experience was, in itself, a great contribution.

Since this program is an experiment in interracial living, psychodrama allows each of us to experience the commonality of our humanity, our problems, and our feelings. Not only did we share across racial lines, but also across generation lines, class lines, and roles. This deepened the understanding of each participant, and freed him to be himself and to learn.

At this time, several other Upward Bound projects have already begun to incorporate sociodrama and psychodrama into their regular program, and it is hoped that other colleges and universities will follow suit in the near future. Although the observations and evaluations we have obtained are necessarily subjective, the directors of the program feel that they are impressive enough to warrant both the continued study and use of psychodramatic techniques with urban disadvantaged youth.

AN EXPLORATION OF PSYCHODRAMA

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During the period October 6, 1967 through December 26, 1967, regularly scheduled groups of boys participated in a pilot project to determine the effectiveness of psychodrama in a training school setting. Four groups of a half dozen boys each met once a week in two hour sessions for ten weeks. These boys had been selected randomly from a sample of 100 consecutive admissions to the training school during the Spring and early Summer of 1967.

METHOD

Preliminary meetings were held in the first and second weeks of October. Immediately much group interest and support were generated. As the groups met on a regular basis, confidence of the members developed so that the most intimate and personal situations were discussed. The group shared common feelings and experiences and reinforced and supported protagonists in psychodrama. The boys under direction played some of the roles normally taken by professional workers (auxiliary ego, double, etc.) in the "Moreno" sense of the word.[1]

Boys were told that membership was voluntary and that remaining in the group was likewise their own decision. This freedom to leave the group was intended as an avenue of escape for any boy who was not equipped to handle either his own problems or the problems that might be presented by peers.

One innovative technique for "warming up" was the introduction of a play period. In the first three or four sessions, fifteen minutes of free-play with a basketball helped to unify the boys into a functioning group.

CONSULTATION

In addition to attending seminars at the Moreno Academy (World Center for Psychodrama, Sociometry and Group Psychotherapy) at Beacon, New York, the Psychodrama Director used academy personnel as consultants.

Regular and intensive consultation also was provided by a Warwick

[1] Moreno, Jacob L. *Who Shall Survive?* Beacon House, New York: 1934, New Edition 1953.

psychiatrist.[2] Administrative supervision was provided by the Warwick psychologist. Regular contacts with social workers provided continuity and coordination between psychodrama, social worker and other phases of the program.

Findings

Although boys understood that participation in psychodrama was voluntary, none of the boys left the groups permanently although some missed a session or two after the content had become too highly charged. The discovery that training school boys, despite stresses of confinement and pre-adolescence, could deal with previous and current life problems in the psychodrama setting was perhaps the most important finding of this study for Warwick's clinical personnel. (Although psychodrama is a regularly budgeted feature of numerous institutions throughout the world, this was its first exploration at Warwick.)

After the first meeting the sessions began to deal with events and scenes from the past more often than from the immediate time dimension. However, any boy who came to a meeting anxious to release feelings accruing from current stress was permitted to do so. Such ventilation was referred to more pertinent life data.

The direction of any particular psychodrama was unpredictable; for example, M. introduced his proposed scene by saying that he was going to tell us about witnessing the assault on his father and then watching the slow, subsequent, dying process. An hour and a half later the group was discussing M. and his anxieties about his mother's sexual behavior.

Another boy, C., began by saying "I want to tell you about when I stole a car," and he did. However, at the next meeting, continuing his psychodrama about compulsive car stealing, he revealed his guilt about a younger brother's accident and his interpersonal problems with his family. He began to express insight regarding his compulsive car stealing as he proceeded in psychodrama.

R.'s casual and seemingly disconnected session suddenly became pointed as he revealed morbid feelings of guilt concerning his mother's nervous breakdown. The role of psychiatrist was proposed by the Director whereby Robert would try to find out what role he really had played in his mother's breakdown. In this scene an extremely perceptive boy, playing an unrehearsed role as a psychiatrist, said to R. "a person is like a lump of clay; you build it up, up and up but sometimes, when you keep adding to it, it gets too heavy and it cracks." The relief that R. achieved from discussing his problem (plus

[2] The writer is indebted to Dr. Francisco More for perceptive support and stimulating consultative advice throughout this pilot project.

the relief gained by receiving similar assurance after being referred to a real life psychiatrist) seemed to help him. In the following months his overall behavior improved: he was removed from Visual Supervision,[3] his medication was ended and he was released, not as a "cured" nor totally stable person, but as one who finally had faced some problems in himself.

The sessions themselves were often very instructive diagnostically. Boys who had been seen many times during their dealings with professional workers revealed, for the first time, suicidal urges, auditory and visual hallucinations, and the like. These were later confirmed by psychiatrists and treatment was initiated as a result of such findings. Often a non-participating boy would suddenly change his posture within the group and become active. On the other hand the apparently non-participating boy was often as deeply involved as the highly involved boys who participated in "action scenes."

Some of the boys who had difficulty within the group were also seen on an individual basis. In some instances these additional meetings helped the boy achieve enough confidence either in himself or in the group so as to become more "active."

Evaluation

Boys in psychodrama groups tended toward a shorter length of stay than did control group boys. Twice as many group boys had stays of more than ten months. Although the difference between psychodrama boys and their controls was not statistically significant, the ten sessions of psychodrama appeared to help some boys to achieve a shorter stay in the training school. The direction of this trend suggested that it might be worthwhile to introduce psychodrama early in the boy's training school program for more rigorous evaluations than was possible in this pilot study.

A statistically significant difference was found in terms of honor rolls achieved during the experimental period. Many more psychodrama than control group boys were on the Superintendent's Honor Roll which requires achievement of three subsidiary honor rolls (school, cottage and vocational).

A statistically significant difference was found between the number of serious infractions of rules committed by psychodrama and control groups during the three months prior to and the three months of psychodrama. Although psychodrama boys accounted for 23 of a total of 43 infractions by both treatment and control groups prior to treatment, they were not reported for any infractions during the treatment period.

[3] Boys listed for "visual supervision" at the training school are very closely supervised because of suicide, runaway or other risks.

SOME ASPECTS OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA USED IN A MODERN RELIGIOUS CULT

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In late 1967 there arrived in New Orleans a most unusual group whose function was, they said, psychotherapy and religion. They called themselves "the process," purporting a dynamic and evolving system of thought. Their ostensible goal was to promote interpersonal contacts and self examination among their followers, with the promise that this would ultimately lead to discoveries of new religious truths.

We as psychotherapists are interested in the kinds of relationships that alter behavior and thought and should be aware that conventional psychotherapy is not the only process that is effective in doing this (1). It was, therefore, decided to study this group with particular attention to techniques that are similar to or different from the psychotherapy process, and to the kinds of alteration of behavior that are sought and that are achieved.

The author attended their meetings toward this end, including basic courses offered by the group over a six-week period.

DESCRIPTION OF THE GROUP AND ITS BACKGROUND

Seven members of the Process arrived in New Orleans from London in October of 1967. Their appearance was dramatically charismatic. The six male members wore beards, shoulder length hair, and all wore a costume of black trousers and blouse with a purple cape. The dramatic effect was heightened by the accompaniment of each member by a large German Shepherd dog during public appearances and at their meetings.

Two additional members have since arrived from London, and two have moved to San Francisco to establish the Process in that city.

Besides their dramatic costuming, the Process members have given themselves names which are emotionally stirring and symbolically authoritarian to persons of Judaeo-Christian background. Christian Immanuel, Aaron, Joseph, Micah, Joshua, and Joel Maximillian are examples. Changing of names symbolizes an alteration of basic identity within the process of group interaction. The promise of a new name and new identity appears to be a motivating factor for followers of the group.

Process leaders are uniformly youthful, ages ranging from 21 to 31

years. With the exception of one woman of South African origin, all were born in Britain. Backgrounds of the members are variable. Three of the original seven members were trained architects. Several were dissatisfied Oxford students who "dropped out" to form the Process and one was a former palmist fortune teller.

The present organization is a hierarchical system of three major levels. *Messengers* are members who have attended basic courses, accepted the religion, and entered individual analysis with an appropriate Process leader. *Prophets* are more advanced members who are felt to possess a high-level of self-awareness and leadership ability. Prophets conduct most of the basic courses in communication and religious philosophy.

Group Activity

Prospective members first attend meetings presided over by Micah, a Prophet who specializes in initiation of new members. He explains that the Process is primarily a religious organization, but that members may not be prepared to communicate with God until they have mastered communication with each other. A statement is made that most people nowadays suffer from a painful state of anxiety born of isolation, and that a state of peaceful openness and readiness for religious experience will be achieved in the Process as a result of intensive communication and mutual acceptance. An organized kind of member participation is then requested, each person in turn being asked to say what is the essential thing about himself that he communicates to other persons throughout the day. The Prophet discusses these communications, then asks for another round of group participation in answer to a question such as "What is the most important thing in the world to you" By means of a series of such questions and rounds, each individual communicates increasing bits of himself to the group, the amount of communication from each participant being significantly neither more nor less than that of any other. The Prophet-leader remains at all times in control of the amount and kinds of communication being expressed.

After attending several such introductory meetings, participants are informed that they are ready to attend communications courses, which meet twice weekly. By this time a kind of natural selection has taken place among interested participants, most of the membership being "hippies," although a few college students are included.

Communications meetings are conducted by Prophets who specialize in this activity. All are opened with a highly structured ritualistic group participation exercise called a "round of successes and failures." Members are

asked in turn to state brief examples of a personal failure which has taken place since the last meeting. Each communication is followed by a stereotyped acknowledgment ("right" or "good") from the prophet-leader. Then an example of a personal success is offered and acknowledged.

This ritual is followed by pairing of members and the performance of "touch exercise." One of each pair is designated as student and the other as instructor. The student is then commanded by the group leader to touch the instructor in a variety of ways, e.g., "Students, touch the instructor's face." Instructors are then told to tell their students how they felt about the touches, especially whether they felt fear was conveyed through tremulousness or moist palms or whether or not they sensed the student was comfortable in performing the touch. Another series of touches is performed, then roles of student and instructors are reversed and the process repeated.

Communications exercises follow. The group remains in pairs and is told the objective is to achieve by direct questions, replies, and acknowledgments, a unique encounter with another person which would reveal some important philosophy, attitude, or life style of that person which could enrich and enlighten the interrogator. The group leader circulates around the room as questions and replies are being exchanged, occasionally interrupting to insist that questions be kept intensely personal and aimed at producing an increasing knowledge of the interrogated.

There follows a didactic lecture from the group leader with a philosophical or religious theme.

As members become proficient at communications courses, they are graduated to a "Second Process" group which generally involves practice and instruction in specific communication techniques, including nonverbal techniques, such as being able to convey silent acceptance by facial expression, unflinching eye to eye contact, *etc.*

The final stage in the evolution of a Process follower is the acceptance of the system of religious thought. This involves the worship of one of three gods: Jehovah, Lucifer, and Satan. Process members are helped to "identify" with one of these three deities and conform to the presumed wishes of their individual god in their subsequent behavior.

Jehovah is presented as a god who demands self denial and suffering. Lucifer is said to prefer that the instincts of man be acted out, but in creative and artistic ways. Satan prefers undisguised sensual experience. The coexistence and interdependence of worshippers of such diverse deities is rationalized as a coalition of these gods to end creation. At a social level this is

experienced as mutual support in rebelling against the attitudes of most of society.

Discussion

Although the Process group members are not trained in any way in psychotherapy techniques, they have evolved techniques for influencing behavior. Some of these are similar to psychotherapy and some are quite different.

The use of group sanctions is apparent. A magical atmosphere promoting regression and dependence is brought about by the charismatic appearance and rather grandiose religious self naming of Process leaders. The anticipation of magic facilitates expectancy and hope of change, important factors in successful psychotherapies (2).

Rounds of group participation are often practiced by group psychotherapists as a way of "bringing out" silent members. Process leaders employ a rigidly controlled version of this, with each member being asked to produce a single statement which is followed by a stereotyped acknowledgment. The result is a feeling of equality among participants, albeit at the feet of and under the control of the leader. Resistance is reduced, but so is individual initiative.

An important departure from standard psychotherapy techniques occurs in the touch exercises. Touching a patient is avoided by psychiatrists, ostensibly to prevent erotic stimulation from muddling the transference.* Touch exercises as performed by the Process seem, rather, to reduce anxiety by deconditioning fears of encounter. An additional sensory modality is made available for communication and "getting to know" about another person.

The motivation for participation in the Process, and ultimately for behavioral change, is another departure from that of psychiatric relationships. The goal is not to improve social relationships, although this occurs incidentally by a process of deconditioning fears of interpersonal contact. Neither is the goal an improvement in reality testing, for the final stage of the Process is the acceptance of religious tenets which can only be called bizarre. Participation in a group psychosis is offered, which includes the opportunity for magical thinking with group acceptance, sanction, and support. Alteration of identity occurs in this context, signified by changing of names. The new

* Those familiar with Moreno's work are, of course, aware that he was the first one to recommend the therapeutic use of "bodily contact." See *Psychodrama, Volume I,* and *II.*

identity is defined and protected by the clearly defined hierarchical structure of the group.

SUMMARY

A modern religious cult, the Process, using persuasion techniques similar in many ways to group psychotherapy techniques is described and discussed. Improving interpersonal contacts is an essential step in religious conversion in this group.

