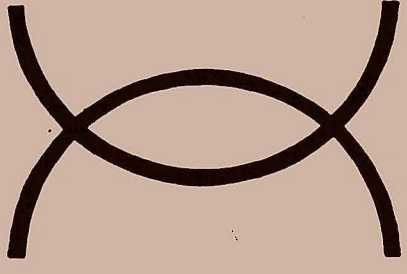
GROUP PSYCHOTHERAPY PSYCHODRAMA AND SOCIOMETRY

Official Organ of the
American Society of Group Psychotherapy
and Psychodrama



VOL. XXXII, 1979

If You Have an Article . . .

We encourage the submissionof articles about psychodrama, sociometry, and group psychotherapy from those familiar with J.L. Moreno's wide range of work in psychotherapy, education, training, and the arts.

Articles should be typed in conformance to the *Publication Manual* of the American Psychological Association, submitted in triplicate, and accompanied by a stamped return envelope to the Editor, *GPPS,* 259 Wolcott Ave. Beacon, N.Y. 12508. Each article is read by one or more members of the Editorial Committee.

As mandated by the Council of Fellows of the American Society of Group Psychotherapy & Psychodrama, the Council of Fellows is trying to encourage interaction between ASGPP members and this Journal. To this end, suggestions, notes on activities, reviews, and articles are especially solicited from ASGPP members.

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Editorial Note

This issue is again divided into sections. We gratefully acknowledge the work of Joe Hart in assembling and editing the Sociometry section. Psychodrama has for a long time filled the pages of the journal overwhelmingly; it is good to see that the sociometric basis for Moreno's work is getting its proper share of attention. The papers cover a broad spectrum of applications. Among others, the attention paid the network theory reminds us that beyond the immediate social atom lies the network, from which influences impinge upon the smaller group and the individual which, though subtle, are very real.

Two articles in the Psychodrama section deal with its relationship to psychoanalysis, theoretically and practically. Does this forebode a trend? We shall be interested to observe this in the future.

ZERKA T. MORENO

PSYCHODRAMA SECTION

ESCAPE ME NEVER

ZERKA T. MORENO

As a very young man Moreno's play with children in the gardens of Vienna proved to be a seedbed from which his therapeutic methods developed. He wrote about these story games in Das Koenigreich der Kinder *(The Kingdom of the Children) in 1908. It was not without pride that he described how, given the opportunities he provided, one child after another revealed true dramatic talent. Some went on in later life to distinguished careers in the theater.*

Of these, perhaps the most talented and most widely acclaimed was the actress Elisabeth Bergner. An ornament to the stage in Max Reinhardt's theater in Berlin, in London with Charles Cochran, in films with Alexander Korda and her husband Paul Czinner, and on tours around the world, the films she made are considered cinema classics. Among her films was her greatest success, Escape Me Never. *Its title could serve to describe her feelings toward Moreno.*

Now Elisabeth Bergner has written her autobiography, Bewundert Viel und Viel Gescholten *(Much Admired and Much Chided). With grace and felicity she discharges her debt to Moreno. By permission of her publishers—C. Bertelsmann Verlag of Munich—I have translated the following excerpts:*

I am still ten, . . . my Papa . . . brings Moreno into my young life. Certainly, certainly, I had the best father on earth.

Jacob Moreno, medical student at the University of Vienna, approximately twenty, but at most twenty three years old. To me he looked like a hundred because he had a beard. In those days only very old men wore beards. My father had a mustache. Moreno had a Christbeard, as I recognized much later. He was tall and slender, had grippingly beautiful blue eyes that always smiled, and dark hair. I believe he was wondrously beautiful. I still believe that today. Most fascinating was his smile. That was a mixture of mockery and kindness. It was loving and amused. It was indescribable. I still believe today that he was deliciously amused at our entire family.

Moreno, that was thus our new tutor. I believe my father knew his mother or something of that sort. But I know nothing more specific about how he suddenly came to us. He was just there. Now a new time chronology begins. It is the start of my spiritual birth. If I were to succeed in making clear what Moreno meant in my life and at this time of my life, then maybe this questionable undertaking of an autobiography would serve a purpose. I have read somewhere once: "History is a Mississippi of lies." I am often forcibly reminded of that while reading biographies, not to speak of autobiographies. And here I am not thinking at all of conscious or deliberate untruths. But what do we really know about ourselves? About our growing and becoming, about the influences—not merely conscious ones—to which we are exposed, which then awaken in us this or that, leading to certain consequences?

So, Moreno is our new tutor, God bless my Papa, about whom it would be perhaps more interesting to write a book than about myself.

It soon became clear that neither my sister nor my brother had any sense of what to do with Moreno, besides lessons. Nor he with them. He belongs to me, to me alone entirely. No, I belong to him! And how! He does not only do lessons with us. He goes also with us into the Augarten and the Prater. Until then, my small brother and I had gone only with the then current cook to the Prater. She took us mostly to the "Artists" in the "Wurschtlprater". The Wurschtlprater is that part of the Prater which is ideally suited for children, domestics and soldiers. It has a roller coaster and a train that runs through grottos and a tramway, sausages and an "artists' theater". We loved the Wurschtlprater, my brother and I. Most especially the "artists". These were, after all, my first experiences with theater.

The "artists" was an open beer garden with an elevated stage and a curtain of red gold silk. There were acrobats, magicians, dancers, clowns and mimes to be seen. My brother preferred the magicians; the mimes bewitched me.

In the normal course of events, the cook would take us there and

"accidentally" meet a soldier she knew who would invite us to his table on which stood a glass of beer.

We were very satisfied and gazed with fascination at the stage without noticing that the cook and the soldier would appear only two or three hours later at the table. "Come, come, it is already quite late," she would say then and we returned home again.

This edenic epoch ended abruptly when we, at one time, my brother and I, sitting all alone with a beer glass, witnessed a tense pantomime in which the eyes of a man were put out. I began to scream and weep. The other spectators and the artists were disturbed and vexed; they noticed suddenly that two children sat there alone, without an attending adult. The cook and the soldier were searched for and found and we left in haste. For a long time I was unable to stop crying and my brother consoled me. "Don't be stupid, that was not real blood, that was only red dye that he had on his face and the cook spoke up, "If you don't stop crying I won't ever be able to take you to the 'artists' anymore".

By the time we reached home I had stopped weeping and no one noticed anything that evening. But, during the night it started again. Screaming and crying I awakened and told my frightened parents about the put-out eyes and the bloody face and that was the end of the "artists" epoch. We were never again permitted to go there.

But this I have to establish here: I am deeply grateful for the memory of the "artists" and quite convinced that this "artist period" awakened in me a fascination for the theater. At least the fascination of being a theater goer. Although until this day I am unable to attend a performance of "Lear" without fleeing into the foyer for the scene of Gloucester's blinding. Merely looking away is not good enough then, I have tried it. It is also possible that this "artists" experience showed my parents the need not to trust us to the cook any longer—and brought Moreno into the house.

Thus, with Moreno a new era begins. The ease and speed with which the schoolwork was accomplished was soon no longer the most important. I was given poems to learn. And not just "The Bell" and "The Hostage" and such things from the school reader, but the wildest, most beautiful "unknown" poems: "The moon is risen, the little golden stars are resplendent"; "Ride, ride, ride through the day, through the night, through the day"; "Many must surely die there where the heavy rudders of ships are streaking"; "Thus far too many things there are at which we smile with confidence, because our eyes do not see them." Oh, it was a new world.

Or, when Moreno went with us to the Prater, we did not go to the "Wurschtl" but very deep, far away into the main avenue where the beautiful large meadows are.

"But you don't need a skipping rope for skipping! Come, let's give the skipping rope to a poor child who never had one!"

"But you don't need a ball to play ball! Come, I'll toss the sun to you, catch it!" "Ow, I burnt myself!" "Come, come, I'll make a bandage for you till the sunburn has cooled."

And on the way to the Prater he would take along a few children whom we met on the street. And all the toys we owned were given away to the children. Then we all had to sit in the meadow and he would say, "So, now we will think up our own fairy tales! Once upon a time there was a king who had seven sons. What were their names? What became of them?" And every child had to create a name, a character and a fate. In between he would pose questions to help the story along.

Many children did not like this game at all and did not return. Others always came back and brought along still more children. I loved these games beyond description, my brother found them dull.

Then Moreno started to play theater with us and to rehearse plays. My first role was that of Toinette in "The Imaginary Invalid" by Moliere. All the children played along. I was as if thrown into the water and able to swim.

What I saw in Moreno is most clearly explained by relating how I once came home too late from ice skating and he was there an half hour before me. I was very frightened. "Doesn't matter", said the cook who opened the door to me, "he's drinking coffee with your mother, just go on in!" I was as if turned to stone. Coffee? He drinks coffee, like the rest of us? Like an ordinary human being? But that was slander! He certainly was not an ordinary human being. She shoved me to the keyhole and I peeped through it and I saw: He drank coffee with my Mama. He laughed and bit off large pieces from a bun. In my speechless amazement I became aware then that I had perceived him quite differently. I was very disappointed. Not until later did I realize that there was something greater here. That an ordinary flesh-and-blood-person could nevertheless be so uncommon.

He remained thus for four years in my life. Indescribably important years, as I know today. In the twenties a new word became fashionable in our vocabulary, the word "abstract". When I pondered over this word and its meaning, I recognized that this idea, "abstract" was, so to speak, my mother's milk. My entire education by Moreno was, after all, the familiarization with and absorption of the "abstract".

At one time he said in my presence to my parents, "She will become an actress". "That's all we need," replied my Papa and they laughed. That was the first time I heard it, but I did not laugh. I have just never forgotten it, "She will become an actress".

These four years were full of new learning and growing for me. For

hospitalize her. The psychodrama progressed to the hospital, with the friend resisting every step of the way, and various scenes developed—doctors, nurses, insane patients, etc. The group had one of its gayest times playing patients in a ward in a psychiatric hospital. (The most fun they ever had was playing the disturbed children in an in-patient treatment center.) The nice thing about psychodrama is that you can assume all the roles that you would never allow yourself to be in real life.

