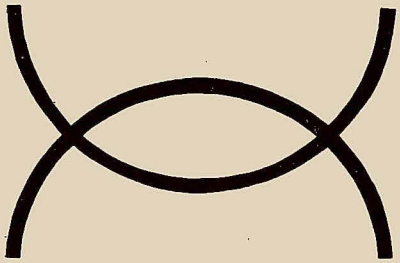
GROUP PSYCHOTHERAPY

A Quarterly



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GROUP PSYCHOTHERAPY

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FOUNDED BY J. L. MORENO, 1947

THE CONCEPT OF THE HERE AND NOW, HIC ET NUNC SMALL GROUPS AND THEIR RELATION TO ACTION RESEARCH

J. L. MORENO, M.D.

Moreno Institute, Beacon, N.Y.

Because of the great importance which the concept of the Here and Now has assumed in psychiatry as well as in the social sciences in the last fifty years, a few quotations and some of my early definitions are given here in chronological order.

From "Mental Catharsis and the Psychodrama," *Sociometry,* Vol. III, 1940, p. 209-210. "The most important concept in all human thought, the concept of the moment—the moment of being, living and creating—has been the stepchild of all universally known philosophical and therapeutic systems. The reasons for this are that the moment is difficult to define; that it has appeared to most philosophers as but a fleeting transition between past and future, without real substance; that it is intangible and unstable and therefore an unsatisfactory basis for a system of theoretical and practical philosophy. Some phenomenon on a different plane than that presented by the moment, itself, had to be found which was tangible and capable of clear definition, but to which the moment was *integrally* related. I believe that I accomplished this in analyzing 'cultural conserves.' A cultural conserve is anything that preserves the values of a particular culture, it is the finished product of a creative process, for instance, a book, film, building or musical composition. The cultural conserve is a concept in the light of which the dynamic meaning of the moment can be reflected and evaluated and thus become a frame of reference."

From "The Philosophy of the Moment and the Spontaneity Theater," *Sociometry,* Vol. IV, 1941, p. 206. "The first step towards a philosophy of the moment is to define and establish the moment as a concept in its right. Previous approaches to the problem of the moment have failed to accomplish this or neglected it altogether. A study of the moment in experimental situations, parallel to and as a follow-up of a philosophical analysis of the subject provides one method of arriving at a definition of the moment. In the establishment of a point of reference, three factors must be emphasized: The *status nascendi,* the *locus,* and the *matrix.* These represent different phases of the same process. There is no thing without its locus, no locus without its status nascendi, and no status nascendi without its matrix."

Philosophic definition from "Die Gottheit als Redner," *Der Neue Daimon,* Vienna, 1919, p. 17. (English translation from the German.) "The

meaning of the decision is in this moment, the Here and Now, even if you have lived through all the instants of the past and will live through all the instants of the future."

Existential definition, 1922, The Here and Now, the Moment, Hic et Nunc, from *Rede Uber den Augenblick,* 1922, also contained in *International Handbook of Group Psychotherapy,* 1965, p. 36. "How does a moment emerge? A feeling must be related to the object of the feelings, a thought must be related to the object of the thoughts, a perception must be related to the object of perceptions, a touch must be related to the object of touching. You are the object of my feelings, the object of my thoughts, the object of my perceptions, the object of my touch. Such is an encounter in the Here and Now."

Psychiatric definition, 1932, Principle of A-Historical Treatment, The Here and Now, from *Application of the Group Method to Classification;* also contained in *The First Book on Group Psychotherapy,* 1957, p. 21, and *The International Handbook of Group Psychotherapy,* 1965, p. 39. "Both Freud and Jung have studied man as an historical development; the one from the biological, the other from the cultural aspect. On the other hand, our approach has been that of *direct* experiment; man in action, man thrown into action; the moment not a part of history but history a part of the moment—sub species momenti."

Kenneth D. Benne and Bozidar Muntyan, the editors of *Human Relations in Curriculum Change,* published by the Dryden Press, New York, 1951, state as follows: "Dr. J. L. Moreno, has pioneered in the areas currently referred to as psychodrama, sociodrama, roleplaying, action dynamics, warming-up technique, group psychotherapy and sociometry, and first introduced these terms into the literature, with some of the meanings emphasized in the present volume. To a great extent, the basic impetus for certain new trends in group and action research can be traced to the work of Moreno and his numerous associates." The Volume contains contributions from Douglas McGregor, Kurt Lewin, Paul Grabbe, Alex Bavelas, David H. Jenkins, Irving Knickerbocker, Alice Miel, Leland P. Bradford, Ronald Lippitt, Herbert A. Thelen, Paul Sheats, Watson Dickerman, Marian Radke, Charles E. Hendry, Alvin Zander, Donald Nylan, Arnold Meier, Alice Davis, Florence Clearly, Helen G. Trager, George E. Axtelle, B. Othanel Smith, and R. Bruce Raup.

This openly acknowledges that the work of Kurt Lewin and that of his associates is based upon the researches initiated and carried on between 1932 and 1951, and up to the present, under my direction. (See "Preludes of my Autobiography," *Who Shall Survive?,* J. L. Moreno, M.D., 1953, Chapter on "Group Dynamics.")

PRESIDENTIAL OPENING ADDRESS, FOURTH INTERNATIONAL CONGRESS OF PSYCHODRAMA AND SOCIODRAMA

J. G. ROJAS-BERMUDEZ, M.D.

Buenos Aires, Argentina

Mr. Secretary of Public Health: Dr. Ezequiel M. Holmberg; The Director of the National Mental Health Institute: Mr. Julio R. Esteves; Mr. Honorary President of the IV Congress of Psychodrama and Sociodrama and the First Panamerican Symposium on Group Psychotherapy: Dr. J. L. Moreno; The Honorary First Vice-President: Mrs. Zerka T. Moreno; The President of the First Panamerican Symposium on Group Psychotherapy: Dr. J. J. Morgan; the Delegate for the Foreign Representatives: Dr. Lawrence Kolb; Delegate for the Sao Paulo Psychodrama Study Group: Psychologist Iris Soares de Azevedo; Director of the National Hospital: Jose T. Borda; Dr. Carlos J. Sisto, Professor of Psychiatry of the Buenos Aires University, Dr. Fernando Fabregues, Ladies and Gentlemen:

In the name of the Organization Committee and the Asociación Argentina de Psicodrama y Psicoterapia de Grupo, I wish to give you the warmest welcome.

We shall be together during this week to talk, exchange our experiences and investigations in the field of human interaction.

We shall be working in common using action techniques in order to achieve the best possible communication between speakers and audience, all this within an affectionate climate in order to bring us closer together and stimulate communication.

In this way we plan to exchange our mutual experiences as individuals interested in solving the conflicts of the human mind, more than specialists merely trying to defend their own psychiatric ideology.

We shall cover various subjects from Individual Psychodrama and Role-Playing to Therapeutic Community and Psycho-Pharmacology. Each of the specialists will give his opinion within his specific field, but will not be limited to words only. Everybody will be able to participate actively in the discussions, express his views and tell about his experiences. This will be made possible through the different activities such as Permanent Theatre, Workshops, Creativity Workshops, Round Tables, Films and Slides.

This Congress is our Fourth one and as in the previous ones it will be honorarily presided by Dr. J. L. Moreno, brilliant creator of Group Psy-

chotherapy, Psychodrama and Sociometry, who in this way supports and adds prestige to the Argentine Psychodrama Movement.

Furthermore, the fact that this Congress is held in the city of Buenos Aires, is an evidence of the high degree of development that this method has achieved in our country, among other world-wide known techniques. The concentration of these schools in the City of Buenos Aires and the influence they have on the rest of the country and throughout the continent, makes it the Psychiatric Capital of Latin America.

In accordance with the principles of Psychodrama of doing more than saying, I shall bring this speech to an end in order to start the activities of the Congress which shall be initiated by Mrs. Zerka Moreno at the Permanent Theatre.

Therefore, as President of the FOURTH CONGRESS, I hereby declare the same open, and invite all of you to participate in its activities.

LAS PALABRAS DEL PADRE*

J. L. Moreno, M.D.

Moreno Academy, World Center of Psychodrama, Sociometry and Group Psychotherapy, Beacon, N.Y.

Amigos:

Es para mi un profundo honor estar aquí en esta oportunidad con nuestro amigo el Dr. Rojas Bermúdez quien ha hecho tanto para preparar el camino.

Pienso que ya los conozco, que conozca a cada uno de ustedes-individualmente, hoy no necesito al Dr. Rojas-Bermudez, cada uno de ustedes es un Rojas-Bermúdez.

Hay un libro que vamos a publicar ahora en castellano, el nombre del libre, es "Las palabras del padre." Qué significa este libro para ustedes y para mí?, qué es lo que el padre desea de nosotros?

"Las palabras del padre" ofrece un compromiso; lo que el mundo necesita en la actualidad es unidad, si no existe unidad en el cosmos, si no existe humanidad, si nos dividimos en trocitos, en pedazos, no existe esperanza para la humanidad, el hombre no va a sobrevivir. Para unir a la humanidad tenemos que comenzar hoy aquí, en Buenos Aires. Ustedes tienen que iniciarlo. La familia, hermanos, y hermanas, amantes, cada pequeño grupo, porque las revoluciones no nos han ayudado. Ha habido una revolución americana, rusa, francesa, china, cubana, a qué hemos llegado? A nada. Tenemos que hacer algo entrenosotros, tenemos que hacerlo con un método y en los pequeños grupos. Ustedes y yo, ustedes, ustedes son los que tienen que continuar.

Hemos llegado a la luna, llegaremos a Venus, Marte, conquistaremos todo el universo físico, pero estaremos en las mismas pobres condiciones actuales; el mundo físico está vacío, perderemos nuestra alma.

Amigos, estas son las palabras del padre, este es el compromiso con la humanidad; hay que crear una verdadera familia humana.

"Las palabras del padre" son: "Yo los creé a ustedes, ustedes tienen que seguir creando, crearse a sí mismos, tienen que trabajar para una forma final de humanidad, para la paz, porque hace falta creatividad y no puede haber creatividad si se matan los unos a los otros. Yo los dejo a ustedes, a mi hijo Rojas-Bermudez, a mi hijo Moreno, a mi hija Zerka, yo les dejo a

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* Closing speech delivered at the IVth International Congress of Psychodrama and Sociodrama, Buenos Aires, Argentina, on August 27, 1970.

ustedes el psicodrama, la dinámica de grupos, la sociometría, la psicoterapia de grupo, pero hace falta que ustedes vivan todo eso, no lo dejen en libros muertos, tienen que vivirlo para llegar a una solución." Las palabras del padre siguen al viejo testamento y al nuevo testamento, es un testamento de nuestra época.

Nunca se trató de trabajar de abajo hacia arriba. Karl Marx fué un gran pensador, pero quiso trabajar con las grandes masas, y se olvidó de los pequeños grupos, de la gente y esos pequeños grupos no tenían padres, no tenían madres, no tenían su propio yo y quedaron pasivos esperando a Hitler, esperando a Musolini. Nosotros no los necesitamos, cada uno tiene que comenzar por si mismo, cada uno de nosotros con nuestros pequeños mundos, porque en esos pequeños mundos es donde hay espontaneidad.

Marx fué un hombre enfermo, no pudo hacer nada por si mismo, murió enfermo del hígado, perdido en sus pensamientos, indefenso. Hitler se suicidó, mató a su amante, qué pasó? Nada, mucho ruido, demasiado ruido.

Vivimos en un mundo desesperado, todos están desesperados, todos vivimos esperando el instante de la muerte, yo puedo ver aquí cadáveres, muchos cadáveres, pera dentro de 50 a 60 años, de modo que hay que vivir ahora en un mundo nuestro y no esperar.

Seguramente ustedes dirán que ya han oido estas palabras, es cierto, ha habido muchos hombres sabios, Buda, Cristo, lo han sido. Son palabras sabias, pero la sabiduría no es suficiente, hace falta acción.

Las palabras del padre no dicen nada nuevo, es algo que ustedes ya saben internamente en sus corazones y saben que es cierto.

Yo pienso con mucha certeza que debemos empezar aquí en Buenos Aires. América Latina comprende muchos paises: Brasil, Venezuela, Colombia, Paraguay, Uruguay; realicemos entonces un congreso cada año en Latinoamérica, pero un Congreso no de Palabras sino de acciones, un congreso para aprender a vivir, porque el psicodrama es un método que nos enseña a vivir a todos, a los médicos, a los esposos, a las esposas, a los electricistas, a las mecanógrafas. Para aprender a vivir, y por ese motivo, hemos decidido que nuestro próximo congreso tendrá lugar en Brasil, en la ciudad de San Pablo, el año próximo. Salud Brasil, salud.

Esta es mi esposa Zerka, ella y yo somos socios, viajamos por el mundo difundiendo las palabrás del padre, porque entendemos que se puede hacer algo ahora, en nuestro tiempo, algo que podemos hacer ustedes y yo, algo para nuestro mundo, para ello no necesitamos dictadores, no necesitamos filósofos.

Las palabras del padre, no es una obra mística, es una cosa relacionada

con hechos, es algo acutal, es operacional, es util si se utiliza; de modo que abro mis brazos al Brasil donde estaremos el año próximo, abro mis brazos a San Pablo, a Río, a todo el Brasil, y también a toda Latinoamérica, vamos a encontrarnos con ellos, que es el encuentro que tengo hoy aquí con ustedes, corazón a corazón.

Un encuentro de dos: ojo a ojo, cara a cara
y cuando esté cerca arrancaré tus ojos
y los colocaré en el lugar de los míos
y tú arrancarás mis ojos
y los colocarás en el lugar de los tuyos
entonces, yo te miraré con tus ojos
y tú me mirarás con los míos.

ADDRESS GIVEN AT THE INAUGURAL PLENARY SESSION OF THE IVTH INTERNATIONAL CONGRESS OF PSYCHODRAMA AND SOCIODRAMA

LAWRENCE C. KOLB, M.D.*

New York State Psychiatric Institute, New York City

Señor Presidente, distinguidos invitados, Doctor y señora Moreno, Señoras y señores: Mis colegas miembros de la Asociación Americana de Psiquiatría, a la cual tengo el honor de representar, siento un gran placer en traer a ustedes nuestro saludo y nuestros mejores deseos para el éxito de estas reuniones: el Cuarto Congreso Internacional de Psicodrama y Sociodrama y el primer simposio Pan-Americano de Psicoterapia de Grupo. Este honor y privilegio me brindan una oportunidad de saludarles personalmente y de expresar mi interés y entusiasmo al reunirme con esta representación de los psicodramaturgos y psicoterapistas (de grupo) de América. Nosotros debemos especial reconocimiento a mi compatriota y colega Doctor J. L. Moreno, vuestro presidente honorario y su distinguida esposa. El entusiasmo, creación y la energía de los doctores Moreno han contribuido notablemente al desarrollo y utilización terapéutica del psicodrama. Nosotros en los Estados Unidos, así como los psicodramaturgos de otras naciones, hemos contraido una deuda de reconocimiento con los doctores Moreno, por su trabajo y dedicación de tantos años. Fue motivo de gran satisfacción el conocer, hace varios años, a vuestro presidente, Doctor Jaime Rojas-Bermudez, cuando ambos compartíamos responsabilidades educativas en un simposio internacional de psiquiatría, celebrado en el Hospital Central del Empleado de Lima. En esta ocasión, me fue posible apreciar su gran talento y liderato como psicodramaturgo. Hay aún mucho que aprender de estos medios de psicoterapia, desde el punto de vista teórico y técnico. Espero que en el esfuerzo común, nos sea posible beneficiarnos con el intercambio de ideas aportadas por los residentes de diferentes naciones. Nuestras diferencias culturales y las experiencias diversas en la práctica de estos métodos, nos darán nuevos enfoques de los que todos habremos de beneficiar nos. Al concluir, permitanme expresar mi gran agradecimiento y satisfacción de haber sido honrado con la invitación de dirigirme a los participantes en este congreso. Muchas gracias.

* Member of the Committee of Honor; official delegate of the American Psychiatric Association.

THE "INTERMEDIARY OBJECT"

JAIME G. ROJAS-BERMUDEZ, M.D.

President, Asociacion Argentina de Psicodrama y Psicoterapia de Grupo, Buenos Aires

The rapid acceptance of the term "intermediary object" induced me to write the present paper, in order to clarify the meaning I assigned to it. I started to use this term—scarcely three years ago—when referring to the doctor-patient relationship, and presented it for the first time at the II International Congress of Psychodrama, Barcelona, 1966.

Historically, the term is related to the experiment conducted with chronic psychotics, using puppets to capture their attention during psychodramatic sessions.