The primary appeal of the Process is to young adults in the "hippie" culture. The author has observed instances where the Process provides an acceptable substitute to the psychedelic drug culture of the "hippie" community for its converts.

REFERENCES

1. FRANK, JEROME. *Persuasion and Healing*. Baltimore, Maryland: Johns Hopkins Press, 1961.
2. FRANK, JEROME. "The Role of Hope in Psychotherapy" in *International J. of Psychiat;* Vol. 5, 1968.

SELECTING A BEHAVIORAL ALTERNATIVE THROUGH PRACTICE*

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It is a basic premise of this paper that behavior is learned, and can be altered and modified at any time during the life space of an individual provided a sufficient number of alternative responses to the solution of a problem are available in an individual's repertoire of possible responses.

It is further postulated that an individual's repertoire of alternative responses can be increased through practice in a controlled environment such as that afforded in action group therapy. In this type of therapy the patient has an opportunity to explore ways of reacting that might offer the most satisfaction and efficiency attainable in a given set of circumstances.

Action group therapy as referred to in this paper is an extension of group therapy technique to include some of the methods of psychodrama as first developed by J. L. Moreno.[4] In action therapy more emphasis is placed on the immediate behavior of the patient as it effects his successful adjustment to life situations. The past history of the patient is considered only in light of the current presenting problem and symbolism is rarely the focus of attention.

Operating on the assumption that an individual engages in ineffective and inefficient behavior because his realm of alternative responses to problem situations is limited, and further assuming, that as life stresses are perceived to increase, the choice range of alternative approaches to the solution of problems diminish, the therapeutic task revolves around the problem of training the patient through practice in the selection of less anxiety provoking alternatives in situations where he has previously become very anxious.

Patients are selected for action group therapy because it is anticipated that the experience will be profitable to them. They are not selected because they are to play roles. The therapy leader tries to select a protagonist whose

* This article presented as a paper at the American Psychological Association Convention in San Francisco, September, 1, 1968, is designed to present some of the concepts of psychodrama as a behavior modification therapy. It is important to note that since the original conception of psychodrama as a treatment approach by J. L. Moreno, many variations of his methods have been presented. The nature of the hospital population we serve and our existing group psychotherapy program seem especially suited to the treatment approach herein described.

presenting problem is seemingly harmonious to the needs of the group. Group members are encouraged to verbalize their problems as they perceive them. When a problem has been verbalized the patient is encouraged to further illustrate his problem by acting it out. Incongruities invariably occur between the perceived problem, as verbalized, and the perceived problem as acted out. These incongruities are explored through the process of group interaction in in a confronting, but insofar as possible non-attacking manner. The incongruities serve as a useful vehicle for other members of the group to assess. Every attempt is made to develop a union of interest among group members that increases the intensity of personal interaction. Wolpe states, "If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli, so that it is accomplished by a complete or partial suppression of the anxiety response, the bond between these stimuli and the anxiety will be weakened."[8] Empirical experience has seemed to repeatedly verify this statement and every effort is made to keep the level of induced anxiety within the limits that both the patient, who is the center of action, and the rest of the group can tolerate.

During the exploration of the problem, and the acting out of the problem, the patient who is the focus of the group's attention and the group members are consistently encouraged to explore possible alternative modes of behavior. In this context the patient finds the reality and universality of his personal attitudes challenged in a way that illustrates to him that his thoughts, feelings, and actions are not necessarily a suitable norm of behavior. His thoughts, feelings, and actions are explored in their relationship to the attitudes of others. Deviant behaviors seem to modify to meet the standards of the group, and this is particularly apparent the more stable and cohesive the group tends to be. By permitting members of the group to assist in the identification and selection of other possible behavior models, it is felt that their own repertoire of possible alternative problem solving approaches, as well as that of the protagnoist, is increased.

By giving the patient an opportunity to try an alternative response in an environment where inappropriate responses or inefficient behavior pose less direct threat to the individual's personal stability the stress level is reduced to the point that the patient can consider other problem solving approaches. When confronted with a threatening situation where the level of the patient's anxiety is high some individual's are unwilling or unable to respond. In this circumstance an auxiliary ego can be chosen to represent the patient in the situation, with the patient standing in as auxiliary ego. As the action progresses and the patient's level of anxiety diminishes, he is frequently able to

assume his own role and practice a behavior he would have been unable to approach under other circumstances. The behavior model practiced is evaluated through group interaction. Group members are permitted and encouraged to verbalize and act out other alternative behaviors. By permitting members of the group to assist in the identification and selection of possible alternative modes of behavior, it is felt that both their realm of possible alternative problem solving approaches as well as the patient's are expanded. The most important consideration during this process is the involvement of the group members in problem solving behavior.

Providing a therapy setting where seemingly effective behaviors are reinforced and ineffective appearing behavior is reassessed, it is assumed that the patient might well have additional alternative choice behavior models available to him as a result of his experience in the action group. The practice of effective alternative behavior models seems empirically to speed a return to marginal adjustment. When a practiced alternative proves successful as a mode of response there appears to be an associated personal and social adjustment which reinforces the patient's attempts to practice other behavioral modifications.

Any seeming increase in the patient's level of efficiency is considered a desirable objective from this point of view. Although the basic underpinnings of personality may not be altered by this experience, it can be argued that more effective behavior permits a reintegration of the patient's ego structure which in turn permits a basic alteration of the patient's ego defenses. Subsequent to this reintegration, and with the reward more effective behavior brings, in depth personality changes might well occur.

References

1. Berelson, Barnard, & Steiner, Gary A., *Human Behavior* (Harcourt, Brace and World, Inc., 1964), pp. 527-555.
2. Burton, Arthur, *Modern Humanistic Psychotherapy* (Josey Bass, Inc., 1967), pp. 71-79.
3. Corsini, Raymond J., *Roleplaying in Psychotherapy: A Manual,* (Aldine, 1966), pp. xiii—206.
4. Moreno, J. L., *Psychodrama, Volume I & II* (Beacon House Inc., 1946): *Reflections on My Method of Group Psychotherapy and Psychodrama,* Ciba Symposium Volume 2, and No. 4, 1963.
5. Stuart, Brett R., *Action Group Therapy.* Paper presented to Colorado Psychological Association, March 1967.
6. Stuart, Richard B., *Analysis and Illustrations of the Process of Assertive Conditioning.* Paper presented at 94th Annual Forum of the National Conference on Social Welfare, May 1967.

7. TRUAX, CHARLES B., & WARGO, DONALD G., *Human Encounters That Change Behavior for Better or for Worse.* Paper for Kentucky Mental Health Institute and University of Kentucky, Research and Development Grant No. 906-P from the Vocational Rehabilitation Administration, United States Public Health Service, 1966.
8. WOLPE, JOSEPH, *Psychotherapy by Reciprocal Inhibition* (Stanford: Stanford University Press, 1955), p. 71.
9. WOLPE, JOSEPH, SALTER, ANDREWS, & RENYA, L. J., *The Conditioning Therapies,* (Holt, Rinehart and Winston, Inc., 1964), pp. 169-179.

A BLUEPRINT FOR A PSYCHODRAMA PROGRAM

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Introduction

Psychodrama first appeared as a therapeutic vehicle at the Fort Logan Mental Health Center in 1963. At that time, the Director of Work Therapy initiated an ad hoc program for patients among the several adult psychiatric treatment teams. Although the psychodrama sessions were voluntarily attended, a significant volume of staff and patients attended regularly. As patients continued to participate in the psychodrama sessions, the staff concurrently began to consider decentralizing the existing centralized psychodrama sessions from total hospital to the level of the treatment team. A major impetus for decentralization was a growing paradox that occasionally some patients disclosed their feelings, pains, and problems quite spontaneously to a heterogeneous group while remaining tacit and aloof from the individuals identified with their treatment unit. That is, patients enacted via psychodrama important areas of their lives in a locus where those staff and patients who might be most helpful were not present.

Upon further decentralization, the author, then Director of Recreational Therapy, became a co-therapist in the growing psychodrama "experiment." These early psychodrama sessions were geared toward diagnostic and training utilization.* [1]

Training psychodramas attempt to provide patients with an understanding of their less creative behavior and encourage the enactment of alternatives which will broaden their base of spontaneity for living. For example, patients would enact a job interview, a family communication impasse, an expression of overcontrolled feelings, or a sensitivity to the feelings of others.

As psychodrama became a growing treatment facility at the Center, problems and questions about theory and techniques concurrently arose. For example, staff experienced discomfort whenever they were called upon to be spontaneous with their ideas and feelings in the presence of patients. As a consequence, they questioned their creativity and potential to add significance to a psychodrama session. In order to offset the "generalized ig-

* Diagnostic psychodramas have as their goal the gathering of information which further clarifies for the group of patients and staff those circumstances that have contributed to the patient's source of pain and immobility.

norance" and add stability to a dynamic treatment methodology, Dr. and Mrs. J. L. Moreno were invited to present a three-day workshop at the Center. Their visitation provided enthusiastic reinforcement to the existing psychodrama program and stimulated additional ideas for its utilization. Recognizing the need for further training the author studied and received certification from the Moreno Institute of Psychodrama, Sociometry, and Group Psychotherapy. Upon becoming a Director of Psychodrama, Sociometry and Group Psychotherapy, the position of Psychodrama Coordinator in the Staff Development Department was legitimized by the Colorado State Civil Service Commission.

Application

Psychodrama is currently employed at Fort Logan to achieve several purposes, i.e., diagnoses, treatment, rehabilitation-planning, and training. Although the primary consumer is the patient, its use is extended for the training and problem solving processes of staff. The average team uses psychodrama once a week for a two-hour period. Greatest emphasis in Psychodrama is placed by the Alcoholism Division who generally schedules four sessions each week. The Children's Division employs it least.

The patient protagonist-centered psychodrama is applied at the Center as a form of group therapy. Beginning with a group-related focus (the warm-up), the Psychodrama Director catalyzes the group to select a central theme and theme carrier (the protagonist) for the enactment of the psychodrama. Subsequent to the psychodramatic enactment, the group receives encouragement to relate to the theme as it was molded and developed by the protagonist. The conclusion of the session is marked by attempts to integrate the individual's feelings with experiences and to enable the group to realize its creative potential and climate for the growth of its individual members.

There are elements of similarity between psychodrama and the therapeutic community concepts. Psychodrama and therapeutic community are existential therapies laying stress on living-learning experiences. Both encourage patients to interact as mutual agents for therapy. That is, patients, like staff, are people and have much to contribute to other patients in the daily experiences of life. Therapeutic community and psychodrama each function as democratic processes through which patients contribute significantly toward the redesigning of their lives in a climate of non-vindictiveness, creativity, and permissiveness. The conventional distinctions between patients and staff are reduced in the therapeutic community and psychodrama environments with greater stress given to a people-qua-people ap-

proach. There are thirty-three psychodrama directors at the Center. The average time spent in a session is two and one-half hours per week. The major objectives of the psychodrama sessions vary, with the most common ones being emotional catharsis; insight; role training; sensitivity training; and spontaneity development. Nearly every clinical discipline is represented among the directors (psychiatrist, psychologist, social worker, nurse, activity therapist, psychiatric technician, psychiatric resident, counselor, and theologian). Experience among psychodrama directors ranges from six years to two months. The group size within which psychodrama is directed ranges from fifty to three. Professional visitors are usually welcomed to attend the sessions knowing that they are free to participate if they choose. The greatest dilemma in regard to psychodrama evolves from those people who still see patients as clearly different people than staff and feel in order to be helpful must convert people into patients before they can be beneficial.

Teams differ in the ways which they utilize psychodrama. Some teams employ psychodrama in its classical form while others extract portions and techniques. Although there are two psychodrama theatres at Fort Logan, psychodrama is frequently held in a group therapy meeting room, on the treatment unit, in a living room, in a patient's home, or in a therapist's office. The application of psychodrama is limited only by the creative potential of the practitioner. Some teams call upon psychodrama in one-to-one situations, in small groups, and in large groups. No one group of patients is any more prognostically suited for psychodrama than another. People in all classifications of mental illnesses are eligible to enter into a psychodrama session.

Staff Development

In addition to its clinical employment with patients, psychodrama is used as a means to both train staff and investigate problems experienced by staff. Represented among the heterogeneous disciplines of the Staff Development Department psychodrama is taught at three levels: as a centralized program for all Center staff; as a decentralized program for the staff on one team at a time; and through critiques which follow classically oriented patient psychodrama sessions.

Because there is a steady influx of new clinical employees into the Fort Logan Mental Health Center who have never seen or experienced psychodrama, a constant need exists to introduce and develop these staff to the basic rudiments of sociometry, psychodrama, and group psychotherapy. This condition has given rise to three beginners' workshops throughout the year. Each workshop is limited to a maximum of twenty participants who attend

one two-hour class session each week. The workshop lasts for an eight-week period. Preceding and at the conclusion of the workshop there is a twelve-hour mini-marathon. The content of the beginners' workshop includes both didactic material and practical experience in order to develop familiarization with the general theoretical framework and the specific skills which are required to function as an auxiliary-ego. The theoretical substance includes spontaneity-creativity-cultural conserve, role, social atom, and group dynamics. The pragmatic experience focuses on psychodramatic techniques, role playing, and sociogram construction. As staff complete the beginners' workshop and gain greater awareness of psychodrama therapy, they frequently experience a desire to move on to greater areas of responsibility: the Director's Seminar and/or workshop.