Various confrontations followed: Friend and doctor, mother and doctor, friend and friend, friend and patients, etc. The session became quite wild, various patients in the group escalating self-chosen roles. When the final confrontations took place, protagonist vs. mother, with reversal of roles, heightened by doubling, enriched by auxiliary egos, a stark truth emerged: Sanity is what mother says it is. And, what do you do when your mother is insane? Especially when she has not been diagnosed as such? That is when patients seek treatment away from mother. They return to her in psychodrama sessions and finish the unfinished business of the past.

Moreno described psychodrama as "the depth therapy of the group." It begins during the assembling of the group, somewhat the way an audience arrives to see the play, in which they may also be the actors. The first phase is the warm-up, when individuals have arrived from their individual preoccupations with their individual time and space, to an awareness of the immediate time and presence of themselves in a group. Often one or more members may experience a problem of such intensity that words do not suffice and begin to act it out in the group before this is explained. The problem is often shared by members of the group; they spontaneously make room for him, giving him space. Another member may argue with him and soon it is obvious which member will be the protagonist. In the main part of the session, the enactment is a spontaneous description of the part of the life script of the protagonist he is already acting out. The skillful director assists by helping the protagonist clarify the situation, with pantomime, with a minimum of verbal description of the situation and with use of other group members enacting the roles of whatever others the protagonist describes as relevant to his problem. The situation is further clarified by the protagonist demonstrating the roles of these others by enacting them as well as others playing the role of the protagonist. Spontaneous "doubling" is encouraged. This is a second person that stands slightly behind, enlarging the role by duplicating it, as well as exaggerating either what is being shown or what it is felt is being concealed.

As in all dramas, it ends with a kind of new integration, which the protagonist experiences either as clarification, catharsis, or resolution. A skillful director has seen to it that spontaneous insights of the group were

utilized to enlarge the drama. Equally important, the director has also seen to it that the problem of the protagonist is as fully understood by the group as the protagonist's script permits.

In this way the drama subsides into the sharing. The protagonist, better understood by the group as well as by himself, merges back into the group while other members verbally reveal what feelings were aroused in them by this psychodrama. Any "analysis" is discouraged. Sharing feelings and owning to them with the pronoun "I" is encouraged. This empathic experience reunites the group, which then begins to disband, first by disintegration into little sub-groups and finally individual separation, until "next time." The sharing is an essential part of a psychodrama although it usually is about the last fifth of the total time spent. The protagonist, lost in a depiction of a world he perceived during his psychodrama, is astonished by the warm empathy of the sharing, learning once again that he is not alone. The group, whose feelings have often been deeply stirred, whether they took an active role in it or remained spectators, are eager to inform the protagonist how at one with him they felt.

It is a play without a script, the group is the author. It is psychoanalysis without a psychoanalyst, the group is the experiencer. The individuals in the group are the interpreters to themselves of what they have just experienced.

To see ourselves as others see us, a group reflects. To see ourselves as our antagonist sees us is what reversal of roles provides. To experience our antagonist (as we usually refuse to do) as he experiences himself, reversal of roles facilitates. To see what is happening to us when our observing ego is weak or overwhelmed, is what reversal of roles with an audience member provides, when the scene is rerun.

One of the most remarkable things about psychodrama is the discovery of the roles in life that we can play extremely well but never permit ourselves to do. In someone else's psychodrama we have a place where it is helpful, not damaging, to play the abandoning mother, the sadistic father, the castrating spouse, the deceiver, the psychopath, the patsy, etc. To feel, think and play them is a freeing experience from suppression and repression.

Moving through the parts gives us access to memories often inaccessible when lying on a couch. Muscular memory is attached to verbal recall. The stimulus of interaction calls forth recollections seldom aroused in the one-to-one situation of patient and therapist.

The resistances in psychodrama that spring up—transference reactions to other group members—are quickly dissolved by the separation of object from perceived object. As in psychoanalysis, it is the perceived world of the analysand that we must help with. Often the perceived world

blinds one to the real world, just as the past unintegrated memories blind one to the current reality of the moment. There are repeated opportunities, in a protected environment, to be the active doer, not the passive endurer in the re-enactment of a life's script. It will be found, in astonishment, that one is remarkably talented as a socializing expert, when playing a successful mother hostessing the party she is giving, and someone else has the old role of the child who must not compete with her, and sometimes be her fall guy, the clumsy oaf that makes her look even more successful. There are many creative and inspiring roles to be played, known how to play, but forbidden to play in life. There may be no recollection that these were forbidden, only the knowledge of "you can't." It is not always I-choose-not-to. It is frequently I-am-not-allowed-to.

The introjected object, at long last, is out there to be seen, experienced passively and actively, and eventually to be understood and forgiven—sometimes to be accepted as a part of the self, sometimes to be left in the outside world from whence it came, as unsuited to the self. A better separation and individuation has occurred.

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A SYSTEMATIC MODEL OF PSYCHODRAMA

THOMAS G. SCHRAMSKI

If one does not have a systematic scheme, a series of problems follow. One does not know which of a myriad of events one should attend. Without system, there are no explicit criteria by which to determine what is relevant and what is irrelevant for one's purpose (Ford and Urban, 1963, p. 27).

The purpose of this manuscript is to describe some aspects of a systematic model of psychodrama that will delineate the psychodramatic process and help the psychodramatist refine his cognitive understanding of psychodrama. Throughout this writing the author's reference to a "systematic model", will refer to a visual representation of the general dynamics in a typical psychodrama session as seen through the eyes of the director. Similar models have been effectively presented by Carl Hollander (1978) and Ann Hale (1974).

Part of the difficulty in presenting such a guide to psychodrama is the complexity of the method, and, according to J. L. Moreno, its "existential" character (Moreno, 1968, p. 3). Each client, or protagonist, is viewed as a person whose life experience is so unique that each psychodrama will be unique; a psychodrama session will not follow the same formula for any given person (Goldman, 1978). The situation is made more difficult in that each psychodramatist may use his understanding of psychodrama in different ways, emphasizing different views of personality dynamics and development.

Terms

A number of terms are defined so as to insure one's understanding of systems-related concepts. Familiarity with the basic psychodramatic terms is assumed.

A *systematic model* refers to a graphic and sequential representation of the communication in a psychodrama session. This is also referred to as a *flowchart*. An example of this is seen in Figure 1.

The *subsystem* is a smaller element of the total system. In the flowchart, the subsystem refers to each of the larger rectangles, such as DIRECT ACTION, which includes a number of functions in smaller rectangles, such as IDENTIFY CONCERNS (see Figure 2). *Function*

refers to a specific behavior or cognitive process. In this model, each function is enclosed by a rectangle, which is titled by capitalized descriptor words.

A *signal path* is the direction of the flow of information on the flowchart, which is represented by an arrow, as in Figure 1.

The *level of detail* is defined as the degree of specificity of any function. For example in Figure 2, the first level of detail is DIRECT ACTION (4.0), a second level of detail is DESCRIBE SCENE (4.4), a third level of detail is TIME (4.4.1), and a fourth level of detail is the RELATION TO PRESENT (4.4.1.1) choice. The more detailed the number level, (example 4.4.1.1 is more detailed than 4.1), the more specific the function.

Feedback denotes the inner control which helps a system to stabilize itself, similar to the process by which thermostats regulate temperature in a room. Figure 1 is an example of feedback where EVALUATE DIRECTOR PERFORMANCE is fed back to THE DIRECTOR. *Feedforward* is a term applied to a signal path showing an output from a subsystem to a succeeding subsystem, where there are one or more intervening subsystems which are unaffected by the signal path (Stewart et al., 1978, p. 59). In Figure 2, the movement from VERBALIZE (4.1.1), by-passing SELECT CONCERN (4.2), to SELECT SCENE (4.3) is an example of feedforward.

The *circle with a point-numeric code inside* is a short-cut means of showing a relationship between two relatively distant functions, as opposed to connecting them with a signal path (Stewart et al., 1978, p. 57). In Figure 2, the function of TERMINATE ACTION (4.8) is distant from RESTRUCTURE GROUP (6.1), so a circle with a point-numeric code inside is used to represent with movement.

Collection dot is a symbol indicating that all data from the various points of a particular function are to be "collected together" or summed, and then carried as a unit to the next function (Steward et. al., 1978, p. 57–58). In Figure 2, the RELATION TO PRESENT (4.4.1.1), and TIME OF DAY (4.4.1.2) aspects of the TIME (4.4.1) function, are brought together to the next function, PLACE (4.4.2).

Performance criteria refers to the criteria which is used to specifically evaluate communication and behavior in the process of a system in this model, performance criteria will consist of process questions about the behavior of the psychodrama director.

Validity of the Model

The systematic model in Figure 1, will be compared with written descriptions of the basic components of psychodrama as presented by