I thus could observe the enormous appeal which puppets exert when expertly handled, as well as the favorable effect they have in speeding up the warming up process. What previously took from 30 to 45 minutes was reduced to 5 or 10 minutes. But I also could observe that the effect produced by the puppets was not limited merely to winning the attention of the patients. The puppets constituted a valuable tool of communication. Here are some examples:

Case I: At the start of a session, patient A is worried about B, one of his comrades; during the last few days B has scarcely uttered a word and appears to be in a hallucinatory state. I try to talk to B about this, but without success; not one word could be extracted from him. Then I devote my attention to other patients. Finally I ask the auxiliary ego puppet player to address B to see if he can get some answer, and if so, to put to him the questions which I previously failed to get answered. The puppet appears and, after a short introductory monologue, he addresses himself to the patient, calling him by name. The latter observes it attentively, and answers its greeting. Thereupon a dialogue starts immediately. The puppet put the above-mentioned question to him, the patient answers without any resistance and, at the same time, shows his sympathy for the puppet.

Case II: A patient suffering from severe auditory hallucinations constantly broke into the ongoing action on the stage, apparently unaware of what was happening around him. We tried various means of communication to establish contact with him, but our endeavors were repaid by only a conventional phrase here and there, after which he surrendered again to his hallucinations and left the stage. One day, however, after a puppet called him by his name and kept speaking to him, he looked very surprised, smiled and then started dialoguing with it. From this first contact between puppet and patient on, a radical

change could be observed in the latter's attitude. Not only were we able, from then on, to have him pay attention to all dramatizations, but he rarely failed to participate in a session, at first with the puppets and later with the auxiliary egos.

Case III: I was informed that one of the patients had had some trouble the evening before with his chief warden. I asked him to tell me what happened, but he stubbornly kept silent. Then I took recourse to one of the puppets, asking the auxiliary ego to repeat my questions to him. The patient not only paid the puppet the necessary attention but related to it all that had taken place.

The essential fact in these three instances is that with the puppets I could get an answer which was impossible to obtain personally. What was the reason for the patients answering when the questioning source was not a human one? In examining this operation we were able to discover the above-quoted phenomenon in all such cases in which the patient found himself in a state of intense alarm, or was experiencing some alterations in his body image.

The common denominator in all of our cases was the fear of being invaded or penetrated by the questioning source when this possessed all the human characteristics. In other words, the puppet, not owning such human characteristics, represents an innocuous object for the patient and thus becomes therapeutically useful.

On the basis of its being an object and due to its function of intermediation, I decided to call it "*intermediary object.*"

The self, as the psychological boundary of the personality, has a protective function and in this sense it is closely related to the defense mechanism. It corresponds, at the physical level, to the peri-bodily life space every individual needs in order to feel comfortable. Experimentally, this can be verified by slowly approaching a person whom we are going to investigate until he or she is manifestly uncomfortable. It thus becomes clear that every individual has the need of a minimal distance in order to locate his interlocutor, and how such distance varies according to the stimuli used and to the psychological moment in which he finds himself. The discomfort one feels when another person enters our "personal territory," when he breaks into one's peri-bodily space, corresponds, at the psychological level, to the moment at which another individual's role comes into contact with the self, and this happens for the lack of a complementary role with which to interact. In such cases the subject may physically step back a little, or push the other person with his hand; psychodramatically speaking, the protagonist steps out of his role or resorts to "irrational acting out."

The roles are extensions of the ego by means of which it enters into relations with the complementary roles, e.g., father-son, seller-buyer, therapist-patient, thus producing a tie, e.g., filial, commercial, therapeutic. There are well developed roles which extend beyond the boundaries of the self, as well as insufficiently developed roles which remain in the area of the self. These roles only come into contact with their complementary ones through the self, except when constricted through anxiety.

The role relationship is characterized by the little compromises it involves and by the possibility it offers to continually objectify the "tie," given the "distance" at which the play is taking place.

> *Case IV:* A girl psychology student expresses fear of institutionalized mental patients. A scene is enacted in which the student is on her way to her own training department in the hospital. A male auxiliary ego, taking the role of a psychotic patient, approaches her. The girl stops walking and in an attempt to be kind and considerate, speaks to the "patient." As she attempts to walk away the auxiliary ego stops in front of her and asks her for some money. She gives it to him, then tries again to part with him. When the auxiliary ego newly confronts her and keeps on talking to her, she stops again and acts as if paralyzed. She is overwhelmed and unable to find a way out. Finally, she implores the director to stop the scene because she is so full of anxiety that she cannot carry it through to adequate completion.

In this case the protagonist enters the scene without hesitation, in the "as if" of the psychodrama. The auxiliary ego, in the course of enactment, assumes more and more the characteristics of his assigned role, inducing her to produce the complementary one which should allow her to resolve this situation adequately. The fit of anxiety aroused in the "as if," mingling fantasy with reality on the role level is, according to the view we outlined above, a consequence of the role of the auxiliary ego coming into contact with the self of the protagonist. The protagonist knows she is acting in a psychodramatic scene and that the auxiliary ego is not a psychotic, but on the role level she responds as if all this is actually happening at the hospital with a patient; she therefore ends in the same manner as in life itself, namely finding it impossible to carry the scene through to the end.

Every time another person's role enters into contact with the self, such a situation is experienced at a personal level and therefore sensed as real. We have described above that we think of the self as represented by the external circumference of a circle, and we compared it to a cellular membrane which covers the ego in its entirety.

The limit is not fixed; it may change in accordance with various con-

ditions in which the individual finds himself. In states of alarm caused by external or internal stimuli, the self expands; this expansion may reach, in some extreme cases, a situation in which it covers the roles completely, e.g.: in panic states. Through the effect of the warming up, however, the contrary happens, the self tightens and may thus come into contact with the ego, e.g.: in the sexual act.

We have referred above to cases I, II and III in which we used the puppets as intermediary objects to make this connection and establish communication. In these and similar cases the state of alarm maintained the self in such a manner that it did not permit the creation of ties as in role relations, since the roles were enclosed into the self. Utilizing the puppets as "intermediary objects," a degree of warming up could be reached which allowed the arousal of the roles and opened up the contact with them. Furthermore, in those cases in which a higher warming up could not be attained and/or the roles were very little developed, the puppet, being an innocuous element, made the communication feasible. The "intermediary object" is able to cross the barrier of the self without releasing alarm reactions; this neutral quality enables it to be used as a therapeutic tool in the role-intermediary object-role relation. On the other hand, this usefulness does not extend to the reduction of severe mental disorders. But it is applicable to all those cases which present insufficiently developed roles and upon which one wants to act therapeutically, and/or alarm states which maintain the expanded self.

> *Case V:* In a group of adolescents, one of the group members reveals his difficulty in expressing his feelings towards girls. An enactment is constructed involving a scene at a party. The protagonist approaches a group of girls among whom there is one he likes particularly and who has motivated the scene. She is portrayed by an auxiliary ego. The boy starts to talk to her about this and that without any apparent difficulty. Upon a given signal of the director the other girls start withdrawing until he is left alone with the auxiliary ego. The latter invites him to go out into the garden with her, where they can talk in greater intimacy, and more quietly. At this point the protagonist, now manifestly perturbed, falls out of his role and asks the director if he must continue the scene. Thereupon the scene is repeated with the intervention of puppets. In this new situation the protagonist carries on until the enactment culminates in a touching amorous scene, between his puppet and a puppet standing in for the girl.

In this case, the protagonist was able to play the role he could not perform with a girl, thanks to the intermediation of the puppets. The puppet, as an intermediary object, allowed the complementary roles to function. Other

examples may be given in which the utilization of the intermediary object is indicated, even where we find a well developed role. We are referring to such circumstances in which the nature of the role played is apt to release an unexpected alarm reaction in which the protagonist feared that he either could not exert any control or would be afraid to lose control as he warmed up to its total enactment. In general, such scenes are those in which aggressive or erotic roles come into play.

The intermediary object may, in turn, be utilized as a stimulus for making manifest unconscious aspects or conflicting behavior which the protagonist has been avoiding through replacing them with innocuous roles.

> *Case VI:* A didactic psychodrama group was passing through a very competitive stage without any overt manifestation of rivalry towards the director. In one of the dramatizations the director put a handkerchief on the floor, without any explanation. The enactment continues, evolving slowly, gradually focussing upon the handkerchief. At a certain moment the five persons involved in the enactment sit down in a circle around the handkerchief, thus introducing this new element into the action. One of the group members puts up his hands, as if in front of a heap of live embers; another one pushes the handkerchief with his foot. A third one picks it up, examines it and pretends to clean his nose with it. Seeing this, the fourth one crumples it as if it were a useless piece of paper and the fifth one picks it up, smoothes it out and lays it out like a tablecloth. The rest of the group react to the last stimulus and enact a picnic. Each of them speaks about the things on the tablecloth and praises what he eats until one of the group members finds ants in the food and blames another for not properly protecting and taking care of the food; two others join this protest, adding that the foods are not well seasoned. Now they start arguing about the responsibility each one was supposed to have for the preparation and protection of the food. The fifth member, who has not spoken so far, starts picking up the handkerchief, keeping it for himself. The others, seeing this, throw themselves upon him and in the midst of the struggle the handkerchief is torn to pieces; this brings all action to a complete stop, leaving them silent and unable to do anything further.

This case offers us a clearly distinguishable view of the different responses of the various co-protagonists to the stimulus: the director's object, as well spontaneous changes successively brought about in the dramatization which developed along lines of interplay according to the way they obviously were relating to the therapist.

It is important to trace the significance of the warming up process under such circumstances, for when it is intense, the participants get lost in the situation, becoming involved to such a degree that they proceed to satisfy

their act-hunger, without any part of themselves being able to stand aside to record and observe their actions.

When we take into account the last example, it becomes easy to understand the possible application of intermediary objects to other, nonpsychodramatic areas, as might, for instance, be the case in occupational therapy.

The following are some of the qualities I consider indispensable for an object to be suitable as an intermediary object:

1. Real, having concrete existence.
2. Malleability, so that it can be used at will in any kind of play between complementary roles.
3. Innocuity, it should not release reactions of alarm "per se."
4. Transmitter, allowing the communication to pass through it and replacing the role tie as well as keeping the necessary distance.
5. Adaptability, to be adequate for the subject's needs.
6. Assimilability, to allow a relationship sufficiently close so the subject can identify himself with it.
7. Instrumentability, so it can be used as an extension of the subject.
8. Identifyability, so as to make it immediately recognizable.

MORENO ACADEMY, WORLD CENTER OF PSYCHODRAMA AT BEACON, N.Y., AS SEEN BY AN ARGENTINIAN

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A small town, about 60 miles away from Manhattan, Beacon, N.Y. is the place where Dr. J. L. Moreno lives with his wife Zerka. The place itself is one more of many small towns along the Hudson River. There is nothing special about it, except for the presence of the most unique training center I've ever seen: "The Moreno Academy," training center of psychodrama. In spite of a statement in the bulletin which reads: "Sessions from 10:00 a.m. until 12:30 p.m., from 3:00 p.m. to 5:30 p.m. and an evening session lasting about two hours," one can say that Psychodrama is the subject at Beacon, 24 hours a day, and 7 days a week. People from everywhere come and go; one may run into a Frenchman, an American or an Argentinian and for as long as you plan to stay you will work constantly, without a day off. As a matter of fact, there is no such thing as a "day off" for J. L. Moreno or his wife Zerka. She supervises the training, runs the afternoon session while "the Doctor," as everybody calls him, is usually seen in the evening. On Friday they go to New York City where Zerka runs a public session at the Moreno Institute. Back to Beacon for the weekend, since that is the time when Beacon has more people coming. In addition, a session open to the public of the Mid-Hudson valley area has recently been instituted, taking place every Saturday night at the Beacon theatre. The reason for weekends being so busy is that many people in training fly or drive in on Fridays and stay until Sunday night or Monday, when they go back to their work.

I shall now explain why I call Beacon a "unique" place. First of all, you have a strange feeling from the very beginning: here people have the opportunity to meet other people, not socially, but in a very peculiar atmosphere, created by psychodrama; you get to know them deeply, intimately, in a very short time. The only way to keep that atmosphere is to ask people in training not to leave the premises while you study; they want you to stay there. I had planned to go back and forth to Manhattan every day because my wife was there. Moreno asked me to remain in Beacon. At first I was rather annoyed and only later I understood the reason for that rule (even if it is not listed as such). They want to have every reaction registered inside Beacon and in the group and if they let

you go out, part of the experience would be wasted, often the most important reactions, such as the aggression aroused by the learning process, which would not be expressed inside the group if they would give you a channel for sending it outside. You feel as if you are captive, and you are, but it would not be such an experience if you were not.

When I arrived at Beacon from Buenos Aires, a senior student met me at the door. He was polite, wanted me to feel at home but did not push me; as a psychodramatist he knew I was in the midst of a warming up process. He introduced me to the rest of the group members; there were people from New York, Chicago, Philadelphia. They were discussing the morning session and there was nothing academic about it. Lunch followed and they went on, arguing loudly. I felt very much a stranger. Dr. Moreno telephoned me and asked to see me at his home and it came as a relief. I had met him in Buenos Aires, at the IVth International Congress of Psychodrama and his warm smile met me again in Beacon. He was as kind as usual. I couldn't help feeling as if I was in the presence of a father; wise, warm, yet firm and knowing exactly what he wants.

I felt much better after our talk. The afternoon session started and to my surprise no one told you what to do. Spontaneity was the only rule. Someone said he wanted to direct, another person wanted to be the protagonist. The subject of the session was something actually that had occurred just after lunch, a real life event in which a number of group members present had participated. They jumped into the scene and—psychodrama started. It took place around an actual event, in the here and now, and was processed thoroughly from every group member's point of view, with opportunity for role reversal and doubling for one another whenever indicated. In this way, our life together became the center of attention; it was a genuinely group-oriented process. By the time the session ended I was a member of the group, sharing the experience the way everyone else did, as a participant and co-experimenter in an ongoing fashion. Now I really had arrived in Beacon, and one thing I feel I learned is the true meaning of "sharing."

PSYCHODRAMA AT A PSYCHIATRIC CLINIC

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PSYCHODRAMA IN SOUTH AMERICA

The first Latin American nation to accept psychodramatic therapy was Argentina, first through some sporadic trials soon abandoned. These experiments were made by Dr. Morgan at the Neuropsychiatric Men's Hospital and by Dr. Salas Subirat at the British Hospital and at Room XVII of the Children's Hospital.

Dr. Jaime G. Rojas-Bermudez, the present Chairman of the Argentina Group Psychotherapy and Psychodrama Association, started his psychodramatic activities in 1957, at the Federal Capital Neurosis Institute, in Room XVIII of the Children's Hospital (1959) and in Room VI of the Hospital of Clinics, First Pediatric Department (1961), when invited to organize the Psychoprophylactic Service together with Dr. Bekey.

In 1962, J. Rojas Bermudez established contact with Dr. Moreno and his collaborators and in the following year he visited the US together with Dr. Maria Rosa Glasserman and Dr. Eduardo Pavlovsky, all of them enrolling for psychodramatic training at the Moreno Institute. That same year, Rojas-Bermudez received his certificate as Director of Group Psychotherapy and Psychodrama, soon afterwards founding the Argentina Group Psychotherapy and Psychodrama Association.

PSYCHODRAMA IN SAO PAULO, BRASIL

In 1960, Dr. Jaime Bermudez took part in the Fourth Latin American Group Psychotherapy Congress in Porto Alegre, Brasil, and presented a demonstration to its participants.

Among the participants Dr. Blay Neto of Sao Paulo enthusiastically undertook an experiment with a group of actors from a Sao Paulo theatre, but abandoned this project after a while. At that time, Iris Soares de Azevedo, a psychologist and sociologist became aware of Moreno's work and started to apply psychodrama techniques at the Colmeia Institute and at her office, together with Dr. Paulo Gaudencio.

In 1965, Mrs. Azevedo started working together with Dr. Alfredo C.

Soeiro and Dr. M. Rosario in their private practice. In 1966, these three took part in the Second International Psychodrama Congress in Barcelona and while there, met Dr. Rojas-Bermudez.

In 1967, Dr. Rojas-Bermudez came to Sao Paula, to attend the Fifth Latin American Group Psychotherapy Congress and on that occasion gave a psychodrama demonstration which attracted great attention among the participants.

Psychodrama is now well accepted in Sao Paulo and various psychodrama programs have been begun at a number of institutions, f.i., the Sedes Sapientes Psychological Clinic, the Civil Service Hospital, the Sao Bento School of Philosophy, the Psychiatric Clinic at the Hospital of Clinics of the Medical School, Sao Paulo University, as well as at several private clinics.