Two areas for staff development are available, the Director's Seminar and/or the Directors' Workshop. Two or three of each are scheduled throughout the year. The Director's seminar is a survey of literature, films, and tapes apropos sociometry, psychodrama, and group psychotherapies. Papers, lectures, tapes of sessions, and films are expected and acceptable methods of contributing to the seminar. Twelve weeks are usually devoted to the seminar. Each seminar is scheduled once-a-week for two hours. Membership is open to either existing psychodrama leaders (directors) or those staff who have completed the beginners' workshop and have decided to advance to the level of director. The Directors' Workshop, unlike the seminar, is primarily pragmatic and has a minimum of theoretical focus. Each workshop extends for eight weeks and is preceded and followed by a twelve-hour mini-marathon. The expectation for participants is to both direct and become a protagonist in a psychodrama session. The participants conclude each session with a half-hour critique of the process and techniques employed during that psychodrama. Videotape playbacks are also provided. The purpose of the workshop is to improve the skills of the experienced and neophyte directors while building on the theories and experiences developed by the participants.

A common form of inservice occurs via team consultations. As a rule, the team contracts (either indefinitely or with a terminal date) with the psychodrama consultant who visits and participates in the treatment program and remains to discuss and critique the group process and techniques employed subsequent to the psychodrama session. Using the Hollander Psychodrama Curve[2] for critique purposes, the team tries to locate areas for growth and areas for group maintenance. (See Figure 1.)

[2] The curve is utilized because it represents a global depiction of the psychodramatic process.

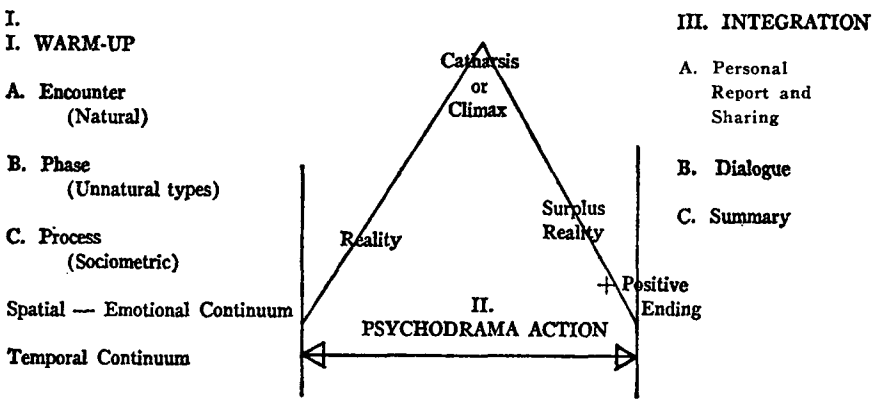

FIGURE 1

Occasionally, treatment teams request a workshop for their team apart from any others. Their request is usually couched in a specialized area or unique part of their program. For example, the Crisis Intervention Team may have a need to learn to apply psychodrama as a diagnostic technique while making a home-visit or to employ it therapeutically to reduce the time element for dealing with the patient or family's agendas. The Geriatric Division has a need to modify psychodrama so it will better apply to their population. Each team has unique needs, and therefore their workships usually vary in length and according to the team's requests.

A significant outgrowth of the staff development training programs is the implementation of intra-team seminars and workshops led by former training-programs participants. These same staff are orienting community mental health programs to psychodrama and sociometric techniques. Similarly psychodrama interns are being sent to Fort Logan Mental Health Center from other hospitals throughout the country for varying periods of time. Their tasks are to return home with a repertoire for beginning a psychodrama program benefitting their program.

Community

Psychodrama is unique as a methodology because it is useful in the areas of social problems, clinical programs, and educational programs. Heretofore the focus of the discussion related to the clinical aspects of psychodrama. There are increasing advantages beyond the walls of the Fort Logan Mental Health Center facility when implementing psychodrama. Schools,

churches, poverty programs, industry, correctional institutions, and governmental agencies have imported psychodrama, sociometry, and group dynamics into their programs. One of the results of the expanding utilization of psychodrama beyond the boundaries of Fort Logan is a growing awareness of non-verbal and extra-verbal communication. There are dilating programs for the encouragement of mental health—not merely to combat illness—but by looking for avenues which facilitate and reduce in complexity interpersonal relatedness and to reacquaint man to his undehumanized parts—his feelings.

Summary

The evolution of psychodrama at the Fort Logan Mental Health Center has grown from a centralized experimental technique to a legitimized therapeutic vehicle which has been decentralized to teams. These changes have necessitated the systematic development of training programs for staff. There are currently three types of in-service programs offered: the Beginner's Workshop, Director's Seminars and Workshops, and the critiques following a treatment team of psychodrama session.

They emanate from the Staff Development Department via the Psychodrama Coordinator and are provided for the neophytes to psychodrama as well as experienced staff.

The rapid assimilation of psychodrama into the therapeutic community ideology seems to rest in the congruence of their objectives; that is, both psychodrama and therapeutic community prize the inter-personal facilities which one human being brings to another and the living-learning experience as the most vital and instructive methodologies thus far designed to enable growth and creativity.

PSYCHODRAMA IN A SMALL, PRIVATE PSYCHIATRIC CENTER

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THE PROGRAM

Psychodrama began as an innovation therapy at Brook Lane Psychiatric Center, Hagerstown, Md. in September, 1963, and has continued to be an important part of the therapeutic program over the ensuing five years. Two patient groups meet in the auditorium on Tuesday and Thursday afternoons for two hours each. There is also a staff training session each Wednesday afternoon. Groups are directed by the clinical psychologist, aided by at least two therapeutic assistants. Private sessions are arranged from time to time for an individual patient. These may also be attended by one or more of his relatives, and his psychiatrist or social worker as well as the director and his assistants. One or two psychodrama workshops for clergy have been held each year with the hospital chaplain and the psychodramatist as co-directors.

A patient is referred to psychodrama by his psychiatrist and generally given a ½ hour interview by the director before or shortly after his first session in order to familiarize him with the method, to encourage his participation and to help him identify problem areas that he might work on while a member of the group. The groups are open-ended so that a few members drop out and a few members are added each week. In this way, the groups are held constant from 8 to 12 members. Since group membership is generally coterminous with a patient's hospital stay, he can expect to attend 10 to 20 sessions and to present a problem at least once or twice while with the group.

THE TYPICAL SESSION

The typical session begins with a warming-up phase which helps the patients become more spontaneous while developing a matrix of individual relationships in an atmosphere of mutual trust. During this warming-up phase, a real-life problem which is of interest to the group as a whole emerges. The person who can best exemplify the problem becomes the protagonist in a series of role-playing encounters until some satisfactory resolution of the problem is achieved. He and the director, or chief therapist, are aided in their creation by specially trained assistants called "auxiliary egos" who play the roles of important others in the life of the protagonist. The auxiliary egos are in effect "stand-ins" for the absentee members of the patient's

"social atom." These absentees may be living or dead, real or fantasized, and the situation portrayed may take place in the past, present or future. As long as it permits pertinent and constructive learning, the situation itself can be strictly fictional. Group members other than the protagonist, or "star," also participate actively. Not only do they become absorbed in the drama and identify with the players, but they also serve as ready consultants and, when asked, players themselves.

During the psychodrama proper, the protagonist becomes completely absorbed in the task. This helps him to drop his need for approval and his fear of disapproval that so often blocks creative expression. He gives up for the moment his dire need to please or to thwart and experiences instead the thrill of free, self-expression in an atmosphere of acceptance. The protagonist is always directed towards a positive resolution of his problem through insight or catharsis. He is never left hanging. He may have to face some painful truths but nothing is ever taken away from him, unless something better is given in return. Only through trust in the group and the director is the protagonist able to expose his areas of personal concern with the openness necessary for a radical change in his neurotic, self-defeating behavior. The protagonist is always accepted where he is at the moment and he is always guided towards personal growth. To be effective, the session has to be led by a director who has been trained in the dynamics of personal adjustment and the psychodramatic method. The session is strengthened by the participation of sensitive and trained therapeutic assistants. Special techniques used to create the peak experiences of psychodrama include: role-reversal, doubling, soliloquy, mirror, restructuring, objective observer, concretization, and alternate solutions.

The session is never complete without a period of shared experiences. By the end of the psychodrama, the protagonist has given a great deal of himself to the group. By facing issues forthrightly, he has become the vehicle of an important experience for most members of the group and the group is called upon to relate to him in a non-judgmental and non-analytical manner. Having identified with him, each member is able to relate some of his own experiences which are similar to or have a bearing upon the experiences of the protagonist as brought to light in his psychodrama.

Relationship of Psychodrama to the Hospital Program

Since Brook Lane is amply endowed with mental health professionals and a favorable staff-patient ratio, psychodrama could not have endured had it contributions to patient welfare not been relevant and significant. Psycho-

drama augments the other therapies so that it is not unusual to find a patient working through a problem in psychodrama that had been first uncovered in individual or group therapy sessions. Psychiatrists and social workers at Brook Lane have always been ready with helpful suggestions and discriminate referrals. "I think Mr. Jones is about ready for a psychodrama on such and such," is typical and is often followed by a conference in depth on Mr. Jones, potential protagonist. By the same token, loose ends of a psychodrama session may be tied together later with the help of the therapist or the therapy group. Information from psychological testing can serve as a springboard to a psychodrama and material brought to light in a psychodrama is often of diagnostic significance to the psychiatrist and his team. Productions in art therapy, along with information communicated by the art therapist, have been particularly valuable in giving clues as to where a psychodrama might begin.

Psychodrama has also been used as a part of the in-service training at Brook Lane. A psychodrama session has the advantage of being interesting, action-oriented and complete. Each session has a well-defined beginning (warm-up), middle, (psychodrama), and ending, (sharing and analysis). It can bring to the beginning mental health worker learning experience that it is immediate, relevant, dynamic and non-evasive. It can, at times of course, be threatening, especially to the higher echeloned staff who are notoriously resistive to taking off the professional mask and letting go. Qualified persons from outside of the hospital have attended closed sessions as participant observers, each time of course, with permission of the group.

Relationship to the Community

Brook Lane's outreach to the community is made difficult by its location in the country, the stigma attached to mental illness and by financial limitations imposed on its programs by the need to keep cost to the patients down. The staff, however, is actively involved as consultants to several community programs and has always provided an active pool of mental health speakers. An important link to the community has been educational seminars for the clergy.

Encouraged by favorable acceptance of psychodrama by several of the clergy groups, the psychodramatist at Brook Lane opened an in-town psychodrama workshop in January, 1967. Here, other kinds of non-psychiatric groups have been meeting for the primary purpose of personal growth. Workshops have included open-ended groups, limited sessions groups, and demonstration sessions. Groups have been variously composed of adolescents, young

adults, couples, adults, single families, and one inter-racial group. Public sessions are held monthly and are open to anyone. Demonstration sessions to all kinds of groups have introduced psychodrama and Brook Lane to the community.

Advantages as a Treatment Modality

Certain advantages of psychodrama as a treatment modality in a small psychiatric center can now be enumerated. Most obvious is the efficiency with which the psychodramatist can zero in on an area of significance to the patient without shaking his foundations and the capability of the method to go further faster. The short term requirements of treatment, fashioned in part by the limitation of insurance coverage as well as the contemporary philosophy of returning the patient to the community as soon as possible, demand methods of treatment that have an immediate, as well as enduring impact. The small psychiatric hospital is essentially involved in crisis intervention. It very seldom significantly changes patients with severe characterological deficiencies but Brook Lane is well staffed and equipped to meet the needs of the acutely distressed mental patient. Suffering is alleviated by chemotherapy and ECT. Talking therapy, both individual and group, also orients the patient towards health. Involvements in a therapeutic community in which all encounters with the patient are as therapeutic as possible certainly creates a matrix for significant change. The activity and occupational therapies provide the needed opportunities for re-socialization and healthy inter-personal contacts. Dignostics help set realistic goals.

To the above services of Brook Lane, psychodrama offers a unique opportunity for some patients to clarify what is going on. Psychodrama can provide a sythesis. It can help the patient focus on who he is and where he is, as well as where he has been or where he might be going. The psychodramatic experience is always vivid. Thinking, feeling and action are evoked within a problem-solving situation of relevance and urgency to the patient.

The usual resistance of patients to giving up their symptoms is compounded in psychodrama by the threat of a semi-public exposure, possibility of being misunderstood, and stage fright. When a patient is helped to overcome these resistances, however, and after he has completed a psychodrama, he is generally grateful and often elated. He will think about his psychodrama and elaborate on it long after the session is over and even after he has left the hospital. Not all patients find psychodrama congenial and not all patients are helped. But many have found the method useful in a unique way and some remember it as a significant turning point in their hospitalization.

Requirements for Psychodrama

To be effective, a person conducting a psychodrama group should be specifically trained in the method and should be aided by a few assistants who are also trained and have a fairly large role-playing repertoire. In addition to being a clinical psychologist, the director at Brook Lane is a student in training at the Moreno Institute in Beacon, New York. The Moreno Institute is an accredited school on the graduate level, offering certificates ranging from a mere "certificate of attendants" to full director. To qualify as an auxiliary ego, the student must have the equivalent of four weeks of resident training; as a director, twelve weeks of resident training and an accumulation of 96 points or 16 weeks of training. A system of reciprocation of credits is in process of being set up between the Beacon Center and its associated establishments. To be a training institute in psychodrama, an organization must have at least two qualified directors.