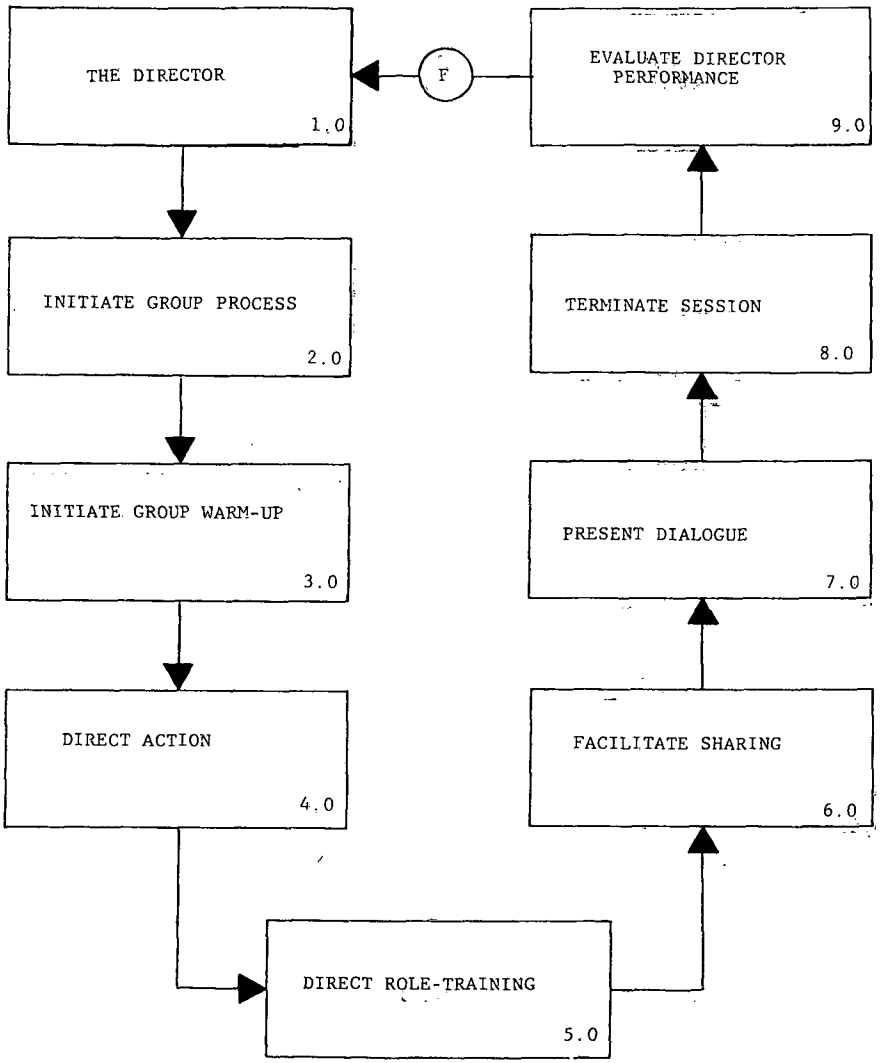

Figure 1: Flowchart of the Systematic Model Psychodrama

several experts in the Field. Among the experts are Elaine Eller Goldman, Director of the Western Institute for Psychodrama, Phoenix, Arizona; Martin Haskell, Director of the California Institute of Socioanalysis, Long Beach, California, and Past President of the American Society of Group Psychotherapy and Psychodrama (ASGPP); Carl Hollander, Director of the Colorado Psychodrama Center, Denver, Colorado and Current Presi-

dent of the ASGPP; the late J.L. Moreno, the originator of the psychodramatic method; and Lewis Yablonsky, noted author and Director of the California Theatre of Psychodrama, Los Angeles, California. All of these psychodramatists were trained under the auspices of J. L. Moreno at the Moreno Institute in Beacon, New York.

The essential elements of a group psychodrama are the protagonist, the auxiliary egos, the director, the stage and the group (Haskell, 1967, p. 11). This starting place is symbolized by the subsystem of THE DIRECTOR (1.0), which represents the psychodrama director and all the experience he brings to the group session.

The director must in some way begin the group through a process of introduction and, if the group is unfamiliar with psychodrama, explain the principle components of psychodrama (Goldman, 1978; Haskell, 1967, p. 28), which are represented by the INITIATE GROUP PROCESS (2.0) subsystem.

With the initiation of the group the director facilitates the group Warm-Up (Goldman; 1978; Haskell, 1967, pp. 28–45; Yablonsky, 1976, pp. 99–101), or interaction of group members. This same process is identified in the INITIATE GROUP WARM-UP (3.0) subsystem of the systematic model. This Warm-Up, includes the director's awareness of the emerging sociometry of the group and potential areas of exploration.

Following the Warm-Up is the Action portion of a typical psychodrama. The Action is the bulk of the session devoted to helping the protagonist (s) clarify and/or resolve his difficulties (Goldman, 1978; Haskell, 1967, pp. 46–75; Hollander, 1978, pp. 5–9; Yablonsky, 1976, p. 13). The Action segment is identical to the DIRECT ACTION (4.0) subsystem of the model.

The process of Role-Training is described in a variety of ways by experienced psychodrama directors. Haskell (1975, p. 283–287) differentiates Role-Training from psychodrama but does not specify when the techniques are to be used, other than after the initial psychodrama exploration. Hollander (1978, pp. 8–9) suggests the use of Role-Training at the conclusion of the Action segment before the initiation of the Sharing. Elaine Goldman (1978) generally considers the Role-Training to be a process that occurs after the Action portion, and likewise the DIRECT ROLE-TRAINING (5.0) subsystem is visualized as occurring after the Action, and prior to the Sharing.

After the completion of the Action or Role-Training, the director requests that the group members discuss the psychodrama session with the protagonist (Haskell, 1967, pp. 76–85; Hollander, 1978, p. 9; Yablonsky, 1976, p. 13). Most directors further differentiate between the Sharing (personal experiences) and the Dialogue (analysis) portions of the discus-

sion with the Sharing preceding the Dialogue (Goldman, 1978; Hollander, 1978, p. 14). This writer's model incorporates these differences in portraying the FACILITATE SHARING (6.0) and PRESENT DIALOGUE (7.0) subsystems.

After the conclusion of the psychodrama, a final aspect of the typical psychodrama session, especially for the student-in-training, is the critique

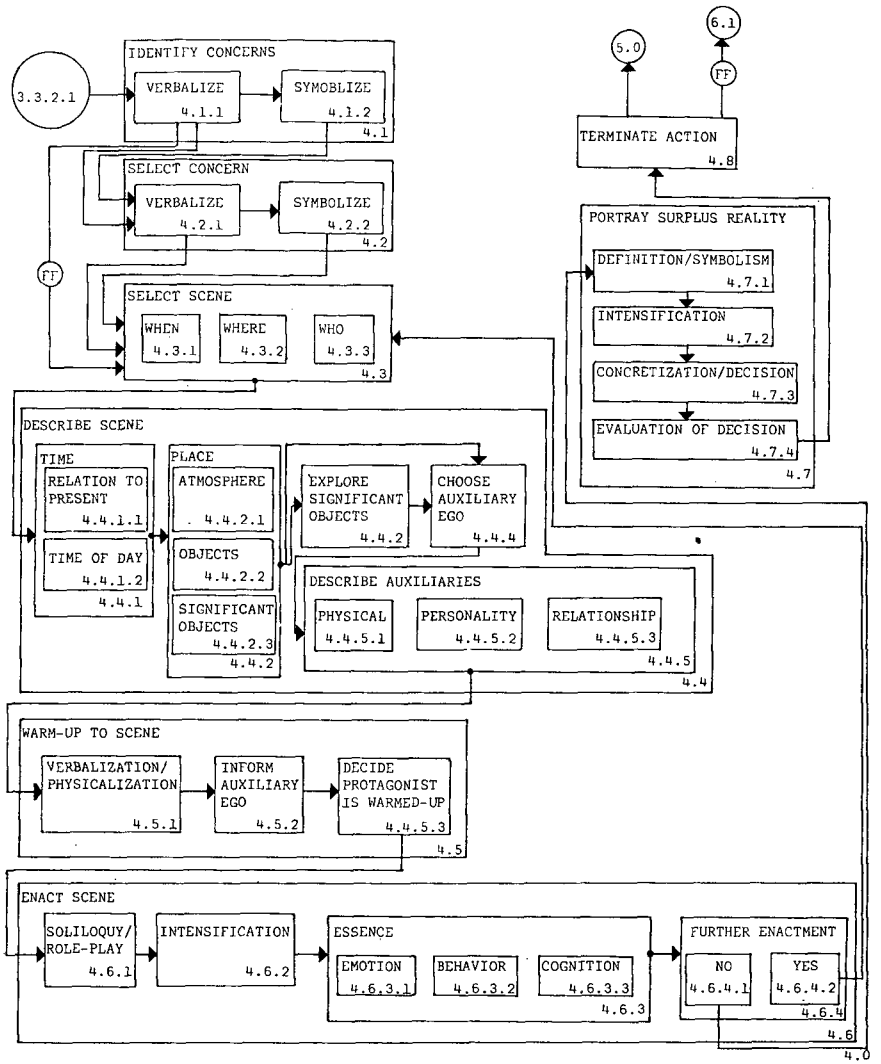

Figure 2: Direct Action

or "processing" (Goldman, 1978). This is represented by the EVALUATE DIRECTOR PERFORMANCE (9.0) subsystem in the systematic model. This model is completed with the process of feedback, in which the director utilizes the suggestions in the critique to improve his performance in future psychodramas.

The Systematic Model

The following model is an original synthesis of a variety of psychodramatic styles. It is important for the reader to understand that this model represents Morenean psychodrama while including the preferences of this writer. As a general rule, the more detailed the level of function, the more apt that function is to reflect the style of this writer. A narrative and corresponding process questions are offered to facilitate the reader's understanding of the model. They are intended to challenge the director to present his rationale for a specific decision, which could in turn encourage the director to more carefully monitor his behavior.

Only one subsystem is described in detail, that of DIRECT ACTION (4.0), while the remaining subsystems are delineated in this author's original manuscript (Schramski, 1978). Most importantly, the one subsystem portrayed conveys a style for interpreting the psychodramatic process, adaptable to the style of the individual director. The point in the psychodrama at which the subsystem (4.0) is initiated assumes the choice of a protagonist in the sociometric evolution of the group, through the warm-up phase. Adaptation would be necessary in the circumstances of multiple protagonists.

NARRATIVE	PROCESS QUESTIONS
(4.0, Figure 2) The Action begins with the director helping the protagonist to verbally identify his general concerns (4.1.1) and symbolizing (4.1.2) the concerns when necessary (i.e., using chairs to identify several problem areas that are confusing), or moving to select one concern (4.2), which involves the same process of verbalization (4.2.1) and symbolism (4.2.2).	(4.1.1) Were the concerns clearly identified? (4.2.1) Were the relevant concerns selected? (4.2.2) If symbolism was attempted, what techniques were used? Was the symbolism clear to the protagonist?