At the Hospital of Clinics of the Medical School of the Sao Paulo University, whence the present paper stems, the author Dr. Jorge W. F. Amaro, Physician in Charge of the Group Psychotherapy Sector, invited Dr. Alfredo C. Soeiro to read a course in Psychodrama for interns, psysicians and psychologists interested in the method.

Numerous therapeutic-didactic sessions have been conducted and Dr. Jorge W. F. Amaro participated as a member of the group. The present paper was worked out from notes taken at these sessions. As a result, in 1968, the Psychodrama Sector was founded and linked to the Group Psychotherapy Sector, under the direction of the authors, Dr. J. Amaro and Dr. Alfredo C. Soeiro, consisting of two pilot therapeutic-didactic groups and of dramatic play, research and training activities.

The Pilot Psychodrama Group

The group consists of psychiatrists, psychologists, medical and psychology students. All of them are well acquainted with analytic group therapy; some were patients in analytic group therapy for more than four years; others have completed their group analytic therapy and have from four to six years experience as group analysts. At the beginning of the undertaking there were approximately fifteen group members. The group started out first by discussing general topics such as schedules, the number of group participants, the viewpoint of the hospital administration, who should and should not participate, etc.

From the beginning, there was great difficulty in accepting the existence of an established authority who exerted restraint on the group's needs for freedom of expression. A psychodrama representing this difficulty was

produced. The person holding the group leading position was assigned the role of a hospital director whose duty it was to issue orders and to set rules deleneating limits and prohibitions. Another member assumed the role of his antagonist and became so involved that a great deal of aggressiveness and verbal plethora ensued. Throughout the scene enacted it was evident that there was much difficulty experienced by group members in dealing with constituted authority. It was clear from the start that within the psychodramatic situation, the general will to oppose aggressive behavior and domination moved the group members spontaneously to try to achieve a positive working situation for the entire group. The person in the power position became the scapegoat by necessity; his position exposed him to these pressures and complications, which were deeply felt by the group members. This two-way tugging was a source for genuine learning and catharsis.

Outside the group, the invested authorities (hospital administrators) threatened the group's existence and freedom, so the group members could protect the present authority, namely the psychodrama director, by concentrating its attack upon the outside authority.

Much relief was obtained from this scene and brought to the group members' awareness their difficulties in dealing with authority; this modified to some degree their expression of hostility.

In the course of the psychodrama, in which the director demonstrated such techniques as the soliloquy, the double and the role reversal, one of the members openly rejected some other member's authoritarian attitude. This member had gone through a personal analytic training; he gave a lot of analytic interpretation which, disregarding their merit, was a way of competing with the constituted authority, namely the psychodrama director. This member always attacked that person whose leadership in the group was just emerging and, at the same time, tried to destroy in himself as well as in his colleague, the will to power and the desire to take over the director's position.

Thus we could observe how the group, aware of group interactional phenomena, tried to defend itself against intense rivalries from within, and simultaneously, attempted to deal with the director's authority and their own feelings in relation to these processes. At this point, some psychodramatic scenes were introduced in which the members represented physician-patient and psychodrama director-psychodrama group member roles, in other words, concretizing psychodramatically the role conflicts going on in the group, here and now. It was observed that the protagonists felt more secure

in the physician-patient relationship—a more analytic situation—then in the psychodrama director's role which is not only difficult to execute, but which carries also the difficulty of being accepted by the rest of the group members.

This psychodramatic insight occurred exactly at the moment when the group members, led by one particular member, were attempting to communicate to one another that there were different ways of conducting themselves and that Dr. X or Dr. Y could do a different job from the present director. When the group caught the idea that the position of constituted power, the desired director's or father's position could not be removed by an external element, but only by common consent, it produced strong regression and transference; this led to a decision to accept the director as a father. From this moment the intellectualizations and interpretations decreased noticeably and a fair number of spontaneous scenes emerged, enriching and enhancing the psychodramatic enactment.

Henceforth, topics or exteriorized attitudes were used as a conducting thread for plots in psychodramatic situations. In our group there were some members who worked in the same setting; this brought out a sociodramatic element and enabled the psychodramatization of the difficulties experienced in working together. These representations resulted in improved working relationships. One important scene enacted was as follows: One group member, actually the head of a department, was tired of being boss and having to carry people around on his lap; there was also a physician whose role was that of being bossed around while he attempted to get closer to the leadership position, to reach the leader, or rather, to attain his much valued position. The latter became angry with anyone who tried to do this first, or with anyone who attempted to interfere with his own intentions. This was a scene of the leader and the led, the father and the son. The psychodrama scene revealed that the member who was led was actually afraid to be the leader, fearful of taking the leading position himself though this is what he very much coveted and desired. The psychodramatized conflict served the purpose of bringing catharsis and sociodramatic integration of the two physicians as they worked together in the same department and, at the same time, it constituted a catharsis for the entire psychodrama group, all of whom were also in a relationship to the leader and to each other. Another sociodramatized plot was that of two working mates, both holding positions on equal levels; they had difficulties in working together due to an unconscious struggle. Each attempted to claim for himself alone the leading position in their department or to attain some equivalent of the father position.

This scene, sociodramatized through approaching, withdrawing and reapproaching one another, produced a catharsis, with the result that this ambition, emotionally involving both, was relinquished by them and they decided to join their efforts to integrate and leave the ambitious power struggle outside of themselves, handing it over instead to the psychodrama director.

This representation, besides helping to improve the professional team relationship between the two physicians, was an incentive for the integration of the other group members, in such a way that the members now approached and integrated themselves around the constituted power figure, the director, turning to him for emotional discharges and admitting their need for assistance in further growth. The persecutory situation now appeared less dangerous and consequently a more intimate, accepting approach towards the director evolved.

One of the group members, a woman physician, had verbalized already in the first session some persecutory fantasies which revealed that she felt she would be expelled from the group in the near future and that this would be done by one of the members of the group who held a high administrative position at the hospital where the psychodramas were being held. Around this typically persecutory situation, several different representations were psychodramatized as soon as the right protagonists and plots arose.

We observed that this physician was trying to escape from a deeply painful, oppressive situation, namely the feeling of not being accepted and loved. She adopted a professional and interpretative attitude, or in psychodramatic terms, the role easiest to represent, in order to be accepted and loved by another group member who would have to take the complementary role as she expected, on the professional rather than on the personal level. In the course of one of the subsequently psychodramatized scenes, the role of the victim, of the abandoned child and daughter, about to be destroyed, appeared spontaneously. Equally spontaneously, right after this last enactment, the complementary role appeared, embodied by a male physician who took the role of a protective father, showing profound depressive sentiments for his sad, suffering daughter. This scene brough about a general catharsis of the psychodrama group, with the consequence that, during the post-dramatic comments, a great quantity of material was verbalized by the members, a genuine group catharsis.

The group experienced, through the protagonists, the situation of being the protector or of being the protected one, of having to give or receive love, the interplay of these roles and the ways of dealing with these emotions. It was evident that the director, a dramatic substitute for the father and

mother, did not take over these roles, as had been expected by the group, but merely had the mission of making them evident. Consequently, the group members had to fulfill the complementary roles.

As time passed, there was an evolution, an approach and integration of roles designated as good and bad, strong and weak, active and passive, father and daughter, mother and son, and so on, and when these roles were psychodramatized, they could be made evident and concretized, giving the group members a chance at learning how to cope with these antagonistic roles.

When the psychodrama sessions first began, the group members wanted a director, a conductor, a father; on the other hand, they wanted to be the director, conductor, father, etc. How to cope with this role conflict became a preoccupation dealt with through the psychodrama. The problem areas: "constituted power", "being a director", "demonstrating the way a director should act", were topics constantly brought up. The oedipal situation, father, mother, son, daughter, began to take psychodramatic form but these themes were still distant elaborations from the real, primary situations. The problem of wanting to be a daughter, the unprotected child who wants protection, to be passive, loved and receptive, were the antithetic parts of being a director, father, giver, and so on. On one hand the group members desired to grow up, but simultaneously wanted to be dependent.

The persecution fantasies shown by the woman physician described above, represented the first such fantasy revealed by the group then in formation, but led to the revelation of many others as experienced by the rest of the group members. It is possible that the roles of father or son, adopted by one or another member of the group represented the easiest, most developed role taken by these members in order to defend themselves against castration fears. If for some individuals being a father or mother brings forth the risk of being punished or castrated, for others, these roles are a defense against the same fears. If one group member took the role of daughter or son, the father role was represented by another, both representing the latent thesis-antithesis carried by all members.

A group member in the father role was competing with the director, simultaneously with taking the complementary role of those members who took the son or daughter role. Thus we had an integration at the father-son, mother-son level. Eventually, in one of the sociodramatic enactments of these roles, a member who had taken a leading role up to that point, began to tire of his commanding and leading position and unconsciously shouted that he was tired of being a father and director, thus his latent wish of being

in the son role, of being led and passive, came to the fore. The member who in this scene represented the son, was thrust into the opposite position, and now had to take the leading position without, however, being successful in his new role. The father also could not really allow himself to be the son for personal, emotional reasons, just as the one in the role of son could not allow himself to be the father, for similar reasons. This event had the value of clarifying the primary relationships of group members with their father-director and with their mother-director.

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GROUP DYNAMICS AND RESOLUTION OF CONFLICT IN COMMUNITY PSYCHIATRIC PRACTICE*

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Psychiatrists in the United States, engaged in the development of local services in city areas of high population density and low socio-economic status, have been confronted and found themselves caught in serious conflict with various citizens' groups. Some citizen groups challenge delivery of mental health services to patient populations considered major by psychiatric planners. The interest of such citizens center on easily perceptible patient populations believed most disturbing to the social unrest of the local area—alcoholics or drug addicts. Others seek in their challenge a means to "power," and thus to personal ego-enhancement and improved mental health. Their interest is not in alleviation of disease. Still others, also interested in power, seek the latter through direct desire to control the funding of new health centers motivated altruistically for their own peoples or sometimes from venal desire.

Urged by various governmental bodies, supported by promise of generous funding, engaged by his own altruistic desires or by the omnipotence of his professional training, the sudden and often hostile challenge to the community psychiatrist has shaken him often in his effort to improve delivery of service to groups relatively deprived in this respect.

There is needed now an articulated theory, or strategy if you will, to aid the psychiatrist to persevere and work through the various emergent conflicts in his contacts with the newly organizing groups in hitherto passive and voiceless communities, particularly in ghetto areas. These conflicts threaten the expansion of much needed health centers to those most in need in North America. These conflicts will be emergent as other specialties of medicine engage in development of health centers in slum and ghetto areas. Historically, too, such conflicts have occurred in the past as other groups in other parts of the world have attempted to improve health through preventive or medico-surgical techniques which challenge the value of the leaders in local communities. The latter are a record of history, a history which deserves, as does that now being written, scholarship and analysis. In the study of these experiences there is contained the data from which useful

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social theories can spring. These in turn offer the source for operational guidelines for health professionals, including psychiatrists, in the future efforts to assist local populations to benefit from the services offered in new health facilities.

Do we have available from our current bank of knowledge, theories and practices helpful in the practice of community psychiatry? I put this rhetorical question to emphasize my conviction that we do—the consternation and confusion which has ensued in some psychiatric circles may be alleviated. The engagement with the community may become, once again, surer and more certain. We do have that knowledge; it reposes in the general domain of group dynamics, the theories and experiences of group psychotherapy.

To be sure, the operational field (the community) is larger, the conflictual issues are more complex as they are supported by groups rather than by individuals. The expansion of the operational field requires expansion of the group dynamic particularly in terms of time to bring resolution of the multiple goals perceived by the many community groups. Thus, those in the role of professional leaders must be willing to seek for the various goals, sometimes obscure, of the many confronting them in the community groups' goals which in many instances are in conflict with those derived from their professional background and perception.

To develop more concretely the theme, allow me to provide as illustration two cases of community confrontation of psychiatrists working to expand services in socially and economically deprived urban communities in the United States. In both instances the professional group were encouraged to plan services for these areas by the federal bureau concerned with mental health (The National Institute of Mental Health) commencing some five years ago. Planning took place among the professional groups and the formal political bodies in the communities. There was little or no recognition on the part of either group of local power groups or small political organizations within the communities to be served. It was generally believed these ventures would proceed with the same facility, when introduced, as had attended most new health, education or welfare services provided local communities in the past.

What went unrecognized were the stirrings of rapidly organizing minority groups who had been encouraged by the theories of social activism, advocated by intelligent and well-educated members of their own groups. They too were supported by members of the staff of the OEO, the federal bureau charged to bring about socio-economic improvement in the blighted

areas of the country. The social theorists urged local planning including participation of the alienated, power through decision making, control of funding and determination of job placements seen as leading to enhanced self-esteem, greater initiative, energy, personal satisfaction and improved mental health. Among the black intellectual groups, the leaders were influenced variously by the writings and actions of Marcus Garvey, Kenneth Clark and Malcolm X. Strategies for action were found in learning from such social activists as Saul Alinsky, so successful in labor organization. Others, particularly students, found their idealistic theories and revolutionary urge to action in the writings of Fanon and Marcuse. The original governmental planners of the expansion of mental health services to populations hitherto aided only in traditional medical institutions were unaware of the potential of confrontation with social activists. Their knowledge, at that time, was similar to that of university leaders confronted suddenly by the outburst of militant student activism. In some instances, student activists participated in the conflict over control of mental health services. They actively planned confrontation, aiding and abetting local groups in their assertion to challenge those planning the newly programmed health stations.

The case illustration involves the Division of Community Psychiatry of my own medical school—Columbia University College of Physicians and Surgeons. Suffice to say that at the request of the City of New York Community Mental Health Board, members of the Divisions gave their time to aid in planning a mental health center to be located contiguous to the university medical center. In that planning they included programs for establishment of satellite clinics in the area. The need for development of interested and participating community groups was forecast and urged. Such groups were conceived as necessary largely to aid in social and vocational rehabilitation of the patients admitted to the mental health center from the communities of a vast urban area housing 277,000 people. That proposal was supported by the local community mental health board and additional professional staff was employed to aid in development of a supporting community group. The community psychiatrists contacted various health, educational, religious and political bodies to develop a "representative" advisory group. Suffice to say what occurred was the takeover of the developing group by a well organized minority composed of militant psychologists and students imbued with the social, political and mental health philosophies mentioned heretofore. They elected a black chairman, ejected all professionals concerned with the early planning, blocked action on plans

produced by the former and have since become involved in numerous parliamentary procedures as various groups vie for power in the community group.

After two years it cannot be said that either new services for health or widespread enhancement of mental health through ego expansion of the population to be served has ensued. (Perhaps some fifty persons have acquired some sense of increased dignity and self-worth from their participation in the community action group in this vast population). As group frustration has set in, a reaching out toward the professional community has taken place—a reaching out to receive direct professional help in caretaking of the ill for whom individuals are responsible, reaching out for personal health aid, a reaching out for advice. A congealing rejection of the militant organizers—non-resident—who oppose forces in the community working together as against the ideology of destruction of all existing authority—the establishment—perhaps is emergent.

In the course of confrontation tactics, mental health professionals have responded by withdrawal, competitive acting out, anger, hostility, paralytic surprise and projection. They have identified variously with the contending forces, possibly on the basis of their own unresolved fixations, perhaps at times on a genuine conviction of the desirability of one course or another.

The issue for resolution is that of bringing together the goals of the various contending groups, leading the groups to gratifying rather than destructive realizations. By these means but through compromise solutions there may be achieved both the establishment of new service centers and the enhancement of personal mental health through participation in local organizations dedicated to common and constructive goals.

The experience then as I review it has proceeded through a series of phases. From the standpoint of the group leader we might denote them as engagement, confrontation, separation, and realignment.

It is here that hypotheses regarding both theory of the dynamic group process and descriptions of that process in evolution seem highly relevant and helpful. They seem so as they provide the psychiatrists or psychoanalysts engaged in community group processes the strategic guidelines for their actions over time whether they individually function as perceived leaders or participants in ultimate achievement of the goal of improved community health.

Let me structure those phases of group processes that have been described (Bennis) and seem relevant in comprehension of actions now taking place in development of many community projects in the United States. Here I propose to comment on the psychiatrist as perceived leader by the

group and the expectations and positions he must necessarily expect for his success in bringing the group goals to achievement. Just as in therapy or leadership groups, the early sessions or meetings will express many manifestations of anxiety with attempts to seek security. This anxiety of the many group members is concerned with the ambivalent feelings toward the perceived leader, regarded as omnipotent. Manifestations of dependent behavior seeking his approval will emerge in some, while others will commence to express evidence of resentment toward him. The later expressions will precede the second subphase of the initial formation of the group.