The psychodramatist requires a continuously available supply of auxiliary egos. Brook Lane has met this need by creating slots for four therapeutic assistants who are required to attend one training session and at least two patient groups each week. The training is augmented by weekend workshops at the Moreno Institute in Beacon, New York and field trips to the psychodrama unit at St. Elizabeths Hospital in Washington, D.C.

Emphasis in the training group is on learning sensitivity and non-verbal communication. The trainees are helped to become more spontaneous and creative in their roles as auxiliaries. They learn to carry out the intentions of the director with a minimum of cues. By becoming a protagonist themselves, they are able to work through some of their personal difficulties so that they become less prone to interject their own problems into the sessions belonging to the patients.

Possibilities for the Future

The psychodrama program has become an accepted part of the therapeutic program over a five-year period. It has begun to extend into the larger community as well. From this base there are several directions it can take. Staff training, a residency program, and extended community service are three such possibilities.

Psychodrama can meet the need that all persons in the mental health field have for continued personal growth. Involvement in psychodrama increases sensitivity, flexibility, and creativeness in one's work. It can help the mental health worker identify his peculiar blind spots as a therapist and

help him work through specific problems in his professional and personal life. Small psychiatric hospitals such as Brook Lane have the resources to provide such continuing training and lack only the ground work and motivation to bring such educational programs into fruition.

There is an increasing demand for qualified psychodramatists and a growing need for training centers that can develop into institutes. A small private center is in an advantageous position to work towards such residency training programs. It takes less than $4,000 and 16 weeks to have a person trained as a fully qualified director at the Beacon Center. An organization such as Brook Lane can reasonably expect to attain institute status if it has two directors on its staff. It could also look forward to an early and compounded return on its investment.

There is also an increasing public demand for non-psychiatric use of psychiatric knowledge and skills. The burgeoning programs of the community mental health centers is symptomatic. Industrial, educational and governmental institutions are increasingly searching for ways of teaching interpersonal skills. Psychodrama theory and practice have always paid particular attention to the needs of the "normal neurotic." It has developed an impressive conserve of methods and techniques suitable for human relations training. It can help well people be better people as well as helping sick people become well. It is a method of learning as well as a therapy. The small, private center can be a bridge between the society of the "sick" and the society of the "well." Psychodrama can be an important vehicle for such rapproachement.

SUMMARY

A five-year program of psychodrama at Brook Lane Psychiatric Center is reviewed. A typical psychodrama session is described. The relationship of psychodrama to the total hospital program and to the community is spelled out. Certain advantages of psychodrama as a treatment modality become apparent. The psychodrama director and his staff of therapeutic assistants require training and qualification. Future possibilities for the program include staff training, residency programs, and extended community service. Psychodrama is seen as a method of human relations training, as well as of therapy.

THE PLACE OF PSYCHODRAMA IN AN INPATIENT PSYCHIATRIC TREATMENT PROGRAM

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This paper is an attempt to conceptualize the effect of psychodrama on the social system of a psychiatric ward in terms of principles derived from sociometry, social psychology, sociology and role theory.

The life of a hospitalized mental patient is a complex system of transactions which can be broken down for study into three perspectives: the institution, the small group configuration and the individual patient.[1]

At the institutional level, two serious ailments of the social system are the institution's extreme boredom and its tendency towards dehumanization of people. Boredom is the affect expressed in certain kinds of impersonal human experience. Social system boredom seems to be the outcome of the systematic negation of self; role behaviors which are mechanical, unrewarding and unreciprocal; lack of participation in the shaping of the immediate system; and isolation of the current social system from other contiguous social systems. Dehumanization is a social process occurring within social systems when the system's chief goal is self-perpetuation. The smaller social systems nestled within the institution are geared to the same goal. The staff and patients have separate social systems which are parallel and in close proximity but which are structured in such a way that integration, mutuality and reciprocity can not occur. Even if psychodrama has no other therapeutic effect, it is at least lively, engrossing and emotional. Its human content of fear, rage, grief, joy, surprise, yearning and fulfillment seems a proper antidote to boredom and dehumanization. As a social process it promotes the presentation of the elusive self, expands and crystalizes roles and model groups, invites participation in its own sociometric system and pushes outwardly for participation in larger social orders.

The small group configuration is used to describe a smaller social system within an institution and includes a patient and the people clustered around the patient—other patients and the people who care for the patients. The small group configuration is often misunderstood and has had psychoanalysis applied to it when it needs a sociometric and sociologic approach. In this area there is an undue emphasis on understanding of ward events in terms of individual dynamics rather than group process. In their study of the social structure and interaction on a psychiatric ward, Caudill, Brody, et al. observed

that the ward staff did not give recognition to the patient world as a social group but rather interpreted the behavior of patients almost solely in individual dynamic-historical terms. Sociology offers a way of conceptualizing and understanding the small group configuration and psychodrama a way of keeping it healthy and functioning therapeutically—for like the people within them, small group configurations and other social systems can develop ailments.

Morris Schwartz[2] provides a sociological interaction model of how social ailments might occur. In this model, the patient's illness can be viewed as troubled modes of participating with others. The staff develops responses to the patient's patterned difficulties. Taken together they comprise a small group configuration with a social interactional pattern which develops stability and resistance to change. The emergent patterns can be patient-illness-maintaining or illness-reducing. The effectiveness or lack thereof of hospitalization suggests that many interpersonal configurations are illness-maintaining. Then an important question is: what are the techniques or interventions for constructive change in the ward's configuration? Psychodrama is one social intervention which can be used to identify and alter the social illness configuration. Ward psychodrama, which should include both the patients and staff, is an opportunity to explore interactions, elicit covert meanings, reverse roles for added perception and work through the conflict or maladaption. This could be called the social psychedelic effect of psychodrama for it expands perceptions of oneself and other particularly in an interactional context. Perhaps the use of the term "psychedelic" is an exaggerated metaphor but people who have taken the psychodrama trip do report expanded social consciousness. Interpersonal events are seen more sharply and vividly. New perceptions are made of things never noticed before. There is movement towards harmony between the self and the generalized-other. There is meaningful integration of perception, thought, feeling, mood and action. The psychedelic effect may be very important in correcting the illness-maintaining configurations because Schwartz found that the chief perpetuators of the illness configuration to be: selective perception, preconception and stereotype response. Jane M. may provide a clinical example of psychodrama altering an illness-maintaining configuration.

Jane M. lived on a 16-bed autonomous ward which has patients of both sexes and varying degrees of impairment. The average stay on the ward is six weeks. There are two or three long term patients who may stay eight to 12 months. The exception to this is Jane who has been on the ward for three and a half years. She is 34 years old and has been hos-

pitalized continuously at various institutions for the last twelve years. In many respects, she typifies the chronic schizophrenic person. She is gaunt, dishelved, and expressionless; she shuffles around and keeps to herself. If she speaks she often does not make sense. Her appearance is such that any new patient immediately identifies her as being very crazy. They are frightened of her and there is a natural ensuing avoidance. Jane is excluded from much of the small group interaction on the ward. She gets much attention and custodial care from the staff who see her as very disturbed. Much of the interaction seems to be highly stereotyped and illness-maintaining. Though surrounded by people there is a great deal of social isolation.

For some unexplained reason she was attracted to the psychodrama sessions on the ward. She came regularly and made various attempts to participate. During one warm-up she asked, in a very appropriate way, the group's help in dealing with the voices that were hounding her. Some of the members of the group responded that they were willing to help but felt helpless because Jane often talked so crazily. The director, at this point, told Jane that she had an important decision to make for herself in the group: either to continue to talk in a sensible way and perhaps get the group's help or to resort to her crazy way of talking and lose the interest of the group. She continued to talk in an appropriate manner about some past events and naturally emerged as the star. She presented much of her life in a dramatic and emotional soliloquy. As painful material emerged she became too disorganized to continue and took a seat but remained actively involved when someone took over the role.

What came out was how unhappy her father was; how he drank too much; how she had tried to understand and help him; that maybe he was the only one who really loved her. She belonged to Boston society, was very popular and knew lots of people. She wanted to get married very much and she often did things with men because she wanted to please them and be loved by them. Now she is ugly and unloveable and no man could be interested in her. The group was very much drawn in by the account and when she spoke of her despair everybody was near tears.

But what is most interesting are the human events that occurred subsequently. That afternoon one of the other patients set Jane's hair and helped her with her personal grooming. At mealtime people were often seen sitting with her whereas previously she ate alone. That evening Jane and a small group of patients went out to the movies. The psychodrama session did not cure Jane but it did do something very important. It altered the ward's perception of Jane. She was no longer a crazy cipher. She became a person of new dimensions. She had a history with its accomplishments, aspirations, pains and disappointments. The "social atoms" around her had a new perception of her. With a different perception of her, they could interact in a dif-

ferent way. In other words, the psychodramatic session altered Jane's sociometric position within the group. It disrupted a stereotyped and rigid role and caused her to assume a role with potential growth. The grooming of Jane by others suggests a childhod role which may be quite realistic and healthy as part of a developmental progression of social roles of increasing complexity, maturity and independence.

A frequent topic of ward psychodrama is the role behavior of patients and staff. Patient and staff roles are particularly troublesome because they are highly stereotyped and ambiguous at the same time. The former leads to sterile interaction without potential for learning and the latter to anxiety and guilt. Leonard Cottrell[3] identifies three basic factors as essential to role adjustment: 1) the degree of clarity with which the role is defined: specifically the proportion of social situations for which there are explicit definitions of action agreed upon by relevant parties, 2) the compatibility of alternate role behaviors required of a person in a given status position, and, 3) satisfactory attainment of goals highly valued in the sub-culture group. A therapeutically-oriented hospital which is concerned with its patients and staff should be promoting and developing these role requirements. Psychodrama, although it often focuses on an individual, is fundamentally a group process and allows explorations of role function in an immediate feedback system where the atmosphere and reactions of others promote learning. Psychodrama helps each to understand his roles and the roles of others as part of a social system in which role is a transactional pattern of reciprocal claims, obligations and expectations.

Acting out behavior is part of the phenomenology of any treatment situation. Its use lies in confrontation and understanding the motives and implications of the behavior. In a psychiatric hospital, acting out is usually dealt with in individual psychotherapy and ward meetings. Although the stated purpose of ward meetings is to promote communication and understanding of others, it discourages acting out by making it an embarrassing public event. There is little insight or understanding of the behavior. The focus is often the patient's dynamics; as a process within a small group it is neglected. Psychodrama may be a more productive alternative to this problem. In a different context, Yablonsky and Enneis[4] state the guiding principle of psychodrama:

> . . . to help resolve problems, the focus must be on the networks of relationships, as well as the individual's personality dynamics, which are hinged on his social atom. Awareness of the group dynamics and the behavior manifestations of underlying sociometric and personal difficulties is an intrinsic part of sociometric understanding. It is necessary to understand sociometrically the individual's social structure in order to

understand *him*. Part of psychodramtic therapy is to help the individual to understand his own unique social atom—his structure of primary interpersonal relationships.

From the patient's point of view, psychodrama has the advantage of overcoming the linguistic restrictions imposed on understanding the self and life by the written and spoken word. Words, which are produced serially and linearly, cannot convey the subtleties of time, intensity or action process. Verbal expressions can not capture the simultaneousness of past and present just as they can not embrace the simultaneousness of thinking, feeling and action. The following may be a clinical example of the limits of verbal interaction:

> Old Joe has been on the ward several weeks and had repeatedly told individuals and groups about his paranoid fears. Invariably the response was verbal reassurance that his delusions were unfounded or not real. This had little impact or meaning for Joe. In one psychodrama session Joe began the warm-up by saying that he knew what the purpose of the meeting was; he could hear some noises from the floor above and it was the machinery that the doctors were moving into place so as to be able to open his skull and expose his brain. He begged for mercy and pleaded that it would be more humane just to kill him on the spot rather than degrade him by opening his skull. He was a good man and had harmed no one and he begged for the mercy of being killed immediately. Some of the company were alarmed by this degree of public irrationality and gave him rapid verbal reassurance that he was wrong. Someone referred to the fact that the night before Joe had a nightmare. Old Joe began to tell his dream when the director interrupted him and asked him to put it into action. As he lay in his stage bed, he described how he was surrounded by devils and demons who would howl, make noises and call his name. He imitated the demons and very effectively communicated his terror. He was particularly worried about his teenage daughter; when he would listen carefully, he could hear his daughter call for help. Did the demons have her? Were they taking her away? He wanted to help her and rescue her but he was too weak and helpless. Others had joined in the action and it was a moving scene: a teenage girl pathetically wailing for her father while being carted off by noisy demons and Joe standing there terrified and impotent. He did not ask anyone for help but the tension was too great for the group. Several aroused members came forth and assisted Joe in restraining and dispersing the demons. The girl was rescued and there was tremendous relief in Joe and the group. For the rest of the day Joe was depressed but he could deal with people on the ward without reference to his autistic and paranoid world. After the session one of the resident psychiatrists expressed puzzlement over the change in Joe and that he had tried to understand paranoid symptoms in terms of unconscious homosexual conflicts.