NARRATIVE	PROCESS QUESTIONS
Once the concern is identified, the psychodrama is "anchored" by choosing a scene in which the concern is evident (4.3), which entails briefly stating the time (4.3.1, i.e., past, present, future), location (4.3.2, i.e., house, business, outdoors, etc.), and people who are present (4.3.3, i.e., mother, father, lover, etc.)	(4.3) What was the scene? Why was it chosen? (4.3.1) Were the when, where (4.3.2), and who (4.3.3) components identified?
Once this information is acquired, the scene is described in detail (4.4). The time of the scene (4.4.1, i.e., past, present, or future), is established as is the time of day (4.4.1.2). If necessary the atmosphere is determined (4.4.2.1, example "give me one word for the way you feel in this room"). Important objects such as furniture represented through the use of props (4.4.2.2), and significant objects, if any, such as a special photograph, are identified in the scene (4.4.2.3).	(4.4.1) Was the scene clearly "anchored" in time? (4.4.2) Was the location established? (4.4.2.1) Was the overall atmosphere of the location identified? (4.4.2.2) Were relevant objects, such as furniture, used in the scene? If not, why not? (4.4.2.3) Were significant objects identified in the scene? If not, why not?
If there are significant objects, the director may choose to further describe these objects (4.4.3), to obtain a better idea of the protagonist's feeling and/or to intensify the experience.	(4.4.3) If significant objects were identified, how were they explored by the director? Is the director encouraging the spontaneity of the protagonist in describing the scene?
The protagonist is then directed to choose significant others in the scene, if anyone else is present (4.4.4). These auxiliary egos are then introduced, (4.4.5) in physical terms, (4.4.5.1, i.e., age, height, attire, etc.), in terms of personality characteristics (4.4.5.2, i.e., caring,	(4.4.4) How were auxiliary egos chosen? (4.4.5) Were auxiliary egos adequately described? Respond to this question in terms of physical appearance (4.4.5.1), personality characteristics (4.4.5.2) and relationship to the protagonist (4.4.5.3).

NARRATIVE	PROCESS QUESTIONS
angry, humorous, etc.), and in terms of the relationship between the protagonist and the auxiliary (4.4.5.3, i.e., honest, closed, enjoyable, etc.).	
With this descriptive information the director helps the protagonist warm-up to the scene, to enhance the emotional experience (4.5). The director can use any variety of non-verbal/verbal techniques to help the protagonist ready himself for the scene (4.5.1). This process is important in obtaining information for the benefit of the director and auxiliary egos for the eventual intensification of the psychodrama (4.5.2).	(4.5) Was the protagonist properly warmed-up to the scene? Estimate the protagonist's level of spontaneity at this point. (4.5.1) What techniques were used to warm-up the protagonist? (4.5.2) Were the auxiliary egos sufficiently instructed in order to enact the scene?
When the director senses that the protagonist is ready (4.5.3), the scene is enacted (4.6). The enactment usually begins with a role-playing situation (4.6.1) involving the protagonist and the auxiliary egos. (However the scene may only be concerned with the soliloquy of the protagonist, and other people might not be present in the scene). During this process the director may need to encourage the auxiliary egos to verbalize a specific message, and can use techniques such as role-reversal.	(4.5.3) On what basis did the director decide to proceed to enacting the scene? (4.6) How did the director initiate the scene? (4.6.1) What techniques were used to initiate the role play or soliloquy?
The director encourages the protagonist to intensify his feelings (4.6.2) in the encounter or soliloquy by focusing on "what isn't being said." An example might include an encounter between father and	(4.6.2) How was the activity of the scene intensified by the director? How effective were the techniques used by the director?

NARRATIVE	PROCESS QUESTIONS
son where the protagonist (son) is verbally bantering with his father, *but* never really saying how much he needs his father's love.	
In this intensification, the director helps the protagonist understand the essence of the encounter (4.6.3) by extracting the primary emotion (4.6.3.1), as well as accompanying behavior (4.6.3.2) and cognition (4.6.3.3).	(4.6.3) What was the essence of the scene? Include emotional (4.6.3.1), behavioral (4.6.3.2), and cognitive (4.6.3.3). Evaluate the director's facilitation of catharsis of abreaction.
Once the essence of the scene is derived, the director decides whether further enactment is necessary (4.6.4), A NO or YES (4.6.4.2) answer is determined by the previously mentioned "clinical judgment" as well as by direct statements by the protagonist that further exploration is necessary.	(4.6.4) On what basis did the director decide to enact further scenes? (4.6.4.2) How was the transition made from one scene to another? (4.6.4.1). If NO, what was the transition to a concretization? How appropriate was this transition?
If further enactment is deemed necessary (4.6.4.2), the director and protagonist recycle to selecting a scene (4.3). If further enactment is not necessary (4.6.4.1) the Action moves to the concretization/summarization segment (4.7).	
The decision to recycle (4.3) to another scene is usually justified by the director's judgment that a more complete sociometric view is needed and/or that past relationships are influencing the protagonist's perception of his concerns.	
In surplus reality (4.7) the director helps the protagonist to symbolize and define (4.7.1) the decision to be made.	(4.7.1) How was the concretization defined and symbolized for the protagonist? Was this symbolism verified with the protagonist?

Once the symbolism is established as accurate, the director facilitates an intensification of the experience for the protagonist (4.7.2). (An example might include a protagonist who feels he is "covering" himself with self-pity. The director could have several group members hold a blanket over the protagonist to emphasize the experience of "covering"). Often the symbolism is not this obvious and the director may explore possible abstractions that are both organic to the session and clearly representative of the issues involved.

The protagonist is then asked to decide (4.7.3) what he is going to do in the symbolic circumstance. (In the previous example, this entails whether or not to shed the symbolic blanket). Based on the protagonist's decision, the director helps the protagonist to evaluate his decision (4.7.4) in terms of appropriateness and previous enactment in the psychodrama.

Concluding this evaluation, the Action is terminated (4.8) and the director decides to proceed to the Role-Training (5.0) or move forward to the Sharing (6.1)

(4.7.2) How was the symbolism intensified for the protagonist?

(4.7.3) What decision did the protagonist make? Was the decision coerced in any way by the director? What evidence does the protagonist offer, if any, of a catharsis of integration?

(4.7.4) On what basis did the director decide to conclude the symbolic action and move to another activity?

(4.8) How did the director terminate the Action? On what basis did the director decide to proceed to Role-Training (5.0) or the Sharing (6.1)?

From the conclusion of the DIRECT ACTION (4.0) subsystem to the EVALUATE DIRECTOR PERFORMANCE (9.0) the progression can be described in similar detail. The feedback loop of knowledge gained from the evaluation into THE DIRECTOR (1.0) subsystems completes the general system, which theoretically improves in quality as the director continues in training.

Conclusion

A model of psychodrama is presented which enables the student observer to more clearly understand the psychodramatic process without diminishing the creativity of the model. Spontaneity necessitates some purposeful organization. The flowchart model appears particularly well-suited to the needs of the neophyte who is developing his or her own frame of reference. Like the young musician, our first psychodramatic actions often seem mechanistic as we try to replicate the artistry of a master. In the same sense this model is a general metaphor which can be used to facilitate our own creativity and spontaneity.

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TIME-LIMITED GROUP PSYCHOTHERAPY: A CASE REPORT

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The financial difficulties which many mental health agencies now face make it more important than ever that cost-efficient treatment modalities are utilized as much as possible. One modality which utilizes professional time efficiently is time-limited group psychotherapy.

A review of the literature on time-limited group psychotherapy reveals that there have been few case reports of actual clinical experiences with this approach (e.g., Sadock & Gould, 1964; Karson, 1965; Sadock et al., 1968; Trakas & Lloyd, 1971). The present paper is designed to summarize our experience with one particular time-limited group. The mechanics of setting up and running the group will be detailed, and the data collected regarding the effectiveness of the group will be reported.

Patient Selection

The group was conducted by the first and supervised by the second author. Members of the hospital staff were apprised that the group was being formed and referrals were made on the basis of intake interviews.

When an individual was referred, a screening interview was arranged with the therapist. It was decided to exclude suicidal, addicted, acutely psychotic and sociopathic individuals from the group, as well as any patient who was likely to be a deviant and therefore prematurely drop out or take up an inordinate amount of group time (Yalom, 1970). Patients who seemed to have some ability to, and interest in, utilizing their observing egos to look at themselves and their problems were encouraged to participate. Of those patients screened, one person did not want to participate and two were thought to be inappropriately referred. The therapist contracted with six patients for treatment.

The first part of the screening interview consisted of a discussion of the patient's motivation for treatment and identification of those issues with which the patient was particularly concerned. Patient 1 was a male in his mid-40's whose wife had just left him and whose self-esteem was severely shaken. Patient 2 was a male in his mid-30's who felt constricted in terms of his ability to recognize and express most of his feelings, though he was clear about being angry that others did not respond to his needs. Patient 3 was a female in her early 30's who was depressed and unable to communicate effectively with her husband. Patient 4 was a women in her late 20's

who was frightened of her anger at her child and felt quite isolated from others. Patient 5 was an obese woman in her late 20's who was significantly depressed about her loneliness and inability to establish successful relationships with others. Patient 6 was a woman in her late 20's who was involved in a number of obviously destructive sadomasochistic relationships with men.

Patient Preparation

The second part of the screening interview consisted of a careful preparation of each of the patients who had contracted for treatment. The therapist made it clear that the group would last for ten sessions and helped each patient to specifically define goals that could be attained within that time period. There was discussion of the importance of active participation because of the limited time available. An effort was also made to deal with patients' unrealistic expectations, fears and resistances concerning entering a group and exposing their problems to other people whom they did not know. The importance of confidentiality was stressed. Finally, the notion that a group is a place where people can learn about themselves, especially in terms of how they relate to others, was conveyed. It was suggested that looking at the ways in which people in the group related to one another might assist the members in learning how they related to other important people in their lives.

Questionnaires

At the end of the interview, each patient was given two brief questionnaires to complete. The first measure was the "Self Attitude Questionnaire", a 22-item instrument which assesses self-esteem (Landy and Sigall, 1971). Respondents indicate on five-point scales how characteristic or uncharacteristic each self-descriptive statement is for them. Split-half and alternate form reliabilities for this instrument range between .81 and .87.

The second instrument utilized was a "Goals Survey", an unpublished questionnaire designed to assess the goals an individual has before beginning a group experience, the extent to which these goals change over the course of the group and the extent to which individuals believe they have accomplished their goals (both original and final) at the conclusion of the group. Initially, patients are asked to choose three goals which most accurately characterize their therapy objectives. Secondly, for each of the three goals selected, the individual is asked to specify a "behavioral criterion" which can be used to test whether the goal has been reached at

the end of the group. The "Goals Survey Follow-Up", given during a post-group evaluation interview, assesses how many of the three goals have been reached, in accord with the specified behavioral criteria.