In the second subphase, open rebellion appears against the perceived leader. Direct or oblique actions, ignoring him, trapping him to demonstrate his vulnerability or ousting him are forms in which this rebellion appears. But it will be important for him to recognize the continuing secret wish of the group for his omnipotence. As Durkin has summarized, the overt behaviors of the group members at this time toward the leader are varied between hostility, suspicion, disappointment and rebellion.

In the third subphase, resolution of the conflict against authority occurs if the leader has maintained a posture of permissive assurance. Non-conflicted members of the group assert themselves and take over the leadership roles in which they dissolve the group contradictions by bringing it to independent responsibility. The challenged leader is now perceived realistically as an expert resource person. Emotionally the relationship between group members evolves toward member-member ties. Group members now interrelate in three general ways: those striving for "form" and "work production", those resisting structure and agenda and those seeking principally affective interchange. Another, those seeking compromise solutions and recognition and achievement of goals, is that generally supported by the effective group leader.

Effective groups progressively differentiate. Thus they proceed through the early phases of anxiety, open hostility, independence, to the second major phase of self identity with recognition of realistic limitations and interdependence. In the latter, the group comes to recognize the need for support from experts including the talents of the original group leader.

As a recent initiate into the forefront of the leadership role in a community psychiatric experience I find enormously helpful this descriptive dynamic of group formation and evolution. It fits with my personal observation of group formation in Washington Heights. It has given me a warming conviction that our successive postures have a basis in group theory discovered earlier from empirical observation.

But there are differences between the evolution of the dynamic in ther-

apy and leadership groups and that in the development of the larger community group.

Let me illustrate from our experience. Undoubtedly, the majority of psychiatrists who participated in the early planning and development phases fostered by the NIMH have been surprised when they suddenly encountered in the field (that is, the local community) the organized power to local minority groups. The expectations of the psychiatrists were for collaborative work with traditional political and professional organizations. The political theorists and activists amongst the minority groups recognized an opportunity for challenging those charged with delivery of health services. Within these groups there were professionals opposing psychiatry per se, opposing the interpretation of mental health as institutional care of the psychiatrically ill, and espousing the theory that mental health might only occur with attitudinal change in those communities where residents were seen as deprived or exposed to dehumanizing experiences.

Before these emergent factions, the community psychiatrist suddenly found himself as the representative of the medical "establishment". Usually he did not recognize himself as a community group leader. Generally he was unprepared for the enormous, vocal and organized hostility which confronted him and which developed a mounting crescendo displayed in all the various expressions described years ago by the group dynamicists.

His original expectation was to be accepted as the respected and bountiful giver of his knowledge and time. Accordingly, his anxiety, in face of group hostility, often was greater than if he had been engaged in the defined treatment of an individual or group. His responses in some instances were very similar to those of the group members—withdrawal, isolation, overt and covert destructive interventions. Thus, his responses in the early phases of the community experiences were not those of the experienced and knowledgeable group leader. He did not sufficiently disassociate himself from the irrational emotionality of the factors in support of attack.

The community group dynamic presents a complexity far beyond that of the small group. Outside the irregularly scheduled community meetings, the anxieties of the various factions within the community group induce many smaller gatherings, to review the experiences, to plot strategies and counter strategies to be directed toward the leader or opposing groups at the next encounter.

So, too, the "behind the scenes" personal visits are made by the newly elected group leaders, and other factional leaders to the original leader. These visits perhaps may be interpreted both as the unconscious wish to

preserve the original authority as omnipotent—the second subphase expected in group development—or, as it later seemed, the emerging need of the new leadership to reexamine realistically the value of maintaining the professional competence of the community psychiatrist within the group.

Thus, on the one hand the elected leadership—representing black power—came equipped with tape recorders to examine and report the attitudes, intentions and perhaps derelictions of the community psychiatrists. Later, confronted with problems of illness in their constituency and also needing guidance as to administrative actions, the professionals were approached for aid.

The lag time for shift from an attitude of adolescent protest toward authority to a more mature and responsible posture is greater for the community group and must probably be recognized as longer. That increased time required in the multifactioned community groups to achieve solidarity and a demand for positive action stems from the number, size and conscious organization of the subgroups within the community. If the community psychiatrists and the newly elected community group leaders are without guilt and also evidence assertiveness toward the undermining faction, their health goal directed attitudes persist. It is in the continuing wish for constructive and omnipotent leadership that the destructive factions face ejection. Depending on their strength, the group struggle continues as they make new and renewed efforts to gain control.

In the area of New York City where my colleagues and I work professionally, the period of constructive group development now seems emergent. The initial struggle for power with its overt expressions of hostility has been passed. The black leaders now are seeking accomplishment in that they now ally themselves with already existing political groups of both whites and blacks.

The original professional leadership now using its strategic knowledge of group process has awaited, without action, the growing frustration within the community group of those who desire change. The latter now have commenced to urge advice from and coalition with professional groups. So, too, they now support on a broader political base as they recognize their own weakness as their potential for accomplishment has been challenged.

Unless the dynamic of the local group formation is held clearly by the existing professional leadership where health planning and new health projects are needed, the eventual collaboration needed for successful community action in the aroused ghetto and slum areas of our countries may not occur.

Local communities will be deprived of change and both the silent and unexpressive average citizen and the social activists will suffer defeat.

Over time, it is my conviction the majority of communities will find successful solutions to a more equitable distribution of health services, as well as more generalized mental health through personal investment and achievement in community activity. These achievements require from us, as professionals, a working strategy in our role as professional leaders in the community. This paper is an effort to elaborate that theory and the related strategy.

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HISTORY OF SOCIOMETRY, GROUP PSYCHOTHERAPY AND PSYCHODRAMA IN LATIN AMERICA

EDITORIAL NOTE

The following were responsible for introducing and spreading the above-named methods in Latin America.

Argentina

Since 1957, Dr. Jaime G. Rojas-Bermudez commenced to work in psychodrama in Buenos Aires. In 1962 he came to New York, established personal contact with Moreno and early in 1963, together with Dr. Eduardo Pavlovsky and Maria Rosa Glasserman, studied at the Moreno Institute in Beacon. Dr. Rojas Bermudez was the first student from Argentina to be certified as Director by the Moreno Institute and became the driving force throughout South America.

Mrs. Marta Pundik and Dr. Juan Pundik from Buenos Aires studied with the Morenos in Beacon in the winter of 1965 and returned for further training in 1970.

Dr. Dalmiro Bustos of La Plata, Argentina was the next student at the Moreno Institute in September, 1969. He has been active in Psychodrama both in La Plata and Buenos Aires for some years.

Dr. Monica Zuretti from Buenos Aires, Argentina, came to Beacon in November of 1969 and stayed until March, 1970, becoming fully accredited as Director by the Moreno Institute.

Ethel Dizner de Gandini of Buenos Aires, attended a short seminar in Beacon in January, 1970.

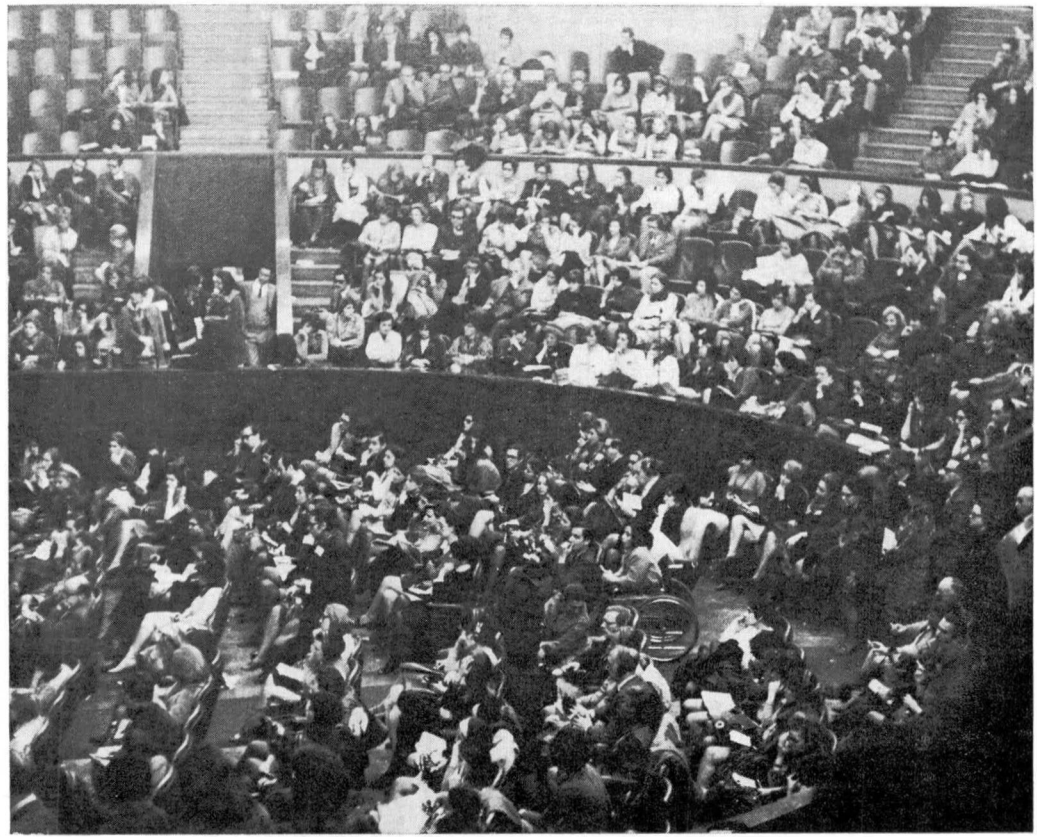
Dr. Jose Salvador Echaniz of Buenos Aires came to Beacon for training in February, 1970, and is a very active member of the Association.

Brasil

Group psychotherapy, sociodrama and psychodrama were introduced in a seminar conducted by Dr. Guerreiro Ramos in Rio de Janeiro in 1949, at the Institute Nacional do Negro, Departamento de Pesquisas e Estudo do Teatro Experimental do Negro. Dr. Ramos was in touch with Moreno and acquainted with his work.

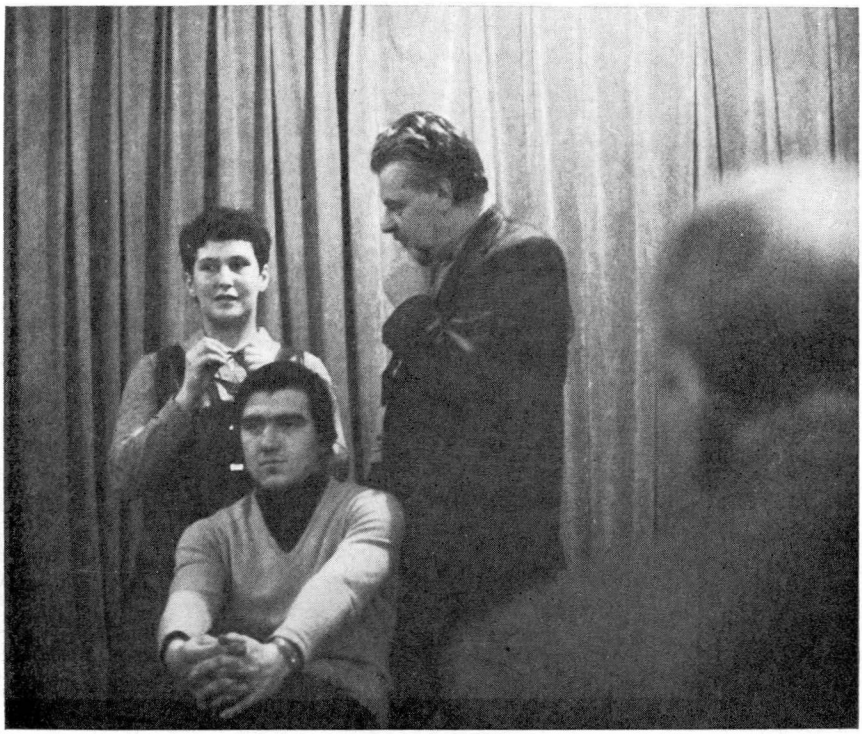
Professor Pierre Weil in Belo Horizonte, Brasil, began to teach and apply sociometry in 1959; psychodrama and sociodrama in industry, education and social psychology in 1961.

Dr. Elizabeth Milan of Sao Paulo, Brasil, attended a four weeks'



Aula Magna of the National University of Buenos Aires, School of Medicine, during the opening session of the IVth International Congress of Psychodrama and Sociodrama.

Mrs. Zerka T. Moreno, Dr. J. L. Moreno, Dr. J. Rojas-Bermudez in the Aula Magna during Dr. Moreno's farewell speech at the IVth International Congress of Psychodrama and Sociodrama, Buenos Aires, Argentina, August 24-31, 1969.



Dr. Jan Rubes, Director of the open, public psychodrama sessions in Prague, Czechoslovakia, attentively listens while a protagonist and his double, representing his conscience, are exploring his feelings. Jan Rubes, M.D., teaches at the University of Prague.

obvodní kulturní dům a socialistická akademie v Praze 6

nápravná technika psychických potíží každodenního života
skupinová psychoterapie a trénink mezilidských vztahů
cesta k sebepoznání a získání nové životní zkušenosti v nových formách komunikace
škola mezilidských vztahů a sebepoznání aktivní účastí a spoluprací ve skupině

řídí MUDr. J. RUBEŠ, klub v kaštanu Bělohorská 150, Praha 6
zahájení 9. 10. 1969 v 19.30 hodin
předprodej vstupenek sluna, pasáž alfa a národní 20

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Poster announcement of Dr. Rubes' psychodrama sessions, in Prague, Czechoslovakia.

training period from November to December, 1969, attaining her certification as Auxiliary Ego from Moreno Institute.

Mr. Jorge Berard of Sao Paulo, Brasil, came in February, 1970, to be trained at Beacon. He is engaged in work in business and industry, applying role playing and role training particularly.

In 1965, Mrs. Azevedo started working together with Dr. Alfredo C. Soeiro and Dr. M. Rosario in their private practice. At the Hospital of Clinics of the Medical School of the Sao Paulo University Dr. Jorge W. F. Amaro, Physician in Charge of the Group Psychotherapy Sector, invited Dr. Alfredo C. Soeiro to read a course in psychodrama.

Cuba

Dr. Jose Bustamente and Dr. Frisso Potts were both active in group psychotherapy in Havana, Cuba since the middle of the 1950's and Dr. Potts also instituted psychodrama as a regular feature of the Mental Health Clinic of that city where he was physician in charge. In summer of 1960, Dr. Potts and Mrs. Teresa Potts came to Beacon to study. Dr. Potts became a certified director of the Moreno Institute.

Mexico

Diana Villasenor of Mexico City studied with Moreno in 1966 and 1967, and is active in her native city doing psychodrama especially with emotionally disturbed and brain damaged children, and with students at the University.

Peru

Dr. Carlo Seguin of Lima, Peru, attended the First International Congress of Group Psychotherapy in Toronto, Canada, August 1954, and reported on his activities in group psychotherapy in that country.

Dr. Pedro Leon, Lima, Peru, came to study at the Moreno Institute in Beacon in the summer of 1955 and introduced psychodrama in his own city in 1955 upon his return there.

Venezuela

Mr. George Hatley from Caracas, Venezuela, attended a training course at the Moreno Institute in 1963.

CREATIVE BREAKTHROUGH[1]

PAUL E. JOHNSON, PH.D.

Professor Emeritus, Boston University, Visiting Professor, Christian Theological Seminary, Indianapolis

I. MEETING YOU HERE

Here we are drawn together in the profound mystery of creative encounter. What is the mysterious power bringing us together? If we could follow step by step the life journey of each person through all the adventures of the years to this hour, what a story would unfold. If you and I could know each other from within the hidden experiences of our life, what deep longings, dramatic struggles, hopes and fears, would draw us together in one great discovery of life.

Each life has a unique individual meaning. Yet when we meet in true encounter to see with each other's eyes, to feel from the center of each other's joy and sorrow, we share the meaning of a greater life. We are lured to this encounter by the mystery of each life, to find the larger meaning of our common life.

Starting somewhere in space and time, you and I come like comets trailing our life histories as flaming meteors across the sky. We come by many paths and searching that converge here and now.

Yet this brief span of time is but a flicker of speeding light in the long journey of life on this planet. What amazing resources of life have been given to our earth from aeons of time flowing to us through the mists of the past; from that time before our time, when our molten fire ball cast off from the sun to whirl through space at incredible speed. Out of the mystery of this ongoing creation vast mineral resources were formed, pulverizing into rich soil. A sustaining atmosphere enveloped this planet, giving sunlight and clouds to warm and shower the earth with moisture. In the life-giving womb of water and soil, sunlight and chemicals, emerged tiny organisms seeking nourishment to grow. From then to now creativity has never ceased or come to a halt, but moved across every frontier to take new ground, where man is building the cities of today.