The example of Joe not only shows the potency of psychodramatic action over verbal expression but also shows the potency of the group as a helping and healing agent. Homosexual conflicts there may be but sociometry might postulate that Joe's immediate social system, first at home, then in the hospital was sociometrically unsatisfactory or inadequate for Joe as a social atom. So Joe created figures in his head with which he could interact in some way that has meaning for him and thereby created his private social system. The ward group psychodramatically dealt with Joe's autistic social system and caused him access to the social system of the small group. This is an important advantage of psychodrama for the individual patient: to integrate an individual, his autotele, and his model group into larger more satisfying social systems.

Psychodrama is a unique therapy because it encompasses reality but it can also exceed reality. It offers the patient an opportunity to address his problems in a situation where the very problems he wants help with arise. In psychodramatic therapy the problems are dealt with *in vivo*. As an experience it can exceed the reality of life because in psychodramatic action, the protagonist can explore alternatives in his life without there being permanent and irreparable consequences or damage to himself or others.

The place of psychodrama in a psychiatric treatment program is as an instrument in the achieving the stated purpose of the hospital. For the individual patient it is a unique therapy. It does not have the limitation of verbal representation; it deals with problems *in vivo:* and it can explore life without being bound by the restrictions of life. In the social system of the hospital, it can identify and heal illness-maintaining social configurations. It integrates, relates and harmonizes the social atom of the individual with his immediate social system and each with each larger contiguous social systems up to and including the institution and community.

References

1. Caudill, William, Redlich, Frederick, Gilmore, Helen, & Brody, Eugene, "Social Structure and Interaction Processes in a Psychiatric Ward," *The American Journal of Orthopsychiatry,* Vol. XXII, No. 2, April, 1952.
2. Schwartz, Morris, "Patient Demands in a Mental Hospital," *Psychiatry Journal for the Study of Interpersonal Process,* 20:3, 249-261, August, 1957.
3. Cottrell, Leonard, "The Adjustment of the Individual to His Age and Sex Roles," *American Sociological Review, VII,* 617-620, 1942.
4. Yablonsky, Lewis, & Enneis, James, "Psychodrama Theory and Practice," *Progress in Psychotherapy,* 1956. Edited by Frieda Fromm-Reichmann and J. L. Moreno. Grune and Stratton, New York, 1956.

PSYCHODRAMA TECHNIQUES IN THE TREATMENT OF ALCOHOLISM

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Psychodrama is a useful and effective method in the treatment and rehabilitation of alcoholics. Used in conjunction with other therapies such as didactic and analytic group psychotherapy, drug therapy, Alcoholics Anonymous, socialization and vocational rehabilitation, psychodrama provides a flexible treatment tool. Weiner[1, 2] has written extensively about the use of psychodrama in alcoholism treatment. She refers to its use in both in-patient and out-patient settings. Cabrera[5] describes psychodrama in a state hospital alcoholism program.

At the Alcoholism Rehabilitation Unit for Men and the C.K. Post Alcoholism Rehabilitation Center for Women at the Central Islip State Hospital, psychodrama has been part of the treatment program for the past three and one-half years. Each unit contains 60 beds and serves voluntary non-psychotic alcoholic patients. The program[3] relies heavily on variety of group therapy methods including Alcoholics Anonymous, individual psychotherapy, antabuse and in a few cases other pharmacological agents are also used. Weekly psychodrama sessions lasting one and one-half hours are held on each of the units. All patients and most of the staff take part. Until recently the male and female groups held their sessions separately, depending on guests, staff members and members of their own sex to play roles of the opposite sex. During the past few months half the male patients and half the female patients have taken part in each psychodrama. A typical session will therefore include 25 to 30 female patients, 25 to 30 male patients, 6 to 8 staff members and a varying number of guests. The guests are visiting professionals, student nurses, staff members from the other parts of the hospital, psychologists, or ministers in training, or others.

Dynamic material brought up during the psychodrama sessions often provides material for analysis in other psychotherapy groups. Individual patients who represent therapeutic problems in their groups are often chosen as protagonists for psychodrama sessions, with the psychodrama helping the

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patient overcome whatever obstacle is blocking his treatment. Thus all aspects of the rehabilitation program bear a flexible interrelationship. One is as likely to see, in one of these psychodrama sessions, a family problem, a group psychotherapy session replayed, a drinking situation, an AA meeting analyzed, a job interview rehearsed or a patient's fantasy realized. Psychodrama techniques have also found their way into the small therapy groups, staff conferences, individual counselling sessions and every phase of the units' operation. The present paper outlines some of the recurring themes and psychodrama techniques that have been found particularly useful and applicable to the treatment of alcoholism.

A. *Psychodrama in Ward Administration*

Occasionally the physician responsible for the day to day administration of the ward is faced with a patient making an impulsive destructive decision and unwilling to consider the matter rationally. He may be following a lifelong pattern of running away from close relationships or he may be acting out in response to unconscious anger or feelings of rejection.

An effort is usually made by the administrator to "talk the patient out of it," or failing that, to explore his motivations for the decision at a level deeper than the rationalizations he presents. When these endeavors fail, the following techniques have been found useful.

The patient is told he will be granted his discharge on the condition that he first take part in a brief psychodrama session. A staff member, conversant in the methods of psychodrama, preferably one who knows the patient well, is called into the office. He is asked to observe a repeat of the previous discussion between the administrator and patient concerning the discharge. The staff member and patient are then asked to switch roles and the administrator continues the argument, this time with the staff member playing the role of patient. Both administrator and staff member remain sensitive to the degree of involement of the patient in their interaction, and may involve him more deeply by appealing to him (in the role of staff member) for support. The staff member may caricature the patient's stubbornness or may bring out unconscious motivation if he feels the patient can tolerate this. He holds his position, however, and does not give in. When the administrator feels that the patient is emotionally involved in the proceedings he throws up his hands in despair and turns to the patient in his role as staff member. Declaring that he hates to see such a worthy and valuable person destroy himself, he asks the patient's opinion. The patient will usually have gained considerable in-

sight and will counsel the staff member playing his role not to be a fool. This usually terminates the request for discharge and returns the patient to therapy in a more receptive frame of mind and more insight into his problem. The entire process rarely takes more than 15 minutes.

B. *Psychodrama in Staff Conferences*

At least twice during his hospital stay each of our patients is interviewed by the entire staff. The first of these conferences follows his one week orientation period. It is designed to evaluate the patient and decide on the most appropriate therapeutic approach in his case. The second, after four weeks of further treatment, aims at evaluating his progress and suggesting new directions of therapeutic effort.

Occasionally at such conferences a patient, asked to explain a piece of his behavior, finds himself at a total loss to do so. A frequent example is a readmitted patient discussing his return to drinking after his last discharge. He might be asked why he failed to keep in touch with the ward, or attend AA or carry out some other part of his pre-release planning. He may be puzzled and disappointed in himself but unable to explain his behavior. The members of the staff may have a pretty good idea about the reasons, but find that simply presenting their hypothesis leads to an intellectual discussion with little emotional involvement by the patient. He may become defensive or compliant but gains little insight.

Instead of discussing the behavior, therefore, the staff member in charge asks the patient to change seats, and roles, with him. The patient then continues the interview and attempts to find an explanation for the behavior. He may scold the staff member playing himself or adopt a number of postures. By switching roles at opportune moments he may be drawn into an interview with himself at considerable depth. The staff member's comments when playing either role serve to guide him to such insight. Other staff members may ask to play the role of the patient or interviewer or to sit behind the patient as *an alter ego*. This technique has proved useful in producing insights which can be explored later in therapy groups.

C. *Personification of Alcohol in Psychodrama Sessions*

During formal psychodrama sessions it has frequently proven useful to have a group member personify alcohol. He may be called Alcohol, Booze, The Bottle, Whiskey or whatever is appropriate to the protagonist. Alcohol may suggest drinking as an alternative solution to a problem being consid-

ered, or may try to seduce the protagonist, using the customary rationalizations used by alcoholics to justify drinking.

At times a very graphic tug-of-war has developed, with Alcohol pulling at one arm of the protagonist and a relative, friend, doctor or employer pulling at the other. Such an experience demonstrates the passive posture habitually taken by the protagonist in life better than any description in words could do. The group members and auxiliary ego will encourage the protagonist to make some active move on his own. A tug-of-war of this type can be followed by having the protagonist break through a restraining circle of people representing the problems in his life including Alcohol. This helps the entire group see sobriety as an active process rather than a passive experience of deprivation of pleasure by others.

D. *Making a Connection between Emotion and Drinking*

Helping the alcoholic to understand the motivations behind his drinking and the way alcohol use fits into his patterns of interpersonal behavior is an important part of treatment.[4] There is often a strong denial of the connection between drinking and distressing emotional states in the patient who says, "I only drink because I like to."

One way to overcome this denial is to work through, in psychodrama, a situation in which this patient returned to drinking after a period of sobriety. The protagonist may begin by denying any emotional problems, but the circumstances will allow his auxiliary ego to supply at least some of the underlying feelings. The protagonist will usually supply the rest. If he does not, the scene can be replayed with another alcoholic taking the role of the protagonist and allowing the protagonist to try to talk him out of taking a drink. In encountering his own resistances in himself (as played by another alcoholic) he will usually recognize the strong emotional underpinning of his decision to take a drink.

E. *Clarifying Identifications with Alcoholic Parents*

Many alcoholics are the products of families in which one or both parents drank excessively. Progress in therapy may be retarded by either positive or negative feelings toward these parents. A man may feel that by acknowledging that some of his own behavior was the product of an illness he will be forced to forgive the father he hates, who was also alcoholic. Another patient may feel that admitting he is an alcoholic is equal to admitting he is "a bum like the old man." Another may have the unconscious motive, "I

want to be an alcoholic because I want to be like my mother and gain her love."

Such identifications are often elucidated in psychodrama by enacting childhood scenes, allowing the protagonist to play both himself and his parent. The identification can then be worked through further in other therapy sessions as well as in the psychodrama itself.

F. *Preparing the Alcoholic for Job Interviews*

A most difficult situation for the sober alcoholic preparing for his post-hospital adjustment is the employment interview. Many patients do not prepare themselves rationally for these interviews, but anticipate their approach with dread and then hastily improvise some story to cover spotty employment records after the interview is already in progress. The results are usually negative, at times fulfilling the patient's unconscious desire to avoid the challenge and responsibility of actually getting the job.

Psychodrama is useful in preparing for such interviews and exploring the motivations involved. Various patients may take turns as protagonist, answering the questions in a variety of ways; honestly or by covering up the truth, explaining or not explaining their problems. Group members then discuss and comment on each technique used.

G. *Preparing Patients to face Social Situations Involving Alcohol*

It has proven valuable to depict in psychodrama various social situations in which individual patients will be offered drinks. These include situations at work, during lunch hour, on dates, at parties and at family reunions. Each protagonist may be asked to anticipate the toughest situation he expects to encounter. Group members enacting the scene urge him to drink. His method of refusal is then analyzed by the group. Unconscious as well as conscious motivations are stressed.

The foregoing are only a few of the many ways in which psychodrama techniques are helpful in the treatment of alcoholism. Some of these are applicable to the treatment of other disorders as well. In general it can be said that psychodrama achieves a quick and useful level of emotional involvement, thereby providing insight in a way that purely verbal methods cannot duplicate.

References

1. Weiner, H., Treating the Alcoholic with Psychodrama, Group Psychotherapy, 18: 27-49, 1965

2. WEINER, H., A Report on the Use of Psychodrama on a Television Show: "Alcoholism, Our Great Failure" International Journal of Sociometry and Sociatry 5: 11-32, 1966
3. MANUAL OF THE ALCOHOLISM REHABILITATION UNITS, Central Islip State Hospital, October 1968
4. WAGNER, R., Psychotherapy in Alcoholism, Journal of the Central Islip State Hospital 1: 21-29, 1967
5. CABRERA, F. J. "Group psychotherapy and psychodrama for alcoholic patients in a state rehabilitation program," Group Psychotherapy 1961 14, 154-159.

FAMILY CENTERED GROUP THERAPY WITH CHRONIC SCHIZOPHRENIC PATIENTS:[1] A FIVE-YEAR FOLLOW-UP STUDY

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The Setting

After decentralization of the Colorado State Hospital in 1962 into geographic divisions, each serving an area of the state, the greatest challenge has been the treatment of large numbers of chronic schizophrenic patients. On the Pueblo Division we became interested in using group therapy with seven selected schizophrenic male patients. These men, although in good physical condition and in the prime of their life, had been allowed to drift into a totally unproductive way of existence, destined to remain in the hospital for the rest of their life. In order to establish a first link between these patients and the community, we decided to involve their families in their treatment.

There were three objectives in undertaking this project:

1. A short range goal of activating and energizing the patient, thus making him a more pleasant, more useful, more self-respecting, and probably happier member of the hospital community.
2. For the relatives: reassurance and support; increased understanding of their kin; also to be liberated from superstitious beliefs concerning the origin of mental illness; alleviating self-blame; and—last but not least—socialization. We found some of them to be lonesome people who welcomed the opportunity to talk things over with others who are "in the same boat," so to speak. Thus, significant members of the schizophrenogenic families were "lured" into group therapy.
3. A long range goal: to release our patients to the community to live independently or semi-independently; or as the next best, to have them engage in useful and gainful occupations within the hospital setting.