The third instrument employed to assess the impact of the group consisted of two forms from the Katz Adjustment Scale (Katz & Lyerly, 1963), an instrument of demonstrated reliability and validity. These forms require that significant others in patients' lives rate the frequency with which they perform various behaviors. The first form employed concerns the patients' symptomatology and social behavior (e.g., "looks worn out," "has strange fears," "is dependable," "talks too much," etc.). The second form focuses on the patient's performance of socially expected activities (e.g., "helps with household chores," "visits his relatives," etc.)

During the pre-group interview, patients were asked to specify two people in their lives who knew them very well and who would be willing to complete two questionnaires about them (pre- and post-group). The therapist then mailed the questionnaire (combining the two forms used) to these people with a brief covering letter indicating that the patient had given permission to have the respondent answer questions about him/her. Respondents were assured that the patient would not be informed of their answers and were asked for honest and prompt replies. At the conclusion of the group, the questionnaire was again distributed.

Therapy Strategy

The group was conducted for one hour per week for ten consecutive weeks. The group began with six patients, but one dropped out after the third session. Thus, only five patients remained in the group until its conclusion. Attendance throughout the 10-week period was quite good; though a patient would occasionally miss a session, some of the patients attended all of the sessions and all of the patients attended at least eight of the 10 sessions.

The following constitutes the therapeutic strategy adopted with each of the five patients who completed the group:

Patient 1—The therapist empathized with the painful loss sustained by this patient and the narcissistic injury it caused. However, the therapist also confronted the patient directly about his overbearing interpersonal style, which clearly had played an important role in the dissolution of his marriage. Furthermore, the patient was encouraged to see that his alternating pleas for help and expressions of resentment toward those who tried to help were a reflection of his ambivalence and confusion about

dependency and significant time was spent exploring how this too had played an important role in the unravelling of his marriage.

Patient 2—At first this patient's helpfulness was appreciated by the therapist, but he soon came to realize that this was used by the patient to avoid acknowledging his own difficulties and neediness. As the patient continued to focus on other members' problems, the therapist pointed out to him that he would continue to find others unresponsive to his needs as long as he did not find ways to make his needs known and he persisted with this theme every time this patient attempted to help another patient (or the therapist himself).

Patient 3—The therapist quickly noticed that this patient assumed a child-like posture in relation to the other group members. This elicited parental responses from a number of the others, which simply served to confirm her feelings of helplessness and worthlessness. The patient was strongly encouraged to recognize this pattern and thereby to take responsibility for her depression, in contrast to the "helpless victim" posture she had assumed at the outset of the group. The therapist decided not to work directly on this patient's relationship with her husband because of his sense that there was not enough time to make meaningful inroads into what seemed to be a deeply entrenched pathological pattern of relating.

Patient 4—This patient also assumed a submissive, child-like posture in relation to the other group members, but responded with anger rather than depression to the nurturing, care-taking behaviors she elicited from others. In addition to pointing out her responsibility for the way others typically responded to her, the therapist encouraged her to accept and express her angry feelings directly, rather than to displace them onto her child.

Patient 5—Once again the therapist focused on this patient's interpersonal style: she would act withdrawn and depressed, subtly inviting others to reach out to her. When they did so, she would over-react by engaging in narcissistic monologues about her travail which would elicit anger and pity from others, but not genuine warmth. She was encouraged to be assertive but not overly indulgent and responded dramatically to this feedback and encouragement.

In general, the therapist's interventions during the ten weeks differed substantially from conventional (time-unlimited) group psychotherapy. Specifically, he tended to focus on the limited goals which had been agreed upon during the screening interview, even when other issues emerged that could have received attention. There was certainly some adjustment and re-definition of goals over the course of the ten weeks, but such changes were relatively minimal. He concentrated on the patients' immediate needs and concerns, and spent relatively little time delving into

the past seeking to uncover the roots of present difficulties. Interpretations were formulated by him and shared with patients much more quickly than in time-unlimited psychotherapy. Of course, the therapist looked for and attempted to respond to any cues which indicated that a patient was simply not ready to deal constructively with a particular area; but there was more risk-taking on the part of the therapist than in more conventional psychotherapy. Furthermore, the therapist's interventions were at times lengthier than they would have been in other circumstances; he went further in spelling out and elaborating his interpretations than he would have in longer term therapy; at times he gave behavioral prescriptions as to how the patient might seek to bring about a change in the area under discussion. Finally, the therapist sought to be more supportive than he would have been otherwise. He directly urged patients to try out different behaviors, communicating his belief that patients had the necessary resources to make the requisite changes in their lives. His strategy was to increase the patients' beliefs that they could exert substantial control over the course of their lives (Gillis & Jessor, 1970).

Termination

The issue of termination pervaded the group sessions from the first week onward. The patients were frustrated at having such a limited amount of time allotted to them, and were able to express their anger about this with increasing directness as the weeks went by. The therapist recognized the reality component of their feelings, but also made confrontive interpretations when he believed these feelings were being used to avoid doing therapeutic work.

At the conclusion of the 10-week period, the therapist met with each patient individually for a post-group evaluation of what progress had been made as a result of the group experience and to discuss whether further treatment was indicated. Reference was made to the goals which each patient had set during the screening interview; an attempt was made to assess to what extent each goal had been accomplished. The directive approach was extended into the post-group interview, in that the therapist often made explicit suggestions as to what kinds of behaviors were likely to result in the consolidation or advancement of whatever therapeutic gains had been realized.

Evaluation

All five patients who participated throughout the group expressed general satisfaction with the experience during their post-group interviews.

Patient 1, though stating that he felt he had benefited somewhat, was, on balance, least satisfied. He had not been able to convince his wife to end their separation, and had still not come to terms with beginning a new life for himself. Patient 2 was quite pleased with the group, stating that he was much better able to identify and give expression to his feelings and desires, especially in the context of his relationship with his wife. Patient 3 stated that she found the group quite useful in terms of helping her appreciate that she bore some of the responsibility for her feelings of depression, and that she had behavioral options she had not been aware of previously. Patient 4 was very satisfied with the group experience, stating that she had become more comfortable with her angry feelings, less punishing of her child, and more satisfied in her relationships outside her marriage. Patient 5 felt that she had made enormous progress, felt less depressed and more adequate in dealing with her family, and was better prepared to have meaningful relationships with peers, both male and female. Patient 6 left the group after the third session, and did not want to participate in a post-group interview.

The five patients who completed the group agreed with the therapist that further treatment was not indicated at that time. Where there were still clearly unresolved issues, it was agreed that the patient should try to work with what had been learned from the group experience before becoming involved in any additional treatment.

At the conclusion of the post-group interview, each patient again completed the "Self Attitude Questionnaire" and also filled out the "Goals Survey Follow-up." On the former instrument, the highest possible score is 110. For the five patients who completed the group, the mean pre-group score was 64.6, while the mean post-group score was 71. Though the data cannot be discussed in terms of statistical significance, the participants seemingly experienced some gain in the area of self-esteem. Of the 15 goals specified during the pre-group interview (three for each of the five patients who completed the group), the patients felt they had attained 10 of them, for a mean of two out of three.

One complete set of the Katz Adjustment Scale (pre and post) was received for each of the five patients who completed the group. On the first form, which assesses symptomatology and social behavior, scores range from 0 to 254; the lower the score, the more well adapted the patient appears to the respondent. The mean pre-group score was 66, while the mean post-group score was 44. On the second form, which assesses the performance of socially-expected activities, scores range from 0 to 32; the higher the score, the more frequently the respondent perceives the patient as performing these behaviors. On this form, the mean pre-group score was 20.8, while the mean post-group score was 24. These data suggest

that the patients' own perceptions of self-improvement over the course of the group were shared by significant others in their environment.

Conclusion

Insufficient numbers of patients and the lack of experimental controls and long-term follow-up measures make it necessary to state our conclusions with qualifications. However, the data suggest that immediate improvement can be gained from participation in groups of quite short duration. This conclusion is supported by the recipients of the treatment as well as by significant others in their environment.

Society's urgent mental health needs require that services be made available to greater numbers of people than have traditionally been served by mental health agencies. Mental health professionals are seeking to accomplish this end by offering traditional services in more efficient ways and by developing new and different models of intervention. Time-limited group psychotherapy is an excellent example of the first strategy; our experience is encouraging in that it suggests that this approach offers the prospect of bringing about meaningful change in an economic fashion. Hopefully, additional research can further refine the ways in which this modality can be used most effectively.

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TRANSFERENCE, COUNTERTRANSFERENCE AND TELE

PETER FELIX KELLERMANN

Comments regarding this paper:

"The time has come to evaluate the advances made by psychotherapy and to spell out, if possible, the common denominators of all its forms". Thus Moreno commenced his paper "Transference, Counter-transference and Tele: their relation to group research and group psychotherapy" which was published in the book Psychodrama, Vol. 2. And he asked in the introduction: "How can the various methods be brought into agreement, into a single, comprehensive system?"

The introduction and the paper have led to my interest in comparing different psychological theories. My answer to Moreno's question is that, to begin with, we must have a common language for communication. All schools have their own terminology and that increases the difficulty of discussing problems which are common in all psychotherapy.

This discussion will stress the common denominators but can of course not completely exclude the differences. Moreno's psychodrama is mostly compared with classical psychoanalytic theory. In part because it is most widely spread and partly because it always has been regarded as dissimilar to psychodramatic theory. The effort is to show that certain aspects of the interpersonal theory in both schools are in agreement, although they may have different presuppositions. Of course, analytic psychotherapy is individual therapy, whereas psychodrama usually is group therapy. This does not however make the comparison impossible.

Introduction

The new development within psychotherapy, which emphasizes emotional insight, abreaction and catharsis, would seem to attach less importance to the relationship between therapist and patient. In primal therapy, for example, the relation between therapist and patient is wholly put aside. Many other schools of psychotherapy, however, have a different approach. They view the therapeutic relationship as the true curative force in psychotherapy. "The warm, subjective human meeting between two people", says Carl Rogers (1969), "is more effective in easing change than anything else". It is thus in relation to the therapist that the patient creates that situation in which his problems can be solved. Among psychoanalysts, the school of Object relation has been foremost in em-

phasizing this attitude. Freud (1920) observed this relation when he decided to no longer use hypnosis or the abreactive catharsis method:

> "It is true that the symptoms disappeared after catharsis, but in order that the treatment should be completely successful, the patient's relation to the doctor showed itself to be especially important. If this relation were disturbed, all the symptoms returned, precisely as if they had never disappeared."