II. WHAT DO WE MAKE OF OUR LIFE?

Now that we are here, what are we making of our life on this amazing planet? How creative are we in these journeys of human history? We are creative in many ways.

[1] Address given at the American Society of Group Psychotherapy and Psychodrama in New York City, April 4, 1970.

1) We have inexhaustible *fertility* to multiply our species at accelerating rate until we are overcrowding cities, countries and the whole world. Now we face a crisis of over-population that spreads hunger, poverty and despair.

2) We show *courage and initiative* to explore unknown continents, the moon, the infinities of the heavens, and the forces locked in the invisible atoms. Yet we quarrel over the spoils, and launch fratricidal wars to control and defend every new discovery.

3) We *invent* machines and technologies to multiply goods for comfort and convenience. Yet our machines destroy life, pollute the air and water, and enslave us to false idols of wealth and materialism.

4) We *exploit* our resources to gratify our insatiable desires, with little concern for the good earth which is our home, or the exploited brothers in our human family who are stripped that we may have too much.

5) We have *energy* to burn, yet we spend our creative energy to consume and destroy life; and if we pursue this headlong course we will defeat ourselves and all who travel with us on this dizzy journey through space-time.

From a distance we look like a great success story, as the lords of creation and the masters of our fate. "Seen from the vast depths of space, the earth is a lovely blue and white stippled island in the archipelago of the planets. It is unique, with its surface wetted by water, cushioned by greenery, and fanned by air."[2] The dramatic wars and achievements of human history furnish a grand spectacle for panoramic screens in vivid color. Shall these heroic deeds become a long march into the exile of a tragic finale?

Coming closer we find man caught in the toils of his restless striving. Until he is pushed aside or enslaved by the machines and structures he has invented, tangled in the multitude of conflicting dilemmas he has created.

This is the story of our creative uncreativity. No less lurid than the melodrama of stage and screen, but this is reality for us here and now. This is our tragic dilemma, that we have to work through—but fast, before the express train runs over us. Or if that drama is outdated, we may see ourselves at an altitude of 30,000 feet trying desperately to save our aircraft hurtling through space when crippled by the explosion of a madman's bomb.

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[2] *Newsweek* (January 26, 1970), p. 36.

III. Our Creative Uncreativity

What is the nature of our creative uncreativity? Though we find an eternal source of creativity in our universe available to man, yet we do not begin to realize our potential.

It is generally recognized by the many scientists who are now converging on creativity, that we use only a fraction of our undeveloped capacities. Herbert A. Otto, from his intensive study of human potentiality, concludes that we are using only 5% or less of our potentialities. "The ultimate capacity of the human brain may be infinite.[3]

We are evidently caught in some kind of constricting bondage. Most often we project the blame outward to the persons and world around us. Yet when we know ourselves more deeply we find the constricting bondage primarily within ourselves. "It is not in our stars, dear Brutus, but in ourselves that we are underlings," as Shakespeare said.

What should be a full stream of mighty creativity is usually reduced to a mere trickle. Unconscious blocks and inner obstructions dam up the full stream, until we become explosive as a volcano under pressure. Or else we divert our creativity into drain hatches and spillways eroding and wasting our potential energies.

Among our many deterrents, we may note our constrictive relations with other persons. Our egoistic striving sets us against others with whom we struggle for ascendancy. Grasping for private gains and advantages is a way of pushing others aside. Containing others whom we see as enemies or fair game for aggression, leads to starving the Biafrans, or "search and destroy" in Vietnam. Controlling others is a game of manipulation, seduction and propaganda of half-truths. Within ourselves we find obsessive fixations, fears and anxieties, tensions and depressive moods of emotional restriction and repetition compulsion.

There are games we play to avoid intimacy and gain a private advantage over others.[4] And there is our reliance on cultural conserves to can and preserve life in uniform containers, frozen to be safe, rigid structures, prejudices, stereotypes and traditions. This we see in our frantic resistance to change and repression of spontaneity to hold firm on familiar ground. We obstruct creativity in others by chronic protest, dropout, non-participation, segregation, privatism, and defeating negotiation by unyielding demands.

[3] Herbert A. Otto, "New Light on Human Potential," *Saturday Review* (December 20, 1969), p. 14.

[4] Eric Berne, *Games People Play* (New York, Grove City Press, 1964).

We lock in the potentialities of childhood by stereotypes we impose upon our children at home and at school. It is now shown that children can most readily learn to read and write at age 2½; yet we hold them back and retard them until age 6 when they learn with greater difficulty. At the age of 12 I started to learn piano and cello haltingly; while in Japan Suzuki teaches 3 and 4 year old children in classes to play violin concertos easily.

We lock in the potentialities of youth with our suppression of their sparkling creativity by lock-step routine education, anger at their protests, and stern rejection of their urgent demand for social change, a new life and a better society for all.

We cancel the creative potentialities of older people by deciding they are useless, puting them away as senile; consigned to a barren existence waiting in lonely misery to die. Actually, older people have great potentiality to learn and change, to enjoy new vitality, and contribute richly to the society that casts them out as unwanted.

We lock offenders of all ages behind prison bars to punish them as hopeless and unworthy, teaching them to hate and lie and steal by the exquisite torture of brainwashing and branding them as public enemies. A prison psychologist was excluding a "hopeless" criminal from his therapy group, when the man said to him: "If you give me up, then there is no hope for me."[5] The psychologist began to see him in a new light and accept him, until hidden potentialities came forth to change his entire attitude and purpose in life.

We lock up the mentally ill behind the doors of remote asylums to vegetate on back wards out of touch with ongoing life in society, banned from our homes and jobs, our churches and the human community.

We lock up Black people in a segregated society; Indians on reservations, and the poor in ghettos, depriving them of life and opportunity, until they are so desperate they riot and burn cities. It was for these and their white brothers that Martin Luther King, Jr., offered non-violent creative change, and gave his life in a martyr's death.

How can we deny this essential freedom to our beautiful human family, on the only planet in the whole universe where life is possible? Here we are with all the amazing resources of human intelligence, scientific invention, social-political organization, and religious devotion, at the peak of the greatest advancing civilization the world has ever known. Why not create a

[5] Stanley W. Standal & Raymond J. Corsini (eds.) *Critical Incidents in Psychotherapy* (Englewood Cliffs, N.J., Prentice Hall, Inc., 1959), p. 3.

society of truth and love, where each works for all, and where all share with each, to call forth human potentialities for the joy of living in a free and creative world?

IV. How Break Through?

How do we break through the barriers to creative fulfillment?

We learn from Jacob Moreno, who finds a creative life through action. He has been acting out spontaneity even before he entered the University of Vienna, from which in May 1959 he received the Golden Doctor Award from the Medical Faculty. Breaking through the barriers of tradition, he responded to the children, the poor, the prisoners and outcasts. Meeting the preacher on the way to church, he asked for his sermon here and now in dialogue not written form. Meeting the children of Vienna barefoot, he acted out stories with them. Meeting adults in open forum he invited them to act out a living newspaper in the theater of spontaneity. The poor came to him in Vöslau, where he was public health officer (1918-1925), and he treated them all without a fee. He came to the prisoners of Sing Sing with group therapy, and the girls of the Hudson Training School, with sociometry, spontaneity training and role learning. He created a theater of psychodrama in Beacon, New York, which has become a beacon light for the world.

We learn from his stream of publications if we see their unifying purpose. He is launching a revolution in human relations, a new ethic of mutuality, a new religion of creativity, that God is in you and me, everywhere bursting forth in spontaneity and new life. "The universe is infinite creativity."

> All men are born to create
> No one shall have power
> Who does not create.
> No one shall have more power
> Then he creates.
> You shall learn to create.
> You shall learn
> to create me.[6]

But how do we create? A study of creative persons at work, shows four stages by which we invite creativity.[7]

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[6] From *The Words of the Father* (New York, Beacon House 1920, 1941), p. 115.

[7] See among such studies, Eliot D. Hutchinson, *How to Think Creatively* (New York, Abingdon Press, 1949); Jerome Kagan (ed.), *Creativity and Learning* (Boston, Beacon Press, 1967); Gerald Caplan, *Principles of Preventive Psychiatry* (New York, Basic Books, 1964), pp. 26-55; Howard J. Clinebell, *Basic Types of Pastoral Counseling* (New York, Abingdon Press, 1966), pp. 157-175.

First, is the stage of *preparation,* which may require years of learning to master needed skills and knowledge. Then at a critical moment, to *warm up* by spontaneous interchange in an emerging group.

Second, is the stage of *frustration* and *conflict* when every effort is blocked and locked in tensions, until spontaneity is chained, bound and gagged.

Third, is the creative breakthrough, when after relaxing tensions and meeting others in outgoing response, we are released from bondage. Insights and perceptions flood into consciousness, we come alive, and interact to free each other, until we have new life and become dynamic persons in vital interpersonal relationships.

Fourth, is the *sum-up of verifications, elaboration and evaluation,* by discussing and confirming the new learning and discovery. This is a sober time of appraisal, checking with other persons, to reinforce and integrate in clearer perspective, as we seek to communicate with others.

Along such a path came my first faltering steps in psychodrama. When Dr. Moreno first called me out of the audience to the stage, a young man was very distraught over the breakdown of his marriage. I was cast in the role of his pastoral counselor, but my preparation was quite inadequate. You can see what a shy person I am, an anxious person stepping on to the stage before the audience of 100 or more experts and embryo psychodramatists.

You know how Dr. Moreno directs psychodrama, pressing auxiliary egos into service on the spur of the moment. He asked me to describe my counseling office, after which the distraught husband rushed in like a tidal wave to overwhelm me. He declined my invitation to be seated, and paced frantically around outside my office, pouring out his anguish in an irresistible torrent.

Nothing I could say or do reached him. He seemed not to hear me or even to recognize that I was there. I was helpless, confused and impotent. Without face to face warm up, the young husband neither accepted or recognized me as his counselor. And without his warm up, I was unable to meet him as I and Thou. So we talked past each other, and neither of us could cope with the sense of defeat and futility that kept us apart as strangers to each other. Leaping hastily over the first stage of preparation we soon fell into the second stage of frustration and conflict.

During the lunch hour we formed small groups eating picnic style on the spacious lawn interspersed with trees. We talked of the morning psychodrama, painfully at first, as I felt quite humiliated by the frustrating

experience. We were strangers to each other, but as we shared our food and explored our feelings about the recent session, we soon became a team. Others were reaching out to accept me and live through the painful search together.

"How would you do that counseling scene over again?" they asked me. As we exchanged views someone asked if he could take my part, and see how he might play the role of the pastoral counselor. Then another offered to play the role of the counselor while I took the role of the young husband, as we compared, replayed and lived through these efforts to communicate.

This lunch hour was a creative breakthrough for me. And after the others had put themselves into the drama, I was invited to play the counselor again, with better results.

The final stage of verification emerged in the sum up,[8] as we exchanged views on the difficult counseling scene, and the evaluation of what each person was living through. I returned to the afternoon and days to follow to reinforce and integrate the discovery of a new style of creativity.

This creative encounter with Dr. Moreno and all who participated that day in Beacon was a historic breakthrough for me. The year was 1947, less than two years after the atomic bomb fell on Hiroshima; when the whole world was seeking to recover from the smoldering ruins. This frenzy of war must not come over us again; and we sought to create a new society to heal the terrible hurt, and transform hate to love.

I was professor of psychology of religion at Boston University, and sensing we needed a new theory and practice of interpersonal psychology to call forth our potential in face to face encounter, I was bringing my graduate students to meet patients at the Boston Dispensary in group therapy with Joseph H. Pratt, M.D. In this year 1947 10 students came with me to the Boston Psychopathic Hospital for a summer clinical workshop in group therapy led jointly with Robert W. Hyde, M.D. Some of us came to Beacon for an Institute in Psychodrama, where I found this breakthrough into more creative learning and teaching.

Returning from Beacon we at once began psychodrama at the Boston Psychopathic Hospital,[9] where all professions meet to learn how to be a therapeutic community. Ever since then the role play has been my basic educational method, and psychodrama a frontier of creative interaction and

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[8] HANNAH B. WEINER AND JAMES M. SACKS, "Warm-Up and Sum-Up," *Group Psychotherapy,* Vol. XXII (No. 1 and 2, 1969), 85-102.

[9] Now called the Massachusetts Mental Health Center.

growth. For this is existential learning in which the whole person involves other persons in the context of concrete situations.

V. Toward Creativity in the 1970s

Now in the 1970s we see the whole world of mankind urgently seeking a breakthrough into larger creativity. Separated as we are by the high walls of nation, race, class, language and locale, each person is lonely, fearful or angry in his private life. Contained by boundaries that keep us alien and estranged, constricted by inner and outer conflicts and weary struggles, we are overdetermined to distrust, resist or evade each other. Conditioned by negative feedback from mass media and critical associates, we are not yet prepared to express our feelings openly or communicate the truth in love.

We know the depths of frustration, in compassion and anger for the tragic sorrows of others under the cruel fate of hunger, despair and unrealized potential. But we shrink from being hurt, and draw back from the agony of sharing the suffering of others. And we seem unable to help each other, or reach out to share life creatively with others, such as the Black Militants, who stand defiantly apart in the beauty of their heroic dignity. The hope of creative brotherhood is always shadowed by the hatreds and exclusions that intensify this uncreative hostility. We all live in one ghetto or another of separation, closed in and suffocated by these walls of fear, hate and resistance.

Yet, if we are ready, the time is coming for a creative breakthrough. The walls are not falling in a dramatic crashing down of barriers all at once. But there are signs of readiness and spontaneous reaching out to listen to each other, and turn from hopeless rigidity to accept each other in many areas of community life.

The dawn is breaking through the clouds of darkness, and in the new light we can begin to see how we have missed our way. Long delayed insights are coming into view to see ourselves more clearly, and live by open truth instead of hidden agenda and repression of honest feelings. At the moment we are caught between wavering battle lines as the struggle intensifies.

There are desperate struggles for power to revolt at any cost, or to clutch the past and resist overdue changes in our society. Crime and violence are rising to undermine a trusting community. National budgets are dominated by military spending and new weapons of total destruction. We

cannot be blind to the edge of the abyss on which we stand, tottering between destruction or creativity.

The peak of this frustration may drive us to despair, to frozen rigidity, or to violent destruction. Yet such a time of intense frustration may well give the impetus for a new and greater burst of creativity. Erich Neumann shows that "in our age, as never before, truth implies the courage to face chaos."[10] If we have the courage to face the chaos in ourselves and others around us, to be open and trusting in mutual appreciation, we may discover new life. It is not enough to "love thy neighbor as thyself," or make him over in *my* image. A truer love is to accept you as *you are,* in all the wonder of your mysterious complexity and unique differences.

In our world crisis it is not enough to break forth in solitary creativity, much as we rejoice and take courage in each forward step. The startling truth is that we are bound together in one human family, in which none can be saved alone apart from the others. No one is to be left out or forgotten or excluded from the new creation. It is a tragic folly to seek to save myself at the expense of others, for that is the way of tragic separation and death. How can we pass from death to life unless we love our brothers? (I John 3:14) Only in love is new life conceived, and born and nourished to mature creativity.

In the passionate search for true encounter, "I will look at you with your eyes and you will look at me with mine,"[11] in the profound joys and sorrows of our journey together on this planet Earth.

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[10] ERICH NEUMANN, *Art and the Creative Unconscious* (New York, Harper Torchbooks, 1959), p. 121.

[11] From J. L. MORENO's first book *Einladung zu einer Bewegnung* (Invitation to an Encounter, Vienna, 1914).

PSYCHODRAMA IN ARMY AND VETERANS ADMINISTRATION HOSPITALS: SUMMARY[1]

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Psychodrama is an existentialist form of psychotherapy—of interaction between people in the here and now. It was introduced by J. L. Moreno, who is a philosopher as well as a psychiatrist.

He created a unique mental hospital in Beacon, New York, centered around a therapeutic theatre where people with interpersonal difficulties as well as psychotic patients act out their problems. Whenever possible the original partners in a conflict participate. If they are not available, they are replaced by substitute actors. All acting is impromptu.

Whereas most psychotherapeutic communications are on a verbal level only psychodrama is a form of therapy in many more dimensions. In hypnosis, psychoanalysis and hypnotherapy the patient is asked to lie down, to relax, not to move. In psychodrama the whole body participates. It may express emotions, such as fear by stepping backwards or joy by jumping, almost like in a dance.