The project was carried out solely by the two writers. Other disciplines gave only minimal support.

[1] Earlier reports of this project were presented at the Third International Congress of Group Psychotherapy at Milan, Italy, July, 1963, and at the meeting of the Rocky Mountain Psychological Association in Salt Lake City, May, 1964.

It has often been demonstrated that co-therapists of both sexes are an effective combination in group therapy. In a residential treatment center a person who is in daily contact with the patients seems to be the ideal co-therapist to the "professional" person. A psychiatric technician usually lives in a socio-economic and cultural environment similar to the one of the patient's family. Not so the therapist who often belongs to a different socio-economic and cultural group; he thus is less able to empathize with the milieu and past living patterns of his patients and their expectations for the future. The technician thus forms a bridge between the patient's home environment and the therapist's understanding of what is needed to return the patient to a productive existence. We believe that in our case the psychosexually underdeveloped males greatly benefited from the sympathetic attention by a young woman whom they might have regarded as a sister figure.[2]

A composite description of the patients' group may be found in an earlier publication,[3] not to be repeated here in detail. Suffice it to say that we selected seven men, all single, ranging in age from 22 to 48 years, and that during the previous three to seven years (of hospital life) they had been living unproductively at public expense.

Group therapy with the patients started in May 1962, once a week. Meetings with the relatives started in August 1962, also once a week. After seven sessions with the latter we decided, with the consent of everyone concerned, to invite the patients as well. Thus, for the major part of the project we held two meetings weekly, one with the patients only and one conjoint meeting with relatives and patients. Because of the senior author's reassignment to another division of the hospital, the project was discontinued after fifty-two sessions.

The group therapist has to be a versatile person. It will do him no good if his range of techniques is limited and if he sticks to only one "school." A hospital psychiatric technician may have learned how to conduct "remotivation" groups with regressed, uncommunicative patients, a procedure very much in vogue in American hospitals in the past fifteen years. He will have a very disappointing experience if he should try to use this method with other types of patients. Likewise, an analytic group-therapist or an enthusiastic psychodramatist both have to give up their "hobbies" when confronted with a group like ours. Every technique must fit the group, as (with a grain

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[2] The junior author, then a psychiatric technician, studied professional nursing after the termination of the project.

[3] International Handbook of Group Psychotherapy (Ed. J. D. Moreno), New York, 1966, pp. 395-397.

of salt) "the punishment must fit the crime." The patient's level of functioning is the crucial starting point.

In a group like ours, the therapist is quite active and directive. He asks questions and often suggests the topics. Our discussions were around concrete situations, the here and now, such as home visits, meals, etc. Occupational topics and employment opportunities were slightly touched upon; in the beginning these were still beyond their grasp, but developed into suitable topics as treatment progressed. When a patient engaged in useless talk, his need for this was pointed out to him, and he was stopped. Encouraging other group members to change the topic was usually futile; even after one year of therapy, it was mostly we who had to direct the conversation into more useful channels.

We soon learned to strive for, indeed, very moderate gains. During the first sessions, the men not only refrained from talking to each other, but also consistently avoided each other's glance. At best, they would reply to our questions or comments. It took several months until they were fully cognizant of each other's first and last names, in spite of their having lived in close proximity for the long duration of their joint hospitalization. For the first few sessions, we almost had to harp on names and repeat them over and over again. Joint "activities" were rarely achieved. Occasionally they could be persuaded to engage in a game of volleyball. We attempted group singing of traditional songs, with little results. During a few field trips, they reacted for the most part with polite aloofness. For a while, we held dancing lessons, conducted by a woman patient, in which some of the men participated with apparent satisfaction. As time went by, they finally learned each other's names, and occasionally even asked each other questions.

The relatives, because of occupational commitments, did not attend their meetings as regularly as the patients. Nevertheless, in every session, we had at least three families represented. The group consisted of the following people: three mothers, two of them widowed and one divorced; one father whose wife attended only the first few sessions; one sister and brother of the same patient; one parental couple, who were seldom able to come; and finally, a group of actual strangers whom we had induced to befriend our alien from Yugoslavia. The sessions with the relatives were held in a permissive manner, allowing them to express any concern they might have at that time. Sometimes, we gave them specific information, which they wanted to have, whereas on other occasions they used the session to plan a group activity, such as a party. In these sessions, we were able to obtain most useful material from the patients' histories which our scant medical

records never touched upon. We became acquainted with the peculiarities and even psychopathology of some of these relatives and attempted to modify the patients' contact with the peculiarities and even psychopathology of some of these relatives and attempted to modify the patients' contact with them accordingly. Occasionally, we observed emotional tension and frustration among these people, while their hospitalized relatives were sitting by rather calmly. We attempted to deal with these situations in a supportive manner.

At the end of the project (after one year) the seven heretofore emotionally isolated individuals (1) improved in their physical appearance, (2) occasionally talked to each other, (3) took fewer ataraxic drugs, (4) assumed industrial therapy or classroom assignments.

Progress to Date

Allen

Background

Allen, age 41, Yugoslavian born, had suffered two earlier schizophrenic breaks; a graduate of the University of Graz. He came to the United States in 1951 as a displaced person; worked briefly as a church janitor and also on a farm in Colorado. Only a week after his arrival in the States, he became acutely psychotic. Allen had been in the hospital for 12 years, receiving electrotonic therapy and various tranquilizers. Except for rare visits by representatives of a local Catholic parish, he had no contact with the community. All those years he had been satisfied with polishing floors, looking at television, and mostly sleeping. A nice looking man, he was extremely negligent in personal hygiene and dressing. On occasion, he was observed to be hallucinating. He rarely corresponded with his mother in Yugoslavia.

At Termination of Project

Was considered more cheerful. Although never initiating a conversation, was willing to reply politely to questions, using his amazingly good English, which he picked up at the State Hospital. Paid a few visits to a local Catholic family which he used as a substitute for relatives. Still very passive and disinterested in the opposite sex. However, during dancing lessons, he did manage to place his arm around his female partner's waist. During the year, the first time away from his ward, had the following work assignments; folding linens in the supply room; later on a more responsible job of sorting and delivering mail in the hospital's post office.

Five-Year Follow-Up

Allen, now 46, has been residing in a local halfway house for the past ten months. The last 18 months, he has been gainfully employed in a sheltered workshop located on the hospital grounds. Here he is being tried on

various types of jobs, undergoing evaluation for future job placements in the community. He is described by his supervisor as being a good and dependable worker. Socializes well with his fellow workers. Attends church regularly every Sunday, dressed in a suit and tie. Speaks to other people in the parish, and appears to regard himself as an established member of the parish. Takes pride in donating small amounts of money to the Sunday collection. Enjoys shopping at local food stores for favorite food items; also viewing television movies and reading the newspaper. Expresses hope that someday he will acquire citizenship in the United States. Corresponds with his mother in Yugoslavia and cousins in Pennsylvania.

Bert

Background

Bert, age 22, admitted at age 12 with a diagnosis of childhood schizophrenia. Had lost his father early in life. Was never promoted beyond fourth grade. Always preferred to stay by himself and over the years made only minute academic progress at school classes in the hospital. A nice looking young man, with childlike features, usually well groomed; preoccupied with eye glasses (which he does not need) and pipe smoking which to him apparently are symbols of adulthood. Also has been preoccupied with Greek mythology, sometimes claiming that Zeus is talking to him, although most of us believed that he was "pulling our legs." According to his mother, a childhood book on Greek mythology was his favorite shortly before his commitment to the hospital. When our group started, Bert lived in a single room, sleeping most of the time or loafing around the ward or, at most, taking solitary walks on the grounds. Visited his mother weekly.

At Termination of Project

In group sessions, he tended to act silly. Two attempts to keep him in our adult school failed; nor would he carry through simple work assignments. For a while, was given private tutoring by a fellow patient member of our group. This was only temporarily successful. He also spent some time in Occupational Therapy classes. At termination, we considered his prognosis is the poorest among the group members.

Five Year Follow-Up

Bert, now 27, attends the Day Care Center of the hospital. Due to recent surgery, his participation in group activity has been limited. Over the past, has been involved in various groups, such as regular sessions of intrusive therapy (a type of therapy which involves making the patient more aware of himself and his bodily functions). He had also participated in the Token Economy System.[4] Bert remained silly and inappropriate at times, but no

[4] A system by which the patient earns tokens, through work assignments and acceptable behavior; these tokens can be exchanged to obtain small items of merchandise, such as tobacco, gum, cosmetics, and special privileges.

longer verbalizes hallucinations regarding Greek mythology. Prior to being placed in the Day Care Center, he helped regularly with ward work. Enjoyed choosing his own job assignment and carried it out well. Also was involved for a time in a "masculine group," which engaged in activities such as hiking, camping, and fishing.[5] Bert, at this time, shows some improvement in accepting the limits set upon him by authority figures, but continues to need much encouragement. Prognosis remains guarded; the best we can hope for is partial self-support in a sheltered workshop.

Greg

Background

Greg, age 24, admitted at age 13 for acting out behavior, stealing, uncontrollable at home, and in school, disinterested in learning. Probably then only borderline-psychotic. Never went beyond the seventh grade. A nice looking but very obese Spanish American boy, who was raised bilingually by very poor parents, among many siblings. One older sister is schizophrenic, the youngest mentally retarded, but several other siblings are healthy and successful in spite of their humble background. When Greg was invited to join the group, he was fulfilling a small assignment (for a few hours a week) as a "receptionist," opening and locking the entrance door. Otherwise, he would sit around or lie in bed.

At Termination of Project

During the first group sessions, Greg often referred to himself as "stupid," unable to learn school subjects. Declared that he planned to remain in the hospital all of his life,which seemed to him easier than living on the outside. However, Greg's ideas changed considerably during the year. With much coaxing, we were able to get him into the adult school of the hospital. At first he tended to slip into old school habits and skip classes; but once he settled down, he was able to pass eighth grade tests, which made him officially a graduate of an elementary school. At the end of the year, he was involved in high school subjects, and even on weekends worked on homework assignments. His goal at that time was to leave the hospital as soon as he obtained a high school diploma. His self-esteem had greatly increased. His parents were pleased with his progress and encouraged him in his school work. In the past, he had been considered the black sheep of the family.

Five Year Follow-Up

Greg, now 29, lives with a foster family and attends the Day Care Center of the hospital. At this time, he is again expressing the hope of attaining a high school diploma. He continues to have periodic remissions of acting-out

[5] The primary purpose of this group was to help the patients involved to identify with the masculine role.

behavior, but for the greater part is functioning very well. Over the past several years he has held different Industrial Therapy Assignments while in the hospital. Also, Greg has been intermittently employed in the sheltered workshop of the hospital, washing pop bottles on a contract with the local bottling company. His counselors report "his social cooperation has been above reproach; very proud of his job and an opportunity to earn a small amount of money." He has periods of depression, with many somatic complaints. At this time, it is difficult to get him to work. During these mood shifts, it was necessary to maintain him on dosages of medication (Thorazine). During periods when he was functioning well, enjoyed attending sports activities, movies, dances, and camping trips. Continues to go home on weekends; enjoys helping his mother with her garden and accompanies her on shopping trips. At present is on a reduction diet, with a marked weight loss; seems very pleased with his new self image. On Sunday, attends local church services, dresses very neatly in a suit and topcoat. Although somewhat fearful about leaving the hospital completely, seems to be adjusting very well to his new situation.

Jack

Background

Jack, age 48, had been confined to the hospital for 16 years. A former railroad worker of athletic bodybuild, with an eighth grade education; came from a rather disorganized family; both parents are dead. In earlier years, Jack was a semi-professional baseball player but had to discontinue this because of an injury. This kept him out of the armed forces. Three months after our group had started, we invited Jack to join us because of a slight friendship he had with another member of our group (Ronald). Jack was a typical "burnt out" schizophrenic, whose speech was rambling and was poorly understood because his teeth were missing. Was usually friendly and repeatedly stated that he wanted to leave the hospital. However, he had the most unrealistic plans; either return to his old railroad job or to become an artist. (This latter ambition was based on the fact that in his school days his ornamental leathering was praised by his teachers.) Jack felt strongly rejected by his family.

At Termination of Project

Jack, instead of sitting idly in the Day Hall all day, started a regular routine job in the supply room, folding linens. During our various group sessions, the need for further education was repeatedly mentioned. At that time, he willingly accepted a new assignment as a student in the adult school, where he began preparing himself for a high school diploma. Slowly he began to acquire a more realistic attitude regarding his future. Continued to talk about leaving the hospital, but realizing it would be neither as a railroad worker nor as an artist. The veils between him and reality seemed slowly to be lifting.

Five Year Follow-Up

Jack, now 53, lives with a foster family and is gainfully employed in the hospital's sheltered workshop. Also, is on "extended evaluation" for a future work placement in the community. His ability to get along with his peers is described by his counselors as being better than average. He is willing to take responsibility; is very conscientious about reporting to work on time and calls when he is unable to come to work. Works in a supervisory capacity; directs fellow patients; admonishes a worker each time he functions poorly. Works safely and carefully. Converses freely with women co-workers and seems to enjoy socializing, although has periodic quiet days when he keeps to himself. While in the hospital, participated in social and group activities. Was involved in "intrusive therapy," Occupational Therapy groups, and a "masculine group" (same group as one of the other patients, Bert). Maintains contact with brother and sister in the community and visits regularly with them. Also enjoys watching television and attends all sports events in the community and throughout surrounding areas.