This paper attempts, from the standpoint of the therapeutic relation, to compare psychoanalysis[1] and psychodrama in seeking common characteristics and to distinguish those differences which are dependent upon clearly defined concepts. When in psychotherapeutic history, attention has been devoted to this therapeutic relation, psychoanalytic concepts have most often been used. One of these concepts, which has been taken out of its original context and applied elsewhere, is that of *transference,* which is used loosely in several different connotations. It is even to be found used as a synonym for "relationship" in general. The concept *countertransference* is used in a general connotation in the same way, both within and outside of psychoanalysis.

It is best to deal with the personal relationship between patient and therapist from the standpoint of Freud's original transference phenomena, for, even though transference does not cover the whole problem, it is an important part of it. This problem has been thoroughly researched. Here it is presented so that it can be integrated with the therapeutic relationship in psychodrama therapy. In this connection, J. L. Moreno's concept *Tele* will be defined and discussed.

Transference

What are transferences? That question was posed by Freud as early as 1905, and countless theoreticians have since then attempted to answer it. It is not here the intention to recount all aspects of the meaning and development of the concept. An excellent summation is presented in Sandler et al. (1973).

With each analyst's special views on treatment, the concept has been obscured rather than clarified. Changes in its significance have occurred as psychoanalysis has developed and its theories have been altered. Not even Freud's followers have been able to unite around a common definition. Nonetheless, understanding and analysis of transference phenomena

1. With the term psychoanalysis, I refer not to psychoanalysis proper, but rather to psychoanalytically oriented psychotherapy.

are regarded as being central to psychoanalytic technique. Freud regarded transference as one of the pillars of psychoanalysis, and he wrote that "finally every conflict has to be fought out in the sphere of transference" (1912).

Transference, as a psychoanalytic term, is a rendition of the German word "Übertragung", meaning literally the act of transforming something from one place to another. But it has become an everyday word, which is widely used even outside the circle of psychotherapists. The idea behind transference is to get the patient to discover the connection between *present* symptoms and feelings on the one hand and *earlier* experiences on the other.

Simply, transference can be described as follows: The patient comprehends the therapist in a manner which is unrealistic and colored by the significant persons in the patient's life. Attitudes and feelings which are "advanced" to the present but which correspond to the patient's own past, are brought forth through what the patient says.

A more exact definition is given by Greenson (1965). "Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present. I emphasize that a reaction in order to be regarded as transference must have two distinctive features: it must be a repetition of the past and it must be inappropriate in the present."

Counter-transference

Transference thus describes processes taking place within the patient. Counter-transference on the other hand, has to do with the therapist's attitudes, feelings and professional posture. Increased attention has been devoted to this aspect of the therapeutic relation in recent years. Nonetheless there still exists a lack of unanimity as to the exact meaning of the term. Most writers emphasize the potential danger of counter-transference and the need for thorough analysis by the therapist, but many advocate positive functions of counter-transference. Much of what has been written about transference could also apply to counter-transference, which demonstrates the inseparability of the terms. If all transference varies in expression, then all counter-transference will also vary from day to day in line with the daily changes in both patient and therapist.

Two aspects of counter-transference can, according to Rycroft (1968), be distinguisned:

On the one hand, counter-transference can constitute the therapist's own transference upon his patient. In this sense, counter-transference is a disturbing, distorting element in treatment. Dewald (1969) writes that counter-transference in this case has its origin in the therapist's *unconscious* tendencies. These cause him to react toward the patient in a way which to a certain extent is inappropriate for the way the therapeutic relation should actually be formed and which constitutes a displacement from earlier relations and experiences in his own life. The therapist's counter-transference is, in this sense, abnormal and represents relations and identifications which have been repressed.

On the other hand, counter-transference can also become an important tool in treatment. In such cases, the therapist's personal experiences and development become the bases for therapy and make his work different in character from that of others. Counter-transference is in this case the therapist's emotional attitude toward his patient, his *conscious* reaction to the patient's behavior. According to Heimann (1950), Little (1951), Gitelson (1952), Racker (1968) and others, the therapist can use this latter kind of counter-transference as a type of clinical evidence. He may assume that his own emotional response is based on a correct interpretation of the patient's true intentions.

Fliess (1935) views counter-transference as an unconscious, disturbing factor in treatment, and he suggests the term "counter identification" in order to describe the conscious, desirable process.

Tele

Transference and counter-transference, as concepts, are not sufficient to describe what takes place between patient and therapist in psychotherapy. Moreno (1959) suggested instead, or as a supplement, the concept *tele*, from the Greek "at a distance".[1] This peculiar choice is no exception from the obscure psychodramatic terminology, which has been largely influenced by classical Greek drama.

The terminology of psychodrama, as well as the terminology of psychoanalysis, has often tended to lead to confusion rather than to understanding. This applies to Moreno's definition of *tele* which is unorganized and sometimes inconsistent.

Moreno defines *tele* as "insight into," "appreciation of," and "feeling for" the "actual makeup" of the other person. Tele should not be con-

1. Tele has no connection with the concept "telos" which means "finish" and/or "purpose/goal".

fused with the related concept "empathy". Empathy is a necessary component of tele and was considered by Moreno as a "one-way feeling into the private world of another person". It was for him a one-way feeling which distinguishes itself from the mutual two-way feeling in the tele relation. "Einfühlung" (empathy) becomes, as tele, "Zweifühlung" (two-way empathy). Tele is thus a "mutual exchange of empathy and appreciation", according to Moreno. He also subjectively described tele as "therapeutic love".

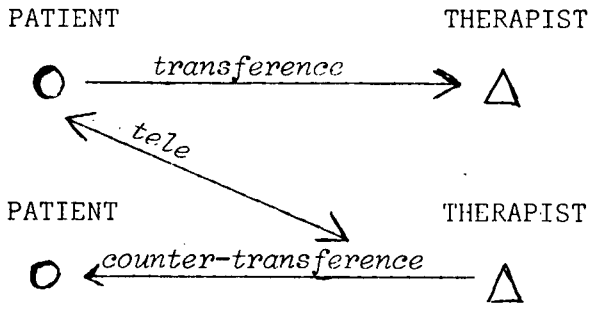
In order to restrict the meaning of the concept tele, it will be regarded as a process, not as a condition. Tele is considered as a sort of relationship and the application is restricted to the level of inter-personal relations. Tele may be simply described as the flow of feeling between two or more persons. It embraces not only the attractive, but also the *repulsive* aspects of relations between people. It is in Moreno's words: "the total sum of the emotional aspects of a relationship".

In a tele relationship, people can communicate with each other "at a distance", be in contact "from far" and send messages "on the feeling level". Like a telephone (tele-far, phone-sound) it has two ends and facilitates two-way communication.

This tele relationship *hopefully* carries with it an open, real communication where persons take each other for what and whom they are. The past which so often influences persons in the present has thus no distorting influence on the relationship. Tele, as opposed to transference, is not a repetition from the past but a spontaneous process which is appropriate in the present here and now.

The concept is strongly associated with the existential *encounter* concept. Encounter, which Binswanger (1975) designates with the German "Begegnung", we can describe as a direct "meeting" between two persons. Rollo May (1967), writes that transference should be seen as a distortion of encounter. Encounter is a human meeting in which tele processes are active. Martin Buber, who around 1920 was a contributing editor to a journal which Moreno edited, maintained that the smallest human unit is not one, but two: I-Thou. I cannot be I except in relation to a Thou. This I-Thou relationship is unlike that which Buber (1970) calls an I-It relationship, in which the I treats the other person as an object rather than as a subject. Tele assumes in this connection the significance of an I-Thou relationship, while transference most nearly can be characterized as an I-It relation.

In the figure below is shown, simply and schematically, how the therapeutic relation is formed in transference, counter-transference and tele.



Moreno's criticism of transference: *Real reaction versus transference reaction*

Moreno observed, that when a patient is attracted by a therapist, another type of behavior arises within the patient as well as transference behavior. At the same time as the patient unconsciously projects and displaces fantasies on the therapist, another process is also active. A part of his ego is not drawn into regression, but rather feels into the therapist, here and now. This part of his ego judges the therapist and appreciates intuitively what type of person the therapist is. These feelings into the therapist's real self are an expression of the tele relationship. Even though it does not seem so strong at the beginning of therapy, one strives to reduce the transference upon the therapist and replace it with this "attraction". The attraction which the patient feels for the therapist is a type of admiration for the therapist as a human being. In reality, it was there all along, but it was eclipsed by the transference (Moreno, 1959).

Even many psychoanalytic writers admit that there exist other interactions than transferences in psychoanalysis. But these are usually seen as irrelevant and trivial according to Greenson and Wexler (1969). However, in recent years, increasing numbers of these writers have become interested in what can broadly be termed the "nontransferring" or "real" aspects of the relationship between patient and therapist.

Analogous to Freud's distinction between real and neurotic anxiety, a distinction between real reaction and transference reaction is desired. The real relation between patient and therapist has different names: Greenson calls it the "working alliance", Zetzel "therapeutic alliance", Fenichel "rational transference", Stone "mature transference" etc. Sandler et al (1973) who traced the concept through the psychoanalytic literature, believes it to be advantageous to put the various terms for the reality oriented elements together under the general heading "working alliance".

The working alliance constitutes an important part of the tele relation, but it can (as with the empathy concept), only describe a one-way process.

Is it really possible to distinguish between a real reaction and a transference reaction? Is it possible to decide what is real or unreal in a relationship, what is appropriate or inappropriate, what is reality or fantasy, what originates from the present or the past? And is there a real reaction which lacks the characteristics of transference?