After three years as Moreno's assistant prior to World War II I introduced psychodramatic techniques in the U.S. Army, at first in an Evacuation Hospital in Germany [1], later in a General Hospital in the United States [2]. No formal theatre was of course available. Any large room would do. Combat experiences were recreated under improvised conditions as effectively as under narcosynthesis.

After the war I introduced psychodramatic techniques at Brentwood VA Hospital in Los Angeles, attempting treatment of interpersonal and family difficulties with active participation of relatives of the patients [3]. Parents, husbands and wives of patients were encouraged to participate in the acting out of their problems. A simple circular stage was constructed, consisting of three sections, which can be carried through a door. Psychodramatic techniques can also be used as a psychological test, using a battery of standardized situations. Situations can be devised to evaluate applicants for a job, e.g., social workers, psychology or psychiatric residents. Forcing a person to act impromptu proves more revealing than answering a questionnaire. Warmth and empathy, tact and resourcefulness, will easily be seen and it will be more difficult to simulate a halo than in written tests.

[1] See REFERENCES for original publications abstracted here.

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NOTE ON PSYCHODRAMA IN A "HELPING RELATIONSHIP"

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Moreno's technology of psychodrama traditionally has been employed as a complex system of action psychotherapy undertaken from within the viewpoint of Moreno's spontaneity-creativity theory. Psychodrama is viewed in this paper from an alternative viewpoint, as an adjunct to a "helping relationship" undertaken from within any theoretical viewpoint. The purpose of this note is to specify the components of any such helping relationship, observe the theoretical applicability of psychodrama to the helping relationship, and suggest the use of psychodrama specifically to enhance the potential of "sensitivity training."[1]

Every helping relationship, whether dyadic or small-group, seems to be able to provide the subject with four specific opportunities. These are:

(a) *expression,* in which the subject is encouraged to present his most pertinent and corollary problems and questions that may range in topic from machine operating, through perversion, to transcendental meditation;

(b) *feedback and information,* in which the helper—parent, peer-group, teacher, therapist, trainer—provides the subject with emphathic verification saturated with cues for more effective differentiations and discriminations that may range from assertions regarding the subject's abrasive laugh, through expositions of Reichian incongruities, to analogies from the cabala;

(c) *instruction,* in which the subject's behavior is formally modified by means of various training devices that may range from the explicit technology of the teaching machine, through the subtle directing toward "genuineness" of the nondirective Rogerian, to the paradoxically disenchanting koan; and

(d) *practice,* in which a pertinent array of relevant, managed interpersonal contexts that resemble real life are formalized into exercises that may range from assertion-focused "behavior rehearsal," through impromptu situational role-playing, to resolving transference in "paradigmatic psychotherapy."

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[1] MORENO, J. L., "Inter-personal Therapy and the Psychopathology of Inter-personal Relations," *Sociometry*, Vol. I, Beacon House, Beacon, N.Y. 1937.

Psychodrama can readily be seen to be capable of providing unusually apt role-playing methods to service each of these operations: *expression*, by use of physical enactment of problem situations; *feedback and information*, by use of auxiliary ego, doubling, role reversal, mirror, and future projection; *instruction*, by use of these role-playing methods applied to learning through modeling and role-played reinforcements; and, *practice*, by use of a vast array of lifelike challenges provided by role-played characters in crucial settings. Moreno has written of the place of psychodrama in a helping relationship, emphasizing its special contribution to *practice*, as follows:

> "After psychoanalysis and even after lobotomy, one must enter the process of living itself, living in a world full of unknown opportunities and boundaries—or at least full of uncertainties; a world ever changing, filled with unknown objects and people. After knowledge has been acquired, a finishing touch is needed; one still needs to learn how to live. This is what psychodrama and its allied methods and techniques propose to do for individuals: to provide them with the science and skills of living, with a "life practice.' "[2]

The applicability of psychodramatic techniques to facilitate sensitivity training, one kind of setting for a helping relationship, can be described as follows: Sensitivity training takes place in different kinds of groups, such as the T group, encounter group, and psychotherapy group. These differ most consistently in terms of their origins and the type of problem (e.g., the psychotherapy group is for psychiatric symptoms or signs). But these kinds of groups have one commitment in common, that of facilitating a kind of empathic, reassuring "encounter."[3] Although encounter can be a satisfying end in its own right, it is important from the behavior modification viewpoint of this paper only as it contributes to the end of providing opportunities for sensitivity training.

Sensitivity training has as its purpose the creation of a setting where prospective interpersonal problems are precluded and past ones understood by means of increasing accuracy in discriminating interpersonal cues and is assessing one's own social stimulus value (e.g., worth), and by means of encouraging behaviors that are more rewarding because they are more "spontaneous." Spontaneous behavior is worthwhile behavior that is relatively uninhibited, or at least is not reduced, by unnecessary attempts to avoid anticipated punishment from others.

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[2] MORENO, J. L., In J. L. McCary & D. E. Sheer (Eds.), *Six Approaches to Psychotherapy*, New York, Dryden, 1955. Pp. 289-340.

[3] MORENO, J. L., *Einladung zu einer Begegnung*, Anzengruber Verlag, Vienna, 1914.

The formal methodology of sensitivity training as actually undertaken and as described in the literature is more-or-less included or can readily be interposed among psychodramatic techniques. But the availability of the additional methods of psychodrama offers unique potential for exploring and attempting to solve specific, individual behavioral problems. It would therefore seem inefficient to permit a group that is warmed-up by the encounter of sensitivity training to deal only with the typical opportunities available within such groups, those of *expression* and *feedback and information*. The careful inclusion of psychodramatic techniques, respectful of the group's best interests, can readily be seen to provide for the extension of sensitivity training to encompass opportunities for *instruction* and *practice*. The interpolation of auxiliary ego, doubling, role reversal, mirror, and future projection promise to maximize the practical utility of the warmed-up sensitivity-training group, and the effectiveness of the sensitivity-training director promises to be enhanced if he were to become familiar with the psychodramatic technology.

In summary, psychodrama, traditionally seen as the therapeutic modality of Moreno's spontaneity-creativity system, was considered here to be an array of methods whose availabilitiy was viewed as potentially enhancing any helping relationship. The components of any helping relationship were described as *expression, feedback and information, instruction, and practice*. The functions of sensitivity training were outlined, and the specific utility of role-playing in augmenting it was suggested.

ROLEPLAYING AS AN EDUCATIONAL AND TRAINING DEVICE IN A POVERTY-ORIENTED, MULTIRACIAL GROUP[1]

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The following paper is a discussion as to the effects and "value" of roleplaying when used in a diverse racial and ethnic group of economically and socially deprived para-professional trainees. Role play was used primarily as a technique in preparing underprivileged youths for placement as social service agents (i.e., gang workers, counselor aides, probation officers, social workers), in addition to enhancing a natural means of human interaction.

The project was conducted at the Para-Professional Training Institute, a part of the Clearfield Job Corps Center contracted by Thiokol Chemical Corporation. The Institute is a pilot project of the Federal Job Corps Program made up of advanced Job Corpsmen selected from all other Job Corps Centers. Prior to their entry into the program, the participants had been school dropouts, unemployable, etc., in addition to having personal, social and vocational problems.

The technique of roleplaying was employed for its immense flexibility associated with almost all forms of learning processes. Because of its diverse application, it was utilized in both the individual situation and group situation, and was even used in self-learning exercises.

The group was composed of ten black youths, three white and one Spanish American, all ranging from seventeen to twenty-two years of age. They had come from areas such as Watts, Harlem, Atlanta, Chicago, and they had brought with them feelings that were congruent with their backgrounds. Most of the participants were training to return to their former neighborhoods to work as social service agents. Those selected for the program were only superficially aware of its content prior to their arrival. They were selected and recommended for their leadership ability, motivation, personal goals, etc. Many had experienced the essence of deprivation both economically and socially and, in entering the program, had taken the first steps toward improving their own life situations, and hopefully, those of others.

[1] I would like to acknowledge my debt and gratitude to Mr. Charles J. Moxley, Dr. William C. Hearnton and especially to the staff of the Para-professional Training Institute for their support and counsel.

Their attitudes had been preconceived and their expectations as to what they were going to find had been solidly imprinted in their minds. Both black and white members had seen integrated programs before and they had all proceeded along fairly predictable lines. For the first time they were entering a training program that would allow for individuality, but most important, would encourage and demand responsibility for their own behavior.

The initial group training sessions, it was decided, should be spent in general theoretical discussions and mutual introductions. Roleplaying and sociodrama were used as auxiliary procedures to enable members to know one another better, and to become familiar with counseling procedures and group objectives, after which the principles were then applied to actual roleplaying situations.

Our primary interest in the training content was to help the trainees gain insight into how they act and react rather than why. Deep interpretations into the dynamics of behavior was rarely attempted.

Most of the participants had developed, in varying degrees, negative attitudes toward formal educational settings. They had come from backgrounds that either financially could not "allow" a person to remain in school or from environments that strongly discouraged participation in the "establishment's" institutions.

In the past they had been expected to perform a passive role in their education, to learn and accept ideas that had little relevancy to reality as they knew and lived it. Through roleplaying, they were able to greatly modify and facilitate learning experiences. Instead of reinforcing a passive role, they were confronted with the task of maximum responsibility for group content with the result that they would, out of necessity, play an active role in their educational and training development, which they readily accepted.

It was believed that roleplaying techniques would greatly facilitate and enhance the learning process for several reasons: (1) Roleplaying approximates real life situations. It is a dramatic force that focuses attention on real problems that closely approximate normal stimuli. For example, most group members had experienced, in some degree, social mal-adjustment in previous academic settings. They had failed, in some way, to perceive or understand their behavior or the behavior of others. Through roleplay the participants could experiment with behavioral changes in an unthreatening social atmosphere. It is not real life, but real life possibly does not permit "new ways" and reality situations could be too threatening. It would

be best if a shy youth could get the courage to confront a teacher on a problem, but if he does not have the courage, he will not confront. In a roleplaying situation, the participant is able to view his behavior and the behavior of others in a simulated but very real experience. (2) It allows the roleplaying participants, the group, and the trainer to see how individuals operate in real life situations, thus permitting feedback, identification of problems, and an opportunity to resolve problem areas of behavior and adjustment, all in an attempt at a greater individual and social awareness. (3) It is a method of training that provides for and expedites the process of reality testing. The participants are able to interact on an ego-involved level that encourages "authenticity". They are able to readily test their responses to anticipated or unfamiliar situations, and to generally problematic situations that in the past had been sources of ambiguity and frustration.

If one fails in actual reality, the results can be harmful. Thus, if the shy boy confronts a teacher concerning a problem and he is rebuked for his approach, he may feel so defeated that he will not try again. But, in training and educational roleplay, one cannot fail. The very fact that the participant has the courage and ability to demonstrate his functioning, no matter how inadequately, is a "success." Consequently, in roleplaying situations, it is often reiterated to the group that one need not be embarrassed by poor performance. After all, that is the purpose of role play in training, to show how one usually functions in an effort to learn from and teach others. Therefore, the only "failure" recognized in training and educational roleplay would be refusal to try.

Our purpose for using roleplaying was not to provide the individual with a set of responses to be used in anticipated circumstances. Rather it was used to focus on the growth and development of the individual. Particular emphasis is placed on the awareness of one's effect on others and others' effect on him. Other purposes include the attaining of sensitivity to the requirements of one's social role in interpersonal relationships, the teaching of the dynamics of human behavior, and the general nature of the para-professional's work.

Each group member brings with him a unique character created from unique experiences that can readily be transformed into roleplaying opportunities.

The following is an illustration of how roleplaying is utilized as a training and educational device while simultaneously focusing on the group members, ability to see situations from another point of view, to become more aware

of his own stimulus value, and to become more flexible and skillful in his interpersonal relationships. A group is divided into two equal parts. Both groups will have the identical task which is: "Based on your own experiences or on your own anticipations of what problems a change agent might be confronted with, you are to write a specific number of problem situations which you would like to see solved in a roleplaying drama. Be sure you define the situation completely, giving enough detail for someone else to understand what is happening. State the number of characters and describe them briefly but fully enough to understand their motives. Do not solve the problem in writing. Leave the solution up to the actors." To further development, a member in each group is selected as an observer of the roleplaying process, who, at the end of the task, gives feedback to the working group as to how effectively the exercise was dealt with.

The following is an actual exercise proposed and resolved by the group using the above format.

Characters:

Robert, a small white boy from a middle size midwestern town, is afraid of Negroes. He is a passive, introverted, youth who finds it difficult to stand up for himself. He is not sure he wants to stay in the Institute program.

Larry is a tall, wiry, very hip black brother from St. Louis. He has run the streets for several years, dropping from school in the tenth grade. He loves to take advantage of weaker cats, black and white. He believes he can really rap.[2]

Situation:

Larry conned Robert out of seven dollars two paydays ago. Robert has asked Larry for the money several times but Larry put him off. The last time Robert asked for the money, he threatened to tell the counselor about it. Larry got real mean and assured Robert he'd be one dead honky if he said anything to anybody. After a lot of fearful anxiety, Robert has finally gone to the counselor. What will the counselor do?

Each group then selects three members of the other group to roleplay the situation provided, including the role of the counselor. Thus, you have a roleplaying device that includes all members of the group and provides a wide diversity of training and educational opportunities for the individual and the group as a whole.

As a means of instruction, roleplaying techniques provide an awareness

[2] Rap is a colloquialism used by urban youths to indicate their verbal ability for influencing and controlling others.

of commonality of problems and life situations. When a problem is worked out through roleplaying, the spectators are likely to be personally familiar or at least be aware of the existence of such problems, so that seeing how others handle difficult situations can be a source of constant self and social awareness on a pragmatic level.

Often it is necessary and advantageous for the trainer to "model" the counselors role through roleplaying. This is often done with a supplementing discussion on the appropriateness of specific counseling methodologies. The trainer may also find it desirable to assume the role of an "auxiliary ego," who can also provide for a more direct and objective analysis of the roles being played.

Since roleplaying was being utilized as a training device, there was a continuous building up process, slowly progressing from one stage to another, thus having the individual accomplish some degree of success with each situation roleplayed and then following each session with a clarifying critique by the total group.

While the roleplaying session is in progress, the trainer continually receives information regarding the "strength and weaknesses" of the participants along with useful non-verbal cues from the audience. In one instance, the roleplaying involved a situation where a white member of the group was assuming a role of a school counselor who had been referred by a teacher to a young black boy because of habitual truancy. A black member of the group was roleplaying the young twelve-year-old boy who had been ejected from his home by a drunk and sadistic father. (This situation may possibly appear as an unlikely or exaggerated example by many, but it is the author's conviction, based on many years of group experience with "underprivileged" young people, that such rejection by parents is not uncommon. For many it is almost an expected initiation rite from youth into forced adulthood.) The particular session was progressing towards what appeared to be a very involved and rewarding educational experience when, unexpectedly, the largest and, up until that time, the most uninvolved member of the group began to get quite emotionally involved in the roleplaying situation. When his involvement became obvious to the entire group, he was asked if he could explain or identify his feelings which, up until that time, had been obviously suppressed.

He then related his own experience of being "kicked out" of his home at the age of ten by his father. His mother had previously deserted the family of four children after which the father's hostilities were focused on the oldest child, who was the group member. After his ejection from his

home, he was befriended by a white neighbor who temporarily cared for him.

Through observing the roleplay, the group member was able to finally identify and attempt to resolve the great feelings of guilt and anger that had accumulated over the years. He was better able to understand his hatred of the white man, his inability to become involved, and many other factors that he had never been able to consciously deal with before.

This is a simplification of the actual situation and of the psychodynamic elements involved, but the roleplaying situation did initiate and permit the particular individual to become aware of feelings that previously had been a great source of discomfort for him and was invariably followed by insights that produced overt behavior changes. The trainer, while observing such interaction, can then design new situations which can produce increased involvement and challenge for those actively involved, while also giving other members an opportunity to gain vicariously from the actual performance.

The most anticipated and challenging element of the group was its diverse ethnic and racial make-up. This presented a great opportunity to not only use roleplaying techniques as a training device but also as a means of enhancing and exploring racial and cultural understanding. It was possible to roleplay situations where it was demanded of the participant that he explore his own racial feelings. All members, at one time or another, were involved in roleplaying that included members of another race, therefore making it inevitable for the participants to look at and, consequently, justify his own racial feelings to the group thereby assuming the responsibility for such feelings.