Leonard

Background

Leonard, age 24, was raised by his divorced mother together with siblings who had made normal adjustments. Drifted through high school with little success; never held a job for a long period. Suffered an acute break at age 18, shortly after having enlisted in the Navy. Had been residing at the hospital for three years. Was released several times, but always had to return. Before joining the group, Leonard mostly stayed in bed, but always was wide awake to get up for ball practice! Believed himself a great player and hoped one day to become a coach; otherwise had no plans for the future. Sometimes acted impulsively; for example, on one occasion drove a delivery truck right to his home, just because the neglectful driver had left the key in the ignition. Leonard was the most forgetful and flightly member of our group; often had to be reminded that the day of the meeting had arrived. It took him many months to memorize the other group members' names.

At Termination of Project

Leonard expressed preference for a job assignment of the outdoor type, but failed pitifully in this. Was assigned to the mimeograph room of the hospital to learn simple routine work; made remarkable progress. In the beginning learned at a slow speed and seemed preoccupied. However, soon got into the habit of attending regularly for working days. Obtained much satisfaction from his accomplishment, particularly from quantity production. The Bureau of Vocational Rehabilitation became interested in him, and he accepted a suggestion to return to school. His knowledge of scholastic fundamentals, however, was found to be very meager (at the seventh grade level). We felt that this was possibly due to past electrotonic therapy. At that time, had the ambition to make up for his deficiencies. Still enjoyed ball playing, but used it now as a hobby, after a day's school work.

Five Year Follow-Up

Leonard, now 29, is currently living in a foster home and participates several hours a day in the hospital's Day Care Program. There, he receives supportive group therapy, which is helping him adjust to his new situation. During the past several years has held jobs in the community such as sanding cars in body shop, and working as a delivery boy in a local jewelry store. At the present time, Leonard needs encouragment to go to work but nevertheless goes daily to the Employment Office in the hope of getting spot jobs. Has shown improvement in his self image. Appearance now is excellent. Continues to have periodic moody spells, during which he is somewhat apathetic and lacking in drive. Has little difficulty in socializing, having friends around his own age group. Enjoys going to drive-in movies, attending sports events and spending holidays with his family.

Richard

Background

Richard, age 29, was the most sophisticated of the group. At the beginning suffered two severe setbacks, including states of catatonic excitement with delusions and hallucinations; also made a suicidal attempt. A tall handsome young man, with basically better than average intelligence, he had been reared in a western community, over two hundred miles from Pueblo. Already had had difficulty in concentration back in his high school and junior college days. Had suffered his first breakdown at age 22 while living away from home in California. Made several attempts to obtain a college education but each time discontinued after a while because of his difficulties in concentration. His mental condition was aggravated after the death of his father, who himself seemed to be mentally unbalanced. Richard was admitted on a voluntary basis; released and returned to the hospital repeatedly.

At Termination of Project

When Richard first joined the group, he had been idle on the ward. We encouraged him to use his talent for photography in which he had obtained some training, and which he desired to develop as a profession. During the year worked with great interest and quite steadily in the hospital's print shop. Returned home during that period, attending the print shop on a "day hospital" basis. Had a period of apparent remission, during which he was eager to become self-supporting; accepted a job as a salesman in a department store, working over fifty hours a week (a poor choice for a schizophrenic, indeed.) After one week of working, Richard suffered another breakdown in his home and was brought back to the hospital by force. Was given electrotonic therapy and rejoined the group. We felt Richard's prognosis was good. He became very active in patient government, and was elected an officer of the therapeutic community. Incidentally, Richard was the one member of our group, who, when in good contact, showed a normal, active interest in the opposite sex.

Five Year Follow-Up

Richard, now 34, has had several discharges and readmissions. From September, 1966, to August, 1967, while living at home with his mother, he spent most of his time at the Vocational Rehabilitation Center, first as a student and later on as an assistant instructor in bookkeeping and office machines. When the regular instructor went on summer vacation, Richard became upset and paranoid under the pressure of increased responsibility. After a brief full-time hospitalization, he was released to live in a halfway house while receiving treatment at the Day Care Center. Only after a few months, however, he became upset and paranoid and again had to be hospitalized fulltime. Since then he has been participating in occupational and recreational therapy, not being able to accept work or study assignment. His only community contact is still his mother. He has asked for individual psychotherapy which he is now receiving. He certainly has benefited least from our particular approach.

Ronald

Background

Ronald, age 33, was probably the most classical failure of the old hospital system, but also (we flatter ourselves) became a credit to our project. Was an only child, an "A" student throughout his school years; also salutatorian of his graduating class. Suffered a severe catatonic episode during his junior year in college away from home while living in a student dormitory. This occurred in 1953 and led to his commitment. After having gone through the usual shock treatment routine and subsequent years of idleness, was released to his parents in 1956. During the next two years was unable to hold a job. His rather untutored, but very doting parents spent a great deal of their moderate income to have Ronald cured by chiropractors and mental quacks. Had been readmitted in 1958 and had lived in the hospital ever since, where he resumed his former idleness. Curiously this rather mild-mannered, shy and well behaved individual who wrote poetry, had at some time been placed with criminal patients where his front teeth had been knocked out. He sat most of the time in the Day Hall, smoking incessantly.

At Termination of Project

In our group, Ronald first resisted any attempt to have him participate. Occasionally enjoyed going to town and even would take Jack along (fellow group member). During the year, without much resistence, conceded to assume the same supply room duties as did Jack and Allen. They would walk to work together. For one month, Ronald went to town every morning to work as a volunteer and trainee at the local public library. Quit his job angrily when no remuneration was forthcoming. Took considerable interest in the dancing lessons of our group; conversed freely with several of the female patients. During the year Ronald made steady progress. His missing front teeth were replaced. At the end of the year, had a job working daily in the

hospital's post office, sorting and delivering mail. Above and beyond these duties, also in the evening hours, tutored young Bert in elementary school subjects. Spoke often about the possibility of finding a girlfriend among fellow patients.

Five Year Follow-Up

Ronald, now 38, has been out of the hospital since April, 1967, living at the same halfway house as Allen. Over the past year has also attended the sheltered workshop at the hospital for extended evaluation. For a short time he held a job at a local orphanage doing maintenance and yard work. Lacking experience in carpentry, he felt inadequate and asked the hospital's assistance in a different job placement. Now is being trained as a food service worker, which seems to be working out more satisfactorily for him. Commutes back and forth to work by bus; is reported to be a steady, dependable worker. Has become more independent and makes his own decisions. His parents are also showing more insight. They seem to be allowing him to go his own pace and to set his own limits. Ronald visits his family only on weekends. His interest in girls continues; he dates occasionally. He enjoys all sports, particularly baseball, movies and automobile rides.

Discussion

Research in the etiology of schizophrenia so far has yielded inconclusive results. The battle between organicists and psycho-socially oriented investigators is still being waged. In the meanwhile, our thinking in the area of treatment has become less fuzzy. The most staunch supporters and practitioners of physical and chemotherapies are willing to admit that these alleviate only the most distressing symptoms, those which prevent effective communication with the patient. Numerous writers since the early pioneering efforts of Paul Federn, have convincingly demonstrated that a personal relationship with a psychotherapist can restore a schizophrenic patient to better mental health. Likewise, numerous group psychotherapists, since the early pioneering efforts of Jacob Moreno, have convincingly demonstrated that the hospitalized schizophrenic patient will benefit from group methods and that these will be more fruitful, if co-therapists are used.

Concerning the families of the mentally disturbed, treatment centers in the United States for decades followed what many believe to be a blind alley. Child guidance clinics, mental health centers, some private practitioners, and the well staffed hospitals rigidly operated on a so-called "orthopsychiatric" philosophy-inspired by misunderstood Freudian concepts: One therapist for the patient, another (or others) for the significant relatives. Between sessions the two therapists are free to communicate to each other anything they wish in order to "plan together." The patient, on the other hand, is ex-

pected to have full trust in the confidentiality of the therapy session. This baffling contradiction probably accounts to a great extent for the numerous failures produced by the so-called "orthopsychiatric team." Treatment of the primary client *together* with his family and with helpers (co-therapists) has a long, though obscure history. It was practised by another early pioneer, Alfred Adler in Vienna, a half century ago; thereafter, for unknown reasons, only by few others. It has become respectable again for the past fifteen years under the name of "family group therapy": practised in Europe, at London's Tavistock Clinic; at Vienna Clinics under the name of "Bifocal Therapy," and in many other cities. In the U.S.A. mental health centers and private practitioners now use it successfully.

Summary

In 1962-1963 for twelve months, seven hospital-habituated, schizophrenic males were involved in conjoint, family centered group therapy adapted to their needs. Five years later, we find six of them living in the community, with the continued support of the hospital. Of course, this accomplishment has only been possible because the Colorado State Hospital has since developed facilities for the patients' transition to community life, such as a day care center, foster homes, and halfway houses. We believe that, in spite of its brevity, our project provided the ground work for the remarkable improvement in six of the seven men.

THE SOCIAL INFLUENCE OF PSYCHODRAMATIC TECHNIQUES

EDUARDO A. PAVLOVSKY, M.D.

Buenos Aires, Argentina

My first contact with psychodramatic techniques arose from the urgency of developing new approaches adapted to the psychotherapeutic needs of psychiatric hospitals. Together with Dr. Rojas Bermudez, I introduced psychodrama in the treatment of groups of children and adolescents during our work in the XVIIIth ward of the Children's Hospital and the psychoprophylactic service of the 6th ward of the clinical hospital of both children and adolescents.

After working seven years in both services, we came to the conclusion that group psychotherapy combined with dramatic techniques within a psychoanalytic orientation was the most effective way to meet the social needs of both services.

Further training with Moreno in Beacon allowed direct contact with psychodrama, sociodrama and allied methods among which role-playing is the one we used for training professional workers in closed groups. These groups, which met weekly for two hours, consisted of members of the hospital staff. We dramatized the most important personal and group problems arising from daily contact with the children. After several minutes of discussion, one of the problems brought up was chosen, according to its urgency.

A director emerged spontaneously from the group: he assigned the roles and the proposed conflict was dramatized. Those members who did not participate in the first dramatization were soon called to assume roles in other dramatizations, each role being assumed by several persons and thus achieving a more complete learning experience. The next step was a discussion in which everyone participated, covering the different points of view arising in the dramatic enactment.

Guided somewhat through intuition, this was our first personally conducted contact with role-playing. There was a gradual growth of experience in this group formed by doctors, psychologists and persons interested in group dynamics and psychodrama.[1]

I perceived then the value of dramatic techniques and their direct application in the training of persons engaged in working with human groups in

[1] Training groups in the Argentine Association of Psychodrama and Group Psychotherapy.

institutions and communities, such as future social workers and group therapists. It is essential to establish the basic differences between the two main sources of dramatic technique and their different social projection.

In a session of psychodrama, the attention of the director and his team is focussed on the individual and his personal problems. As the protagonist's conflicts emerge in the group, the group members are involved in the action through their own conception of the roles and that of the central individual.

The attention is centered on the protagonist and, as Moreno says: "the group's opinion is used as a therapeutic means to reach several individuals in the same session. In psychodrama the group's opinions are related to a bunch of private individuals, and the group of these individuals is in a certain way private group.

"In sociodrama, the protagonist is the whole group, its aim is to know the group and the interpersonal relations between the members of a community. Psychodrama is directed especially to personal problems and aims at a personal catharsis, sociodrama treats social problems and tries to obtain social catharsis. In sociodrama the group occupies the place of the individual in psychodrama."

Role-playing, one phase of psychodrama, consists in playing roles existing in the community which need to be investigated. Our focus is on roles and not on personalities, and we attempt to study dramatic expression of the basic anxieties arising in human interaction. The issues arising out of the dramatization may be analyzed from varying frames of reference. We personally are inclined towards a psychoanalytic approach to group dynamics.

Our role-playing training groups are made up of social workers, therapists determined to apply group methods to juvenile delinquents and psychiatrists who have problems with staff members of the section under their charge. The dramatic techniques offer the possibility of concretizing the situations they face at work, permitting insights that lead to correction of inadequate conduct; they integrate the areas of thought, feeling and action.

The areas generally concerning the groups are: 1) problems of professional social work; 2) the creation of diagnostic techniques for the treatment of individuals or groups; 3) achieving insight into the group members' attitudes towards each other.

Role-playing is a dramatic action technique and basically prepares for action. Dramatization centers on concrete problems. It is assumed that members of the training group have specific situations to explore in their professional work: psychiatric settings, an emergency village, a family group, or group psychotherapy in the community.

The subject of dramatic investigation is important even though many times the real conflict emerges after several dramatizations; in that case, the proposed problem may represent a resistance to uncovering other, deeper underlying anxieties. Thus, a group of psychiatrists may dramatize personal problems of the team, to avoid facing the fear of insanity evoked by their psychotic patients.

Nevertheless, the investigation and understanding of interpersonal conflicts produced between the members of a training group allow us to comprehend the latent tensions existing in the investigated community and thus anticipate and prevent future conflicts. The training group is transformed into representative role carriers of the community and the tensions investigated will allow us to understand and deal with conflicts existing in the community.