I believe that all reality, that is to say, all relations contain elements of transference, just as all transferences contain a measure of reality. Relationships contain most often a mixture of both components. One is more or less dominant. If we were to place both processes on two sides of a continuum it would perhaps be easier to envision the problem:

WORKING ALLIANCE	TRANSFERENCE
here and now	*then and there*
reality	*fantasy*
appropriate	*inappropriate*
rational	*non rational*
new response	*old response*

It should be established that our transference ability, even though it exists and is universal, is nonetheless undesirable in personal relationships. Intensive transference is to be regarded as an abnormal expression, and the goal should be to reduce its intensity. Even if, as in psychoanalysis, transference neurosis is used as a therapeutic instrument, this neurosis must finally be dissolved. In order to ease this dissolution, it is important toward the end of therapy, to distinguish, accept and even encourage the real reaction which exists between patient and therapist. Certain psychoanalysts, however, regard such interventions as non interpretive or nonanalytic, but they are according to Greenson and Wexler (1969) not anti-analytic. Harry Guntrip (1971) writes:

> ". . . psychotherapy involves that the patient must grow out of unrealistic positive and negative transference relations, in which he is seeing his internal fantasized good and bad objects projected into his therapist, by means of discovering what kind of actual relationship is given to him by his therapist as a real person. This involves much more than experienced psychoanalytic interpretation" (p. 66).

The theoretical dilemma of psychoanalytic technique has to do with the difficulty of managing the working alliance and the transference. The

analyst has to maintain communication with both poles at the same time. The analyst's double role arises because on the one hand he is the therapist (reality) and on the other hand he is experienced as someone out of the patient's past fantasy. The patient alternates between a condition where transference is dominant, and one where the working alliance is dominant. A breakdown in the working alliance would lead to an interruption in treatment and a suspension in transference to a failure of the psychoanalysis. The question of how this problem is to be dealt with, is the core of psychoanalysis.

Kanzer (1953) pointed out how the analyst always must be aware of the two images which are projected upon him—the one from the past and the one in the present. He should not concentrate on either image so much, but rather on the relationship between them. In the same manner, Sterba (1940) emphasized the necessity for the psychoanalyst to bring to pass in the patient the ability to distinguish those elements which are oriented toward reality and those which are not.

Dewald (1969) writes that there should be an attempt to give rise to a split in the ego function between emotional reaction and intellectual reflection:

> "As the emotional experience has been allowed to assume increasingly regressive expression, the patient is encouraged to seek emotional distance from himself and to observe and reflect over what he has just experienced and expressed".

These nuances in emphasis between an *experiencing* ego on the one hand and an *observing* ego on the other, recur as a central element in most schools of psychotherapy. One is reminded of the division between intellect and emotion, objectivity and subjectivity, secondary and primary processes. All of these dichotomies are well integrated in healthy individuals. The aim in psychotherapy is to unify, to progress from disunity to integration of these dichotomies.

Moreno's criticism of counter-transference: *The attitudes of the therapist*

"If the transference phenomenon exists from the patient toward the physician it exists also from the physician towards the patient", writes Moreno (1905, p. 5). "It would be then both ways equally true. That educational psychoanalysis produces a basic change in the personality of the therapist cannot be taken seriously. . . . It provides him at best with a method of therapeutic skill. According to this we could just as well call the physician's response transference and the patient's response counter-

transference. It is obvious that both the therapist and the patient may enter the treatment situation with some initial irrational fantasies."

In the sense described above, counter-transference is found by Moreno to be a disturbing unconscious factor in the treatment. The similarity between Moreno's formulation and that of psychoanalytic writers such as Balint (1965), A. Reich (1973), Hoffer (1956) and Tower (1956) is worth stressing. Greenson (1965) explains counter-transference thus:

> "When the analyst reacts to his patient as though the patient were a significant person in the analyst's early history, counter-transference occurs. Counter-transference is a transference reaction of an analyst to a patient, a parallel to transference, a counterpart of transference" (p. 348).

"A personal analysis", say Menninger & Holzman (1973) in their classic volume on the Theory of Psychoanalytic Technique, "no matter how long or thorough, is never sufficient to eradicate all of one's blind spots or all of one's tendencies to find surreptitious satisfactions for infantile needs in other than realistic ways" (p. 92). These quotes show that Moreno's critique of counter-transference is also found in psychoanalytic theory itself.

The idea of classical psychoanalysis is that the patient follows the laws of free association, while the analyst follows or attempts to follow the laws of interpretation. The analyst assumes the form of receptive passivity known as "free floating attention".

The analyst remains neutral and does not manipulate the patient through suggestion, maintained Freud. He compared this behavior to a blank screen which is nontransparent. The behavior and attitude of the analyst should reflect back to the patient nothing but what the patient had manifested. The analyst's "shadowiness" was instituted, among other reasons, in order that he should not "transfer back" feelings which the patient had transferred upon him. This makes it possible for the patient's distorted and unrealistic reactions to be demonstrable as such. Freud recommended observation and interpretation instead of participation and activity.

> "The motivation for this requirement of emotional coldness is that it creates the most favorable preconditions for both partners" (Freud, 1958).

Greenacre (1971) has also elucidated the reason for this attitude. She writes that the analyst should analyze, not act as a guide, model or teacher, in order to protect the patient's autonomy. Because of the

analyst's non-contagious, non-directive attitude, the patient's self-reliance is not compromised, thus his associations are freer.

"Human beings do not thrive well in isolation, being sustained then mostly by memories and hopes, even to the point of hallucination", Greenacre (1971) wrote. If a patient is emotionally isolated in some way or other, and at the same time finds himself in the same room as an analyst, he will most likely develop a transference upon the analyst. Isolation and the analyst's neutrality, are thus indirect methods of bringing about a transference.

> "One must conclude that the analyst as a mere screen does not exist in life. He cannot deny his personality nor its operation in the analytic situation as a significant factor. He will appear as he is actually: in manner, speech and general spontaneity" (Gitelson, 1952).

Beside Gitelson, a number of prominent psychoanalysts have criticized the so-called neutral attitude of the analyst. The disciples Adler, Jung, Reich, Fromm etc. assumed a standpoint other than that of Freud on this question, and within the International Association of Psycho-Analysis the question has been hotly debated for many years.

While transference in psychodrama occurs in the protagonist when he acts towards an auxiliary ego, in psychoanalysis it arises in the analysand in relation to the analyst.

Psychodrama: protagonist ⟶ *auxiliary ego*
Psychoanalysis: analysand ⟶ *analyst*

In this context we may examine possible similarities and differences between the functions of the analyst and the auxiliary ego.

As a consequence of the emergence of psychoanalytic ego-psychology and the treatment of the so-called borderline cases, the function of the analyst has changed radically. It has in fact become more like the function of the psychodramatic auxiliary ego. The therapeutic situation is now regarded as containing certain elements of the mother-child relationship and the therapist can use himself more or less as an instrument. In recent years, the entire human milieu has begun to be described with the term "holding environment".

Gitelson (1962) emphasized that it is necessary for the analyst to present himself as an appropriate object for the patient and as an "auxiliary ego".[1]

1. Moreno (1972) writes: ". . . the infant binds its spontaneous energy to the new milieu, via . . . auxiliary egos—mothers, midwives, and nurses—If they would not come to his rescue by caring and feeding him, its spontaneous energy would subside" (p. 54).

". . . the analytic attitude, as manifested in the good analytic situation, provides 'presence' to the libido and operates as an *auxiliary to the patient's own ego with its own intrinsic potentialities* for reality testing, synthesis, and adaptation". (my italics)

With almost the same choice of words, Strachey (1934) writes that the patient sometimes uses the analyst as an "auxiliary super ego". The therapist in Dewald's (1969) supportive psychotherapy, has the function of a "substitute ego" or a "surrogate ego". Blanck & Blanck (1974) write that "it is inherent in the therapeutic situation that the therapist is a potential identification model". The therapist can also function as a "transitional object" according to a concept created by Winnicott (1953).

The analyst's passive attitude can be compared to the psychodrama-therapist's active attitude. The difference between them is not only due to their different temperament, but also to different theoretical foundations. The theory of psychodrama holds that even increased stimulus can give rise to memories and hopes through the use of directive techniques. As opposed to the analyst's non-transparent "free floating attention", the psychodrama therapist assumes a transparent, subjective attitude toward the patient.

On the one hand, the application of manipulative techniques have a damaging effect on the patient's independence, autonomy and self-confidence. On the other hand, can techniques which emphasize spontaneity, self-actualization and the finding of one's own solutions be insufficient for patients who by themselves do not have the ability to change?

Empathy, transference and tele in psychodrama

The way in which the theory of psychodrama attempts to solve problems of transference and counter-transference has been studied by Leutz (1971), who compared the role of the psychodramatist to the role of the psychoanalyst. Leutz writes that the processes transference, empathy and tele varies in expression in the three different phases of psychodrama. She writes (p, 114–115):

"In the *first phase*, the so called warming-up process, the psychodramatist mobilizes his *empathy* to size up the psychic structure of the protagonist in order to understand his problem and to warm him up to action. During this phase the protagonist may transfer images of persons of former importance on the psychodramatist . . . But this transference is of short duration. . . . the psychodramatist does not let the protagonist "act out his feelings" with the therapist, instead he cuts the narration short and moves into the *second phase* of psychodrama, that

of enactment. The psychodramatist does not let the protagonist act out his conflict with him in person but encourages the patient to take it up in a psychodrama. He asks him to choose members of the group to spontaneously play his father, mother, wife, friend, etc. While the protagonist chooses these auxiliary egos he already *transfers* his memories, feelings and ideas of these people to the chosen group members. . . . During this process the psychodramatist is hardly even noticed by the protagonist. Certainly he is not the target of the patient's transferences. He follows the course of the psychodrama with empathy and sovereignty, to which Freud attributed great importance."

The *third phase* is called "sharing" to describe the group discussion which follows every psychodrama. The transferences on the auxiliary egos are interrupted and discontinued consciously through, for example, de-roling and role-feedback. Protagonist, psychodramatist and group members see and take each other for what and who they are. The *tele process* is in effect.

In summation, the processes in the psychodrama consist of the following phases:

1. Empathy—from therapist to patient
2. Transference—from patient to auxiliary ego
3. Tele—between all the participants in the group

We may now compare empathy, transference and tele, each concept by itself, with their respective meanings in the theory of psychoanalysis and psychodrama.[1]

Empathy

The term *empathy* from the Greek "empatheia" (affection), is constructed as an equivalent to the German word "Einfühlung", lit. "infeeling" and connotates a mental entrance into or appreciation of the feelings of a person or thing. In psychotherapy, the concept was widely applied by Theodor Lipps (1907) and taken over by Husserl as a name for acts which give address into the consciousness of others.