The following is a brief and actual illustration of how such feelings can be discovered and resolved through roleplay: Don, a white member of the group, felt that he was being discriminated against by the black majority and that the other white members of the group were also rejecting him. When the group felt that Don's feelings were negatively affecting the group, they decided to deal with them through the method of "role reversal." He was asked to exchange roles with another group member in an attempt to better identify and work through the sources of conflict. Don, therefore, assumed the role of his antagonist and another group member played the role of Don. He was then able to observe "himself" as played by another group member. Through role reversal, Don began to see himself as the other group members saw him. He was forced, almost literally, to become his antagonist and, consequently, began to appreciate their point of view. This

isolated situation awakened Don to social reality quickly and forcefully. Through a painful, but necessary, process, he realized that he was the one who was rejecting the group by isolating himself from the group. He had been projecting his anger and fear onto the group which, in return, reinforced Don's fears by permitting him to withdraw gradually. The pertinency of role reversal was not confined only to those playing active roles, but, once again, helped the entire group to gain insight into individual, as well as group, behavior.

In summary and conclusion, roleplaying techniques were used for three primary purposes:

(1) As a method of instruction.
(2) As a method of training.
(3) As a method of enhancing and developing subjective and social awareness.

From an educational standpoint, roleplaying affords a very effective way of teaching and demonstrating skills and attitudes in preparation for para-professional careers in the social services. It was found that such techniques as an educational device places the emphasis on discovery by the trainee; on setting one's own goals; on setting goals with others; on assuming responsibility for one's own and the other trainees actions, learning, growth, and development. It is a method of learning in which growth can be seen and measured by which one can gain exposure to real life situations and problems.

From the standpoint of individual and social awareness, roleplaying methods permit an infinite number of means for exploration and growth. It places emphasis on the development of trust, candor and concern for others, while simultaneously developing increased responsibility, awareness, and understanding of one's effect on others, along with a myriad of other practical and effective professional skills.

Suggested Readings

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Raymond R. Corsini: *Roleplaying in Psychotherapy: A Manual*, Aldine Publishing Co., Chicago, 1966.

CONJOINT FAMILY THERAPY WITH CLINIC TEAM IN A SHOPPING PLAZA*

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I

Over the past decade, a quiet but nonetheless dramatic shift has been occurring with reference to the treatment of choice. In a wide variety of mental health settings, group techniques have become so accepted and valued that there is every reason to expect they will soon be more popular than the traditional individual counselling and therapy approaches. Since one of the primary goals of therapy is to help the individual person to function more genuinely and effectively within his or her social milieu, this trend toward group techniques makes a lot of sense professionally. In other words, if after treatment our patient or client is loaded with insight but still cannot find a *meaningful personal role* for interaction with the outer world, then we simply have not been successful.

Healthy personal functioning means being able to function effectively and genuinely with others; living only with oneself and for oneself can in no way be regarded as an emotionally healthy state of mind. And yet, implicit in a therapeutic or counselling relationship which depends solely upon a one-to-one experience is this very concept of focussing upon just one individual's perspective. Within such a system, there is only a limited possibility for checking-out the validity and reliability of the client's point of view. It seems obvious, therefore, that an interactional approach with other persons can provide a much more dynamic setting for emotional growth and change.

About three and a half years ago, in response to the need to provide a more adequate treatment approach, it was decided to expand our treatment orientation by adding conjoint family therapy to other available clinic services. This decision was prompted by the obvious fact that in the great majority of our cases, the child or adolescent referred as the identified patient was often a symptom of the dysfunction within the larger nuclear family unit. It had become increasingly obvious that the conditions in the

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home which were contributing to the development and maintenance of the child's particular problem merited more attention. Thus, over the years, the clinic's approach became more and more family oriented. A natural development of our increasing awareness of the importance of interpersonal relationships in the family, was the transition from concurrent treatment of the child and the parent(s) to conjoint interviewing of the total family unit.

The York Child and Family Psychiatric Clinic is a tax-supported community mental health service available to all pre-school to school-leaving age children and their families residing in the Borough of York, one of the six municipalities which make-up Metropolitan Toronto. The total staff of the clinic, though comparatively small, is nonetheless well balanced and consists of four professionals and two secretaries. The director, a psychiatrist, was also trained in psychology and has had considerable experience in a variety of medical, educational and psychiatric settings. The two social workers have had graduate training in social work and worked in family welfare and child protection services before coming to our clinic. The author has had both training and experience in psychology, sociology and education.

In the early summer of 1967, in a further attempt to be more closely integrated with and available to the local community residents, the Clinic moved into new premises in a recently completed shopping plaza at the geographical center of the Borough. It was felt that by placing the clinic in such a setting amidst familiar shops, many of the underlying fears and terrors which the public commonly associate with institutional psychiatric services could be eliminated. This appears to be quite true, although the clinic has not been in this setting long enough to make a definitive statement as yet. The non-institutional design and interior decoration of the clinic provide for an unusually colorful and home-like atmosphere appropriate to a service providing counselling and therapeutic assistance to disturbed families. Referrals are accepted from parents, physicians, schools, public health nurses, social agencies, juvenile and family court, and from other community clinics.

In the past two years, as a result of changes within the community's population and increased guidance and psychological services provided by the schools, the type of cases being referred to the clinic are generally much more serious than before. To deal with this situation, a more efficient as well as more effective system of family treatment has been developed which assists the clinic staff in their efforts to help each family come to grips

with the basic problems much more quickly and intensively. The system continues to allow for the integration of a psychological assessment and individual interview sessions where needed and also provides group psychotherapy separately for both the children and the parents if more extensive treatment is indicated. However, the orientation is focussed most upon family therapy and assisting the family members in making improved adjustments in their lives through learning to function in a more healthy way within the family setting.

There is, at the present time, some professional controversy over types of therapy possible within a family orientation. Boszormenyi-Nagy and Framo differentiate between *Intensive* and *Supportive* therapy. They define intensive family therapy as a depth family transactional approach to psychopathology and treatment and define as Supportive Family Therapy those therapy aproaches which focus most upon clarifying communication patterns and/or changing interaction patterns in order to help the family better cope with specific stress situations. Within these definitions, the type of treatment service provided within our community clinic would best be described as Supportive Therapy, since long-term analytic-type therapy is not possible nor even practical in terms of our size and current case load. However, this does not preclude the possibility of intensive family interactions occurring in our clinic, for as Franz Alexander points out, there is no clear correlation between the duration of treatment and its results. It is possible, therefore, for very intense experiences and changes to occur within relatively few family therapy sessions. It would seem that one must focus more on the quality of the therapist-family interaction, rather than the quantity of time spent in therapy or the particular theoretical approach used by the therapist.

The structure and overall concept of the plan currently being used in our clinic, relies most upon Virginia Satir's concept of Conjoint Family Therapy, Robert MacGgegor et al and the concept of Multiple Impact Therapy with families, Carl Rogers and his concept of the Client's Innate Capacity for Health, Sol Gordon's Concept of Group Therapy as the Treatment of Choice and Sidney Jourard's concept of the Need to Discern between educating our young people for meaningful life experiences as opposed to training them to adjust and accept (hence conform) to the status quo. Needless to say, we of course bring our own bias, e.g. of seeing psychotherapy as being basically an educational process wherein the therapists and clients operate on a more symmetrical and congruent level for meaningful shared experiences which are felt to be *mutually beneficial.* Our

clinic team consists of the psychiatrist, one social worker and myself, thus following the model described by MacGregor and his associates.

II

Our clinic's present operation is based upon a plan offering brief service to families. It is an approach designed to reduce the waiting period between time of referral and the onset of treatment in order that effective psycho-therapy can be provided at the time when the family is most ready to accept help, and what is most important, most likely to accept the structure within which help is to be provided.

Lippman states a very important principle with reference to a family's readiness to cooperate with a particular clinic: "Parents who bring a child to the clinic for treatment usually are ready to participate in any plan the staff may formulate". The key word here is "plan"; the key idea is the readiness to accept a plan; and the key implication, I believe, is the expectation that a certain *plan of action* will be proposed by the clinic team. Where no plan of action is proposed, or where the plan of action is not explicitly stated or takes on a certain vagueness which is difficult to perceive or understand, then there is a corresponding confusion in the mind of the client, a decrease in the level of confidence felt for the clinic, and a significant drop in motivation.

The answer to these problems has become more and more apparent throughout the wide range of out-patient clinic services offered today throughout North America; there is the urgent necessity to offer shorter waiting periods for families needing help, more explicit short-term treatment, and more varieties of treatment to suit particular needs. *In other words, clinics must offer better treatment in less time. Brief Service as opposed to long-term therapy has become a modern-day necessity.* And there are techniques available today which make brief service not only possible, but potentially even more effective than some of the approaches developed in a more leisurely and less crowded period of history.

Our basic approach, as presently conceived, operates within the concept that long-term treatment (where the end or termination is not apparent) is philosophically and professionally unsound. Philosophically it is not sound, because by nature man is constantly driven to know the boundaries within which he exists and is expected to function. Where realistic boundaries are not provided, man becomes uneasy—and substitutes artificial boundaries of his own. Professionally, it is unsound to continue the therapeutic relationship indefinitely because both the therapist and the patient may become

increasingly dependent upon each other—which works against the development of better mental health. So, to avoid the creation of artificial boundaries and the danger of over-dependence, the clinic must provide each family with realistic goals within comparatively short-term periods of treatment which will *encourage* the development of more self-confidence and independence. (I emphasize *encourage*, because no clinic approach can guarantee such development.)

III

Our plan is divided into two segments, each spread over an 8 week period, or roughly two months;—this results in an overall structure approximately four months in length. The attached Calendar Plan gives the breakdown of contacts with the clinic within a session-by-session system. The following descriptive layout, will explain the immediate function of each family's sessions or contact with the clinic as presented by the team to the family.

First Week

This is the first and often crucial meeting between the family and the Clinic Team. It provides an opportunity for everyone to become acquainted, *and to relieve the pressure on the Identified Patient by involving the whole family*. Initial statements of the problem by each member of the family are encouraged, and social assessment of the family is begun. The Clinic Team conveys to the family the expectation from the beginning that the family will be able to make constructive use of their Clinic experiences. Active team intervention is begun in the form of preliminary suggestions designated as "family homework"; these are based on the family's initially expressed concerns.

Second Week

a) The psychiatrist has an individual interview with the identified patient in order to better understand the problem from the child's point of view. Also first clinical impressions from the Conjoint Family interview can be explored further, and the child's personality functioning assessed. After a brief preparation for testing, which is explained as a way of discovering his assets and of understanding him and his problems better, the child is individually introduced to the psychologist.

b) The Team Social Worker has her first interview with preferably *both parents* together. This session permits further statement of the problem by the parent(s) and clarification by the worker of the problem from the parents' standpoint, as well as interpretation to them of what appears to be the problem from the child's point of view. Recommendations given in the Conjoint

Family Session may be further explained, and the parents are encouraged to continue to work on the suggestions.

Third Week

a) First Testing session of the identified patient with the psychologist.

b) Second interview with Social Worker and parent(s). Continuation of social assessment and further clarification of problems.

Fourth Week

Second Conjoint Family Therapy Session with the Clinic Team to ascertain how well the members of the family are making use of their respective clinic experiences and how effectively they have been able to utilize the suggestions given at the first Conjoint Family Session, and in subsequent individual sessions. *Also, hopefully the team may offer a model for healthy interpersonal exchange of differences as a better approach to solving and handling problems.*

Fifth Week

a) Second testing session with the psychologist of the identified patient.

b) Third interview between social worker and parents. Worker begins or continues preliminary interpretations re the child to the parents and pursues more deeply the assessment of the family functioning and areas of dysfunction emerging as parental defenses tend to dissolve.

Sixth Week

a) Third testing session with psychologist of the identified patient which completes the routine screening testing. Psychologist explains two weeks interval before next clinic contact as a trial "working period" for the child and the family.

b) Fourth interview between Social Worker and parent(s). Worker also explains two weeks interval as a trial working period without clinic intervention.

Seventh Week

Trial working period; no appointments with the family. The Clinic Team discuss informally their respective impressions of this family and the identified patient, and formulate a tentative plan regarding further clarification and recommendations to be implemented in the next session.

Eighth Week

a) Third Conjoint Family Therapy Session with the Clinic Team prior to a two months (8 weeks) "working period" during

which the family is encouraged to "strike-out on their own" and work very hard to see how well they can handle family disturbances and problems *without relying on the Clinic Team.* Of course, if a real emergency arises which they feel is too difficult to cope with alone, they can contact the clinic—but the Team conveys strongly, during this family session, their *expectation* that the family will be able to handle any problems which arise, and their confidence in the family's improved ability to function more effectively in their living together as a family.

b) During the two months "working period" for the family, the Clinic Team will complete their diagnostic write-ups and reports, and confer together in a Provisional Diagnostic Conference as to the validity of their assessments.

Ninth Week

First Clinic contact after the two months "working period" is another Conjoint Family Therapy Interview with the Clinic Team. Focus is on how the family progressed and how they handled their difficulties which arose. Based on this final family session, the staff will complete the diagnosis and arrive at specific recommendations.

Tenth Contact Ending Brief Service

Parent Interpretation—This tenth and last contact of the brief service offered to the family, is designed to provide a meeting between the team and the parents in order to discuss the clinical provisional diagnosis and recommendations made by the Team. In a large majority of cases the case can be effectively terminated at this point since the family members have generally learned to cope more effectively with their problems. In those cases needing further help, recommendations may include one or more of the following:

a) Continuing Conjoint Family Therapy

b) Individual or group therapy for the identified patient (play therapy may be utilized, depending upon developmental level of the child).

c) Group sessions for parent couples

d) In certain cases where preliminary screening indicates the need for additional testing, such testing would normally be scheduled during the seventh and eighth week, just prior to the family's two month "working period."

Two or more of these approaches may be alternated or combined, but if continuing therapy following brief service is offered there is once again the need to structure the "further therapy" within a foreseeable end-point. Such sessions are judiciously spaced with varying lengths of "working periods" between ses-

sions, the focus being upon the family's assuming a major responsibility to work on their difficulties.

When clinic services do not appear to be meeting the specific needs of the patient and family, referral to another agency is often arranged. The Clinic Team assumes the responsibility for preparing the family for this transition.

IV

The plan just outlined has been in operation at our clinic over the past year, and on the whole appears to have resulted in the kind of organization and structure within which we as professionals can function better and within which the families who come to us for assistance can find the support and encouragement they need to resolve their difficulties. But this system is not the final answer, for just as it has developed slowly out of the experience and contributions of many staff persons during the Clinic's existence these past nineteen years, so it will continue to grow and improve in the years to come. In fact, changes are currently being made in our approach so that the amount of testing being done with the Identified Patient will be reduced in favor of a more family-oriented appraisal. This will not only increase our effectiveness in family therapy, but will also place the diagnostic emphasis on the family as a unit which is more professionally consistent with the clinic's focus and therapeutic aims.

As mentioned earlier, our approach functions within the philosophic premise that effective therapy consists of *meaningful shared experiences* for both the family members and the clinic team members. This requires spontaneity and great flexibility on the part of the clinic team as a whole, which in turn relies upon the flexibility and openness of each professional member of the team.

The utilization of many techniques and approaches which might potentially be of assistance is necessary to meet the almost infinite variety of emotional needs and levels of responsiveness which is found in human beings, and we find that the system which we have developed for brief service, is a structure which allows us just this type of freedom and variety. Although not as concentrated as the Multiple Impact Therapy approach, we still utilize their philosophy that within a clinic's procedure there must be "considerable room for variations appropriate to the family's dynamics and the pathological condition of any one person." And as Jourard stresses, such variations should provide all participants with experiences which will allow more of the world to be included in their consciousness. Don Weitz says it so well; the therapist "not only shares himself with, but involves himself *in* other people and sit-

uations. He feels and immerses himself into his own and others' life experiences."

In a study conducted at the University of Toronto by Cappon and Bartoletti it was demonstrated under stress conditions that the group cohesiveness of psychiatric patients dissipated rapidly as compared to the group cohesiveness of control subjects, i.e. "normals" with no history of psychiatric illness. It was suggested from this study that not only do normal persons have a higher level of sustained intra-psychic energy, they also *discover and effectively use activity* to stimulate alertness and group morale. The inference is clear, then, that therapists should utilize their natural spontaneity—not repress it. They should feel free to initiate any thought and activity which might stimulate the latent alertness and inter-personal morale within a family. Such reciprocity between the family and clinic team members allows the professionals to assume their more natural roles as individuals and human beings, and this, in turn, encourages the family members to reject the "patient" vector in favor of more active roles as significant persons with important ideas and contributions.

Purely and simply this is *dynamic eclecticism,* and it conveys a spirit of discovery and inner freedom to all the participants—which in turn can develop that sense of human joy in living which we call "mental health."