Unfortunately, the rich possibilities of psychodrama and role-playing are perceived only through personal experience and involvement. The genuine dramatic insights which require no interpretation, are a special type of existential discovery, of a kind which can only be found in the actual process. The dramatic "here and now" has been, up to now, too little investigated in terms of a psychological scheme.

In our training groups we emphasize that the fundamental objective of role-training is to study roles, not to analyze personalities, to train, not to cure. Members of groups in training must be sensitized to search for the differences between the action of those dramatizing and the feelings the actors are conveying. The action is interrupted when the situational climax has been reached, after which there is a period of discussion dealing with the kind of feelings provoked by the enactment. The opinions of the actors are important, though the discussion is not focussed on their own personalities, but on the roles they represented. Usually the discussions center around the different premises on which the action was based, or on incidents similar to those dramatized and experienced in life itself.

If the group is large, it may be divided into two or three smaller discussion groups whose conclusions are then compared with those of the other groups.

A few illustrations of sessions follow, showing how we proceed, and indicating the dynamic opportunity for intense learning provided by this approach. A group of psychiatrists dramatized a session involving discussional group psychotherapy. After ten minutes of this there was only confusion. The director interrupted the scene and divided the group into two, for discussion of the dramatized situation. After brief discussion a new subject was suggested, namely, the first group psychotherapy session with institutionalized

psychotics. The roles were distributed thus: five doctors assumed the roles of psychotics, one the role of the therapist and the other that of the observer. The enactment led to a truly psychotic scene in which no attention was paid to the therapist, there was an atmosphere of deep hostility between the so-called "patients." When the confusion reached a rather alarming point, the director interrupted the scene and when the anxiety had receded, it was possible to begin discussing the enactment. The doctor who had played the role of therapist declared he had felt real panic because he sensed he had been confronted by a "real" group of psychotics in the scene. Those who had acted as patients really feared the "loss of control." while the observer, who had at a certain moment taken pains to safeguard the therapist, had felt the latter was in "real physical danger." The discussion centered on fear and from the group emerged a common anxiety, that of dealing with psychotic patients and having to face severe anxieties. The director pointed out that the first enactment (dealing with group psychotherapeutic techniques) was an intellectual defense to avoid confronting anxieties that emerged in the second. Obviously, a discussion, however heated, over techniques was more reassuring than dealing with fear of psychosis.

Another illustration is: the group suggests that a future social worker enacts a scene in which she knocks on the door of a family to be investigated. The members of the group assume various roles in the family. Three scenes are to be dramatized: 1) the family having supper; 2) a soliloquy of the future social worker as she walks towards the house and expresses her expectations; 3) the interview itself. After a suitable period the roles are reversed. New group discussion follows. The future social worker accounts for her behavior in the family group: "I pointed out to the mother that she has 'ideas of persecution,' and to the son that his difficulty in joining the family group is caused by 'his competition with his younger brother.' "

The director suggests that the social worker re-enacts the situation and shows the group how he arrives at the interpretation of "persecution" and "competition," that it is important to analyze the "what," not the "how" of the situation. It is surprising to discover how language can create distance and how it may be used as a defense against basic anxieties experienced in life situations. Thus, group members can experience that one basic problem is being reproduced in the dramatization, namely that the social worker's language used with the family members is too technical, too remote from the daily language of the low-income group members. Instead of language serving as a bridge for communication, it serves to set up enormous barriers—the very opposite of what the social worker is attempting to achieve.

The group proposes to follow up in their next meeting the problem of language and to listen to the tape recording of the scenes enacted. There is agreement that the level of communication was not good. This type of role-playing of the various roles of such people with whom the social worker will have to work permits the group members to obtain vivid knowledge of their experiences. In the dramatization of the role of the humble mother, the father, the son, etc., genuine insight is gained into the situation. It is amazing to discover the discrepancies between what the social worker believes she said and what she actually said in the interview. Role-playing shows the dissociation very clearly.

Dr. Anzieu considers role-playing very useful for psychologists as it helps them to break the dissociation caused by a long intellectual preparation and almost no practical training. Sometimes we think we know the people with whom we are dealing professionally, but our knowledge is merely an intellectual abstraction and completely without any real, concrete design.

Still another example: A psychiatrist wonders how to face an institutionalized patient's family, now that the patient is returning home. The group suggests the following scenes: 1) the psychiatrist takes the patient's role, when returning home; 2) the psychiatrist assumes the role of the patient's wife when they meet; 3) now the psychiatrist takes his own role facing the patient's family.

These same situations are dramatized from several different points of view. It is useful to record the scenes on tape to enable the students—in this case the psychiatrist—to hear his own words and have him soliloquize what the other person might have felt and thought when dealing with himself. For example, what would a low-income mother feel when told her child needs psychotherapy? What might be her ideas of mental illness, mental health, or of how psychotherapy might take? All these uncertainties are dramatized by the members of the psychotherapeutic team of a hospital service. One half of the group members take the role of the mother and express her doubts and expectations. The other half discusses the role enactments and then a final discussion with all the group members takes place.

Reformulating our earlier opinion, we must always bear in mind that the conflicts which emerge in the training groups in contact with institutions and communities are representative of the conflicts existing there. Therefore the group members embody not only the problems of their own work situation, but sometimes the group acts (in the sense of acting-out unconscious behavior) actual conflicts of the community through mechanisms of identification. During the psychodramatic dramatization, Moreno's therapeutic acting-out

takes place; the community's acting out is the irrational acting-out. The dramatic representation allows the acting to be made conscious and thus changes it from latent to overt, from unconscious to conscious. The "here and now" of the conflict produced is an identification with the conflict of the community group members whom they are facing.

Frank Riessman, in a paper entitled "Role-playing and the lower socio-economic group" (*Group Psychotherapy,* edited by J. L. Moreno, Volume XVII, No. 1, 1964), bases the success of this method with low income people on four main principles:

I) It is more appealing to them because of the physical action it implies and deals with concrete situations where intellectual reasoning and introspection are not required.

II) It allows the social worker, psychiatrist, etc., to honestly reduce the distance between their role and that of the person disagreeing with them, as well as to learn from inside "more about themselves".

III) Changes the setting of what appears as a bureaucratic, impersonal, institutional and strange world (verbal methods).

IV) It is an excellent way to develop verbal facility in persons with inadequate education.

I agree with Riessman especially as to the importance attached by persons of low socio-economic status to physical and motor activity, particularly that of the large muscles. Not only is their physical activity related to their work, the punishments they impose on their children, their religious expression, etc., but also when they become mentally ill, they translate their illness into their motor symptoms, such as hysteric conversion and catatonic disorders which are due to malfunction of voluntary muscles. They devote much time to sports and respond especially to extra-verbal language (gestures). They elaborate on mental problems better when they can do this physically. It is their own style.

Miller has come to some psychotherapeutic conclusions regarding this motoric style among low income persons. I believe it is important to search for a motoric style which may subordinate language and concepts not to verbal, but to motor activities. Role-playing adapts perfectly to this method for it enacts situations, not only refers to them. Humble people are less introspective and more readily attribute their problems to external forces, they tend to project and manifest more guilt. The psychology of the lower classes is therefore based on exteriorization, not on introspection; they are more readily affected by a therapeutic system which occupies itself more with interchange and exteriorization than with classic introspection.

Our deep interest in the use of psychodramatic techniques in groups is directly related to our belief that in the times in which we are living, where the need of collective effort is imposed on the individual due to the socio-economic and technical developments, maximim skill in handling human groups is indispensable.

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Officers for 1969-1970

President: Hannah B. Weiner; President-Elect: Abraham Knepler; First Vice-President: Doris T. Allen; Second Vice-President: Abel Fink; Secretary-Treasurer: Zerka T. Moreno.

Canadian Psychodrama Society, La Societe Canadienne de Psychodrame

Effective January 1968, the abovenamed society has been incorporated under Charter of the Federal Government of Canada. The founding directors are: Allen A. Surkis, M.A. (Ps), Montreal General Hospital, Que.; Martin L. Solomon, M.D., Hopital Ste-Justine pour les Enfants, Montreal, Que.; Mrs. Marjorie Bedoukian, P.S.M., Montreal Children's Hospital, Montreal, Que.; Miss Ann M. Sims, Montreal General Hospital, Montreal, Que.

Officers of the society are: President—Allen A. Surkis; First Vice-President—Carmen des Francs; Second Vice-President—Tobi Klein.

The primary goals of the Society are:

To foster psychodrama as a therapeutic approach; to further the interest and advance the standards for all hospitals, clinics and other agencies utilizing this method.

To improve professional functioning through offering a teaching program and the sharing within the membership of problems.

The sociey also aims to:

Stimulate research in the field of psychodrama.

Establish an interdisciplinary association which is bilingual, the official languages being English and French.

Form liaisons with other associations working in related fields.

Information concerning membership and activities may be obtained from: Miss Ann M. Sims, Department of Psychiatry, Room 669, Montreal General Hospital.

Convicts and Judges Swapping Roles in Psychodrama

A Workshop on crime and correction inspired by Dr. Richard Korn, Berkeley, California, has taken place in Annapolis, Md. sponsored by the National College of State Trial Judges and financed with a $67,000 grant from the U.S. Department of Health, Education and Welfare. The sessions were attended by 21 convicts selected to represent a cross section of inmates in Maryland prisons. A group of policemen, judges and prison officials took part. (See Time Magazine, June 27, 1969, page 78).

"In the Company of Men", a documentary film.

This film is presented by Newsweek Magazine. It examines the conflicting attitudes between so-called hard-care unemployed and company foremen, using the techniques of sensitivity training, role-playing and psychodrama.

American Psychiatric Association is developing an Archives of Memoirs.

They are obtained through taperecorded interviews of persons who have made significant contributions to psychiatry. Dr. J.L. Moreno has been asked to participate in this project. The interviewer of his taperecording is Dr. Ronald Robbins of Poughkeepsie, N.Y.

Fifth International Congress of Psychodrama and Sociodrama.

A Fifth International Congress of Psychodrama and Sociodrama will take place in Amsterdam, Holland in the fall of 1971. Honorary President is J.L. Moreno, M.D.; President, Dean G. Elefthery, M.D.; Secretary, D.H. Grunwald, M.D.

Magic Charter of Psychodrama

A short introduction into psychodrama is available at $1.00 per copy in English, German, French, Spanish and Dutch.

ANNOUNCEMENTS

Fourth International Congress of Psychodrama and Sociodrama

The Congress will take place at the Faculty of Medicine, University of Buenos Aires, Argentina, from August 24-31, 1969. The final two days will consist of a Panamerican Symposium Of Group Psychotherapy.

Honorary President: J.L. Moreno, M.D.; Honorary Vice-President: Mrs. Zerka T. Moreno; President: J. G. Rojas Bermudez, M.D.; Secretary: J. Bartolini, M.D.

Information may be obtained by writing to Dr. J. G. Rojas Bermudez, Coronel Diaz 1564—8 p. 34, Buenos Aires, Argentina.

Travel arrangements should be made through: International Congress Coordination Center, 9 East 38th Street, New York, N.Y., 10016; Telephone: (212) 683-3974.

Honorary Awards Extended to J.L. Moreno, M.D.

The "Golden Doctor Diploma", will be presented on May 14, 1969, by the Dean of the Faculty of Medicine of the University of Vienna, in the presence of Professor Hans Hoff, M.D., Director of the Psychiatric-Neurological Clinic of the University of Vienna, Austria, where J. L. Moreno graduated as physician in 1917.

While in Austria for this occasion, the Mayor of the City of Vöslau will officiate at a ceremony to be attended by Dr. and Mrs. Moreno on May 15, 1969. A plaque will be unveiled which has been affixed on the exterior of the building in which J.L. Moreno lived and functioned as Public Health Officer of that city between 1918 and 1925, and in which he wrote his early books on sociometry, the encounter, psychodrama, group psychotherapy and his theologic position as set forth in THE WORDS OF THE FATHER, among others. Dignitaries of the City of Vöslau and of its most important industrial organization, Die Kammgarnspinnerei, a large textile mill employing more than three thousand workers who Dr. Moreno attended as physician during his seven year tenancy of the position as Public Health Officer, prior to his arrival in the United States, will also be present.

Moreno Academy, New Directors

Elaine Goldman, Chicago, Illinois; Byron Eicher, Kansas City, Missouri; H. Donell Miller, St. Louis, Missouri, have been certified as Directors since the publication of the Directory.

American Psychological Association Meeting, Washington, D.C., September, 1969

J.L. Moreno will participate on the program of this meeting in the section "Demonstrations in Psychotherapy: Current Trends in Techniques of Psychotherapy—Live Demonstrations", Division 29, Monday, September 1, Room 115 East, Mayflower Hotel, 12:00-2:50 p.m.

Two motion pictures: "Psychodrama of a Marriage, Including the Psychodrama of a Dream", and "Psychodrama in Action", both directed by J. L. Moreno, will also be shown in the course of the meeting.

A New Associated Establishment of the Moreno Institute

A third Associated Establishment on the West Coast has been approved by the Moreno Institute: The Berkeley Institute of Psychodrama and Group Psychotherapy, under the direction of Dr. Richard Korn. Further details will be contained in the next issue of the Directory of the Moreno Institute.