Gitelson (1962) views empathy as a two-way relationship, whereas Moreno, as mentioned above, sees empathy as a one-way process. It appears that Gitelson's concept of empathy is in some way congruent with Moreno's tele-concept, which is also a two-way relation, in which empathy has decisive significance.

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1. For papers on transference, empathy and tele in German, see also Leutz, 1972 and 1974.

Dewald (1969) explains the therapist's empathy as a state of regression in the service of the ego. By this controlled regression, the therapist attempts to understand the unconscious meaning behind the patient's words. Thus the therapist attempts partially to identify himself with the patient such as he has shown himself during therapy. The therapist tries to experience the patient, as if he himself were the patient. This formulation is very similar to the way we describe the "double" technique in psychodrama: "an auxiliary ego is asked to represent the patient, to establish identity with the patient, to move, act, behave like the patient".

According to one definition by Jane Kessler (1966), empathy was described as the ability to put on the other person's shoes and then step out of them. Here again the potential danger with counter-transference becomes evident. To step out of the shoes means to be able to see the patient "objectively". At the same time we stress the importance of the emotional sensitivity into the patient's inner subjective life. This problem was discussed above with reference to the critique of the old psychoanalytic concept of counter-transference. The psychodramatic solution of this problem—how can the psychotherapist be subjective and objective at the same time:—now claim our attention.

Transference

Psychoanalytic and psychodramatic theory both regard transference phenomena as something undesirable, but nevertheless something which can be used as an important instrument in therapy. Through the dissolution of transference, the patient gains the necessary insight (psychodrama terminology: action-insight) for a cure. The psychoanalyst has to struggle with transference in the "real" patient-therapist situation. He has to safeguard the development of both the transference neurosis and the working alliance. The psychodramatist, by letting the patient play his conflict toward the "unreal" auxiliary ego, is free to engage with the patient in a direct person-to-person relationship.

Anna Freud (1965) writes that the child uses the analyst as a new object, as an object for externalization and as an auxiliary ego. Finally, Gadpaille (1967) writes about the analyst as auxiliary ego in the treatment of action-inhibited patients. These examples have been selected because they represent the so-called "orthodoxy" in psychoanalysis. The neo-freudian schools have long been in agreement with Moreno.

Transference, in psychoanalytic treatment, can also be exploited as a possibility for direct influence of the patient. Franz Alexander is perhaps the foremost advocate of this concept. He maintains (1946) that when infantile conflicts are repeated in transference, the therapist must assume

an attitude which contrasts with that of the parents and thereby gradually give the patient a "corrective emotional experience". This attitude has been much criticized in the psychoanalytic literature. This sort of influence, with the therapist playing a role, opposes the psychoanalytic canon of the therapist's objectivity.

Expanding Alexander, Greenson (1967) writes

> "In a strange way the analyst becomes a silent actor in a play the patient is creating. The analyst does not act in this drama; he tries to remain the shadowy figure the patient needs for his fantasies. Yet the analyst helps in the creation of the character, working out the details by his insight, empathy, and intuition. In a sense he becomes a kind of stage director in the situation—a vital part of the play, but not an actor" (p. 402).

In this case, the analyst becomes a sort of psychodramatic figure and the psychoanalytic situation can be compared to a *psychodrama a deux*. The role of "the other" is played by the director himself.

The psychodrama therapist, however, need not participate as an actor or opposite to the patient, but can completely concentrate on directing, according to Moreno. An auxiliary ego, sometimes especially trained for this assignment, is chosen as the counterpart. The auxiliary ego is not to analyze and observe, but is expected to assume intimate roles and mannerisms consistent with the patient's mental image of "the other".

Instead of "talking" to the patient about his inner experiences, the auxiliary egos portray them and make it possible for the patient to encounter his own internal figures in both dialog and action. An auxiliary ego becomes the instrument which is used to help the patient solve his problems. Schützenberger (1966) is not in agreement with Moreno in his opinion of the absence of transferences in psychodrama. She writes that transferences upon the directors *do* exist in a psychodramatic group, though not so often as in psychoanalytic psychotherapy.

A key question thus is whether there is counter-transference experienced by the psychodrama therapist. It would appear that the therapist can retain a certain degree of objectivity and neutrality, but naturally, he is not completely free from some of his own transferences upon the patient. The suggestions he gives the patient, the questions he asks, the distance he prefers to hold and the entire way he directs the work on stage, can influence the process. If the director is not sufficiently perceptive this influence can disturb the psychotherapeutic process. This distorting element in treatment is considerably minimalized because of the instrument of auxiliary egos and the constant possibility of the group to "guard" the patient and guide and supervise the therapist.

The counter-transference of the auxiliary egos can also influence the process. Moreno (1972) writes:

> "A minimum of tele structure and resulting cohesiveness of interaction among the therapists and the patients is an indispensable prequisite for the ongoing therapeutic psychodrama to succeed. If the auxiliary egos are troubled among themselves because of (1) unresolved problems of their own, (2) protest against the psychodramatic director, (3) poor portrayal of the roles assigned to them, (4) lack of faith and negative attitude toward the method used, or (5) interpersonal conflicts among themselves, they create an atmosphere which reflects upon the therapeutic situation. It is obvious, therefore, that if transference and counter-transference phenomena dominate the relationship among the auxiliary therapists and toward the patients, the therapeutic progress will be greatly handicapped" (p. XVIII).

Moreno is here referring to the professional auxiliary egos. Usually, however, a group member or "another patient" is chosen to play the role of the other. In this case, it is of course not required that the auxiliary egos be free from "counter-transference". On the contrary, it can be very productive if the director knows how to make use of it. The psychodramatist R. Korn has developed a special technique to select particularly "warmed up" auxiliary egos.

The dilemma of the patient who needs love to become healthy and the therapist who does not want to act as a love partner, can be solved through the engagement of a third party. An auxiliary ego should be someone other than the therapist himself, and provides the best solution to the problems of transference and counter-transference.

Tele

In psychoanalytic terms, tele may be defined as the mystical affective contact between analyst and analysand without which analysis could not function. The hypnotist calls this patient-therapist relationship "rapport" or "psychological rapport" (Jung).

The school of "object relations" which arose from the work of Klein and Fairbairn expresses much which is in agreement with Moreno. Guntrip (1961) describes mature relationships as two-way relation between equals. These relationships are characterized by mutuality, spontaneity, co-operation, appreciation and preservation of individuality within the friendship. The theory of "object relations" could by this definition just as well be called the theory of "*tele relations*".

As noted in the introduction, psychotherapy is now viewed by some

people as a type of human relationship in which the therapist's personality is of greater significance for the treatment than the techniques he uses. It is thus of the greatest importance that each patient be assigned to a therapist who fits his special needs. All therapists are not appropriate for all patients—there exist definite limits, writes Moreno. The choice and formation of pairs is dependent upon an advantageous tele process. Persons who enter into the relationship must be drawn to each other because of real aspects of their personalities. Both the patient and the therapist can be attracted, repulsed or indifferent to the other's real individual qualities. It is precisely because of this tele factor that a therapist can succeed with some patients and fail with others. Moreno recommended that each patient be carefully assigned a therapist through sociometric choice, based on a functioning tele relation.

Conclusions & Summary

The concepts transference, counter-transference and tele are defined and discussed within the framework of interpersonal theory. Their application in psychoanalytic and psychodramatic therapy are compared and certain similarities are stressed. Both schools have the dilemma of how to handle the real reaction contra the transference reaction of the patient in common. In the attitudes of the therapist, the analyst has to struggle with counter-transference, while the psychodramatist assigns an auxiliary ego as the "counter-part" which gives the psychodramatist the opportunity to develop a real and congruent tele relationship.

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THE APOTROPAIC PSYCHODRAMA AND THE MORENO SCRIPTS

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• *The interview reveals that the protagonist, de-energized and discomposed by his insomnia, attributes it to quarrels with his wife. On the stage, he encounters her through an auxiliary, reverses roles and ventilates his feelings, working through to a rational exchange, but he is not moved to great depth, profounder feelings are not experienced. There is no catharsis. The Director says, "What is the very worst thing that can happen between you and your wife? Let's see it." After considering the question, the protagonist says, "She could have a stroke and die while she is screaming at me." The scene is set and enacted. At the climax, the protagonist is in catharsis.*

• *Dependent on her job, the protagonist suffers from excessive tension at work because of the sexual aggressiveness of her employer. Her enactment of her problem is less than fully dimensional because of her inhibitions and resistances. The Director asks her to imagine her worst fears. Between quitting her job to become unemployed and being raped after hours in the office she decides that the rape is most fearsome. She is nearly hysterical as the scene is enacted. De-roled and calmed, she begins a healthy laugh. Asked about it, she says she feels ridiculous, "That couldn't happen." She leaves the stage declaring that she is much relieved.*

• *The protagonist is in training to become a psychodramatist. His efforts at directing have been rigorously criticized and he lacks confidence to continue, no longer certain of his abilities. He has enacted, with the assistance of the group, his disappointing experiences and his feelings. They are scenes he has repeatedly envisioned in his mind and evoke no real emotion on the stage. He is asked to fantasize the worst thing that could happen to him professionally. He imagines that in the midst of a drama he is directing, the protagonist and auxiliaries walk off the stage and denounce him as incompetent. The event is psychodramatised and he reaches catharsis. After being de-roled and after sharing, he leaves the stage convinced he can become a capable director.*

The apotropaic confrontation through ritualistic enactment of the ulti-

mate evil or tragedy that may be anticipated is familiar practice in some primitive and preliterate cultures. Through the mounting tension of magical rites, Dionysian in their abandon, participants close with the demonic and conditions of *ex stasis* are achieved. It is catharsis. With the return to reality, there is an awareness of extended resources of courage and the feeling of new and greater power.

For the primitive, the fears confronted may be real or illusory. For the protagonist in psychodrama, the "worst possible fear" is by definition beyond probability. In its enactment, he is safeguarded against pathological trauma by the Director's ability to strike the scene, de-role the actors and return the protagonist to reality. But the curative effect of the encounter with the "worst fear" inheres in its becoming self-evident as an illusion, thus palpably phobic. What can be expected in life is less harrowing than what has been experienced in psychodrama. He has already met on the stage the most his imagination can dread—and he has been restored and revitalized by the drama's closure and the sharing of the group.

J. L. Moreno directed his first apotropaic psychodrama in 1939 and reported it