Suggested Readings

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Cappon, Daniel and Bartoletti, Mario D.: Group Dynamics of Sleep Deprived Patients and Controls, in J. L. Moreno (Ed.), *The International Handbook of Group Psytherapy,* Beacon, N.Y., Int. Council of Group Psychotherapy, 1966.

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PRACTICAL ASPECTS OF PSYCHODRAMA*

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The postulate of "Sociatry" is that what needs to be healed is not individual psyches alone, but *all of society*.[1] Sociatry has two roots, Greek—eiatrea, to heal, and Latin—socius, companion along the way, the other fellow. The focus of attention is upon the interaction between psyches, between group members, their adhesions to other groups and the nature of interaction between groups.

The following are guidelines for the director of psychodrama by which to conduct the session.

RULE I

The director (or chief therapist) must be the most spontaneous member of the group, that is, more spontaneous than the other professional group members as auxiliary egos and even—and this is often the most challenging and difficult—more spontaneous than the patients or protagonists. According to Moreno,[2] the personality of the therapist-director is his greatest skill. The more spontaneously or flexibly he can deal with the protagonists and other therapeutic team members, the better he will be able to guide the group interactions. Spontaneity and anxiety are linked and are functions of each other; anxiety will increase if spontaneity recedes; conversely, anxiety will decrease if spontaneity is allowed to rise. Spontaneity has been defined as "a new response to an old situation" or "an adequate response to a new situation."[3] *New* in this context means fresh, novel, creative, in the here and now, not fore-ordained or predetermined, but arising out of the immediate situation with which the group is struggling, a genuine rising to the occasion in a fluid manner.

Thus, if the protagonist is rigid, compulsively repeating his old type of behavior in the psychodrama, the director must offer the protagonist the opportunity to try out a new set or order of skills, here, now, on the spot,

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[1] Moreno, J. L. *Who Shall Survive?*, Beacon House, 1953, p. 118.

[2] Moreno, J. L. "Constant Frame of Reference for all Methods of Psychotherapy," *Psychodrama*, Vol. II, Beacon House, 1959, p. 236.

[3] Moreno, J. L. Philosophy of the Third Psychiatric Revolution," *Progress In Psychotherapy*, Vol. I, Grune & Stratton, 1956, p. 29.

as a rehearsal for life. Psychodrama is a living laboratory for experimentation with life, with all its encumbrances *except* punishment, for trying out new ways of living it. Some of the immediately effective techniques are: role reversal, the mirror, the protagonist as his own spectator, as-his-own double, as-his-own-director, as-his-own-counselor, to mention but a few. He might, for instance, observe himself in role reversal, or in his own role, watching from the side, as the auxiliary egos repeat the scene he has just completed, before him, duplicating the essence of his own portrayal, either in his own role or in the role reversed position as the other person (or persons) involved in the interaction. He may be placed in the role of the therapist by the director: "What other ways could you recommend for Jack to try out here? Make whatever suggestions you may have for him to change his behavior." This forces him to devise new channels of warming up for himself; he shapes his own therapy.

One may sum up this rule as follows: "Throw away your old script. It hasn't worked very well for you. Here you can try several variations on this theme." It is another illustration of the "liberation of the actor from the script,"[4] not in the theatrical sense, but in the midst of life.

Rule II

The director must be aware of his own psychodramatic needs, as against those of his protagonists. Be sure you are not foisting your own views and needs on them. We frequently see directors whose religious or moral imperatives make it difficult for them to deal with those of their protagonists and group members who carry different imperatives. The parallels and similarities should not trap him, but neither should the differences.

A recent example of this was experienced during a training seminar in which a student from a foreign country was misperceived and misinterpreted by his student-director. The foreign student's behavior in the group was based upon his desire to be a good ambassador for his country—a troubled land in the near-east, and he worked dilligently at this sociodramatic role in order not to cut off interaction with students who might otherwise reject him. He wanted to build goodwill for his country while abroad. The student-director accused him of hypocrisy, stating with conviction that his protagonist's behavior was hypocritical, that there was no way any human behaved except on the basis of "individual dynamics." During the group members' sharing in the post-action period, a number of group members revealed their own feelings of loneliness and isolation in strange groups, with the conse-

[4] Moreno, J. L. *The Theater of Spontaneity*, Beacon House, 1947.

quent loss of feelings of identity as a person. One very perceptive group member then stated that it was not even necessary to go abroad to feel this way; one could feel cut off and suffer anomia in one's own country, but how much more emphatic this experience must be when one's own background, language and culture, mores and views of life, have to be replaced by a completely new set. The student-director stated he had never been abroad and claimed to be unaware of such sensitive sociodramatic experiences on that basis. But beyond that, he denied ever having had such discomforting experiences, in any groups into which he moved. This aroused much protest from the group members who pointed out to him that he had been noticeably withdrawn in this very group, having remained without meaningful, personal contact with others and he, in fact, emerged as "the stranger," the sociometric isolate, within it.

For a psychodramatic director, a little modesty goes a long way. One may quote Shakespeare's Hamlet for this rule: "There are more things between heaven and earth than are dreamt of in your philosophy."

Parenthetically, this is just one more indication of how much role testing, role training and role sensitivity is needed for our diplomats. These methods would produce fruitful results if applied to them before they are sent abroad to represent our country.

Rule III

The director must put himself into a subjective relationship with the protagonist, so to speak, borrowing terms from the field of sports, be in the protagonist's corner with him, as a partner, at least at crucial moments.

This is not the posture of the analytic person, rather that of a lover or mankind. The director must make his emotional equipment available to the protagonist as much as his intellect, as one human being with another. Once the protagonist senses the director to be genuinely "with him," the director is free to move again into a more objective position, whence he can survey the further needs of the protagonist and those of the other group members. This delicate balance of the subjective-objective relationship is one of the most crucial sin qua non demanded of the director for effective achievement of his task. It is the basis of true "tele contact" between himself and the protagonist, himself and the group members. Tele should sustain the director even when initial contact with the protagonist is difficult.

To illustrate this rule the following experience in a recent session is relevant. In an open sesion conducted in Manhattan, attended by a large number of persons, the majority of whom are professional workers who have come for a didactic session, the psychodrama director, a woman, is attacked

loudly by a group member, a female therapist in the group. She starts off by violently accusing the director—whom she has never seen before—of being intolerable in every respect. She rejects her face, clothing, shoes, speech, manner, and even at considerable distance, her body odor. The director, caught by surprise, asks her quite calmly nevertheless, to step upon the stage, to show her what she wants to do about her. The protagonist leaps aggressively upon the stage, apparently desirous of taking over the session. The audience is shocked into stunned silence at the violence and completeness of the attack. Because of the irrationality of the protagonist, they are deeply puzzled and begin to fall into several subgroups, as is often observed in groups, some for the protagonist with whom they identify, some for the director for the same reason, a large number assume a careful wait-and-see-how-she-handles-this position, anxious because of its potential dangers, wondering how they would handle such powerful, abject rejection.

The director has recovered her balance and invites the protagonist to use an empty chair on stage to represent the director and to do anything to and with it that she wants to. The protagonist whom we shall call Nora, kicks the chair viciously on the legs, it slides off stage and collapses. Nora bursts out: "I feel exactly the same way towards my mother. In fact, you resemble her."

Now the director moves the protagonist into various confrontations with her mother, taking her scene by scene from the present into the past, at the most crucial turning points in the relationship, as indicated by the protagonist, from step to step.

Nora sees her mother as a cold, controlling, critical, superior, manipulative, dishonest person. She has hardly anything positive to convey about her. She relishes taking the role of her mother in role reversal and pushing her "auxiliary ego Nora" around with her awesome power over her. Nevertheless, in this embodiment of her mother she becomes gradually a very statuesque, gracious, albeit somewhat distant and impersonal woman. The director asks her: "Now that we understand you better and your feelings towards your mother, would you tell me whether you ever had a better or substitute mother? One who, though not your biological mother, was emotionally close to you and met your needs better?" "Yes," Nora states and eagerly warms up to this new relationship. To psychodramatize it, she chooses from the group present as auxiliary ego the professor who brought her and her classmates to this session. The climax of the session now proceeds fast, as we see Nora go through the psychodramatic paces. The "real" mother is her governess; they are all German Jews. Nora is a refugee from Nazi Ger-

many. The governess—also a Jewess—is her constant companion in her childhood, protecting her lovingly from all shocks and pain in the pre-Nazi period. When that period erupts, when Nora is thirteen years old, the governess becomes emotionally ill and is hospitalized, leaving Nora doubly abandoned. She schemes to get her out of the hospital and to smuggle her our of the country, whence her family is planning to depart. Her plan almost succeeds but once again, the "mother" is taken away from her into the hospital, completely out of contact with the world. Soon afterwards, the Nazis emptied all such institutions in their infamous "clean-ups." Nora, having re-enacted all these scenes, breaks down and sobs uncontrollably. At this point she allows the director to comfort her, even permits her to put her arm around her. When she has calmed down sufficiently, the director gives her an opportunity life did not give her: to complete the rescue of her good mother, without whom her life is meaningless. Nora once more meets her "Mutti" and psychodramatically carries out to a succesful conclusion the deeply buried rescue fantasy. Nora is a very attractive woman in her forties, married, with two children; she works in a clinic for the emotionally disturbed, doing nonverbal, body and movement therapy. One may, of course, look at her professional role as an attempt at self-therapy as well as making good the rescue failure in life, but apparently it is too indirect and diffuse to remove the scars she has been carrying around with her for over thirty years. The psychodrama is meant to assist in the healing process, over and beyond that which she could achieve on her own, in life itself. It supplies emotional need satisfaction.

When the session ends, Nora looks at the psychodramatic director, with amazement and kisses her warmly. There is an overwhelmingly sense of relief in the audience; the silence in the group is pregnant with emotion. There is a sense of existential anguish so deep that no words can suffice. The director closes the session. What has occurred, in spite of all the difficulties with which this session began, is a genuine "encounter."

Rule IV

The psychodramatist emphasizes the warming up of the protagonist, encourages and assists him to focus on action and interaction. To prevent the protagonist from "interpreting himself"—which leads too much to being his own spectator rather than being his own actor—instructions should clearly be stated in simple terms: "Here we do *not* talk about how we feel, here we *act out* how we feel. It is happening *now, here.* Let's live it through, together." *Show* me, *do not tell* me."

We give the protagonist the freedom, the license to go into action, including embodiments of all dimensions of his world, positive, negative, real, fantasied, it is immaterial. He must have the freedom to feel at home in his own world.

This is one of the biggest stumbling blocks for many therapists who insist upon analysis and teaching patients to stop and think, those whose own training have come from different orientation. They fear that teaching their patients this way of achieving catharsis is going to turn them into delinquents or criminals; that it will teach them to behave irrationally in life. Our position is exactly the opposite: that to prevent this from happening in the therapeutic setting where the patient can learn from it, is to invite disaster on the outside, where there are no controls.[5]

Psychodrama is similar to vaccination: it is a small dose of insanity given under conditions of control.

Rule V

The director's own "surplus reality" awareness should stimulate him to follow the protagonists without fear, to enter into their own world of "surplus reality." Surplus reality is that realm beyond reality in which the protagonist may live most deeply, his fantasy world.

A recent example follows: The protagonist, Neil, is a teacher, married, devoted to his wife, with three adolescent boys. He is at present engaged in research on the west coast involving the educational processes, completing his doctorate.

His presenting symptom is violent sado-masochistic sexual fantasies which he states interfere with relations to his wife, although she is not aware of them. Because of his fear that she will discover them or that he will force her to carry them out with him, he has decided to relieve himself through psychodramatic enactment. He is allowed to choose those persons in the group whom he wants to have present. The sociometric group construction before the session helps to strengthen his feeling of trust. He also chooses a male director.

The bizarre, Genet-type fantasies which occur in the protagonist's mind when he is in bed with his wife are reproduced with the assistance of a female auxiliary ego, a group member, chosen by the protagonist. The director guides the process very sensitively, without stimulating exhibitionism, but delicately exploring, side by side, in action, the dual situation: the actual one taking place with the wife, and the fantasy one occurring in the

[5] Moreno, J. L. *Progress in Psychotherapy,* Vol. I, p. 37.

protagonist's mind, simultaneously. It becomes clear that the protagonist is more intrigued by his fantasies than involved in the lovemaking of his wife. The resulting split becomes disastrous for his real performance. When he is permitted by means of psychodrama to *complete* his fantasies, instead of fighting against them as he tries to do in life, he begins to be better able to control and integrate the fantasies, intensifying his being in-the-here-and-now in subsequent performance with his wife; this intensified warm-up in the real situation in turn increases their mutual satisfaction, a classic "catharsis of integration."

In the post-action sharing of the session, the members of the group are aware and state that they have had some fantasies of a similar sort, though not as intense as those produced by the protagonist who is, however, delighted and much relieved to know this. The director especially remarked that his own experiences along these lines helped him to appreciate the nature of these phenomena in the protagonist; he felt that this was one of the reasons he did not consider them bizarre and was not afraid to enter into the psychodramatic exploration. Indeed, he was gratified to see that this type of fantasy experience lends itself so well to psychodramatic processing. The most important thing was that he did not "fall out of the role of director," but made his own sensitivity available to the protagonist.

The psyche of man is not transparent. Action methods such as here described are the most suitable instruments for dealing with the multiple, invisible dimensions in which all of us live in life by ourselves, but which we learn to open up and share through the psychodrama.

Psychonauts of the world, unite!

World Center for Psychodrama, Sociometry and Group Psychotherapy—New Developments

Special examinations for candidates on the West Coast including the California Institute of Socioanalysis, the California Institute of Psychodrama, and the Berkeley Institute for Training in Group Therapy and Psychodrama were held in San Francisco on Sunday, May 10, 1970. All candidates passed the examination on various plateaus as Auxiliary Ego, Assistant Director and Associate Director.

Auxiliary Ego

Joan E. Collins, B.A.
Sandra Garfield, B.S.
Edward Gilbert, B.A.
Betty Gumpertz, B.A.
Gordon M. Gumpertz, B.A.
Ellen Louise Swenson, B.S.

Assistant Director

Jean H. Klenes, B.A.
Ieda Silva, M.A.
Frank Mayer
Samuel D. Friedman, M.A.
Karla Baker, B.A.

Associate Director

Eva Korn
William G. James, A.B.
Esther Small, M.S.W.
Marguerite Rubenstein, B.A.
Ike Sofaer, M.A.
Mimi Silbert, M.A.
Winona M. Christeson, M.A.
Walt Anderson, M.A.
Evelyn P. Baum, M.A.
Ira A. Greenberg, Ph.D.
Donald E. Hartley, M.A.
Michael Solomon, M.A.
Colman J. Mullin, M.E.
Rochelle J. Haskell, B.A.
Leo Sandron, Ph.D.
James L. Young, M.A.
Bobker Ben Ali, M.A.

ANNOUNCEMENTS

Sixth International Congress of Psychodrama and Sociodrama, Amsterdam, August 22-27, 1971

Honorary President: J. L. Moreno, M.D.; Honorary Vice-President: Zerka T. Moreno; President: Dean G. Elefthery, M.D.

American Psychological Association

All day Workshop in Psychodrama, Sunday, September 6, 1970, Miami Beach, Florida. The list of participants are: Laurence Abrams, Eugene Eliasoph, Leon Fine, Carl Hollander, J. L. Moreno, Zerka T. Moreno, Walter O'Connell, James M. Sacks, Barbara Seabourne, Brett R. Stuart and Hannah B. Weiner. J. L. Moreno, Chairman; Organizers, Robert F. A. Schaef and Ted Aidman.

Das Stegreiftheater

A second, revised edition of *Das Stegreiftheater,* by J. L. Moreno, M.D. has been published by Beacon House Inc. Write to Beacon House Inc. for particulars.

OBITUARIES

Anna B. Brind, Ph.D.

May 9, 1895 to August 6, 1969. Dr. Brind has been a member of the American Society of Group Psychotherapy and Psychodrama from its beginning. She contributed numerous articles to this journal in collaboration with her husband, Nah Brind.

No one who knew Anna Brind will ever forget her devotion as well as her brilliant mind.

Marvin Wellman, M.D.

December 15, 1904 to May 1970. Dr. Marvin Wellman was Clinical Director of Northeast Florida Mental Hospital since it opened. Dr. Wellman was one of those who attended that first historic meeting on group psychotherapy and sociometry within the annual meeting of the American Psychiatric Association in Philadelphia in 1932. Dr. Wellman was a highly regarded psychiatrist and has made a number of contributions to the literature of psychodrama and group psychotherapy. His death is a loss to all members of our society and those who knew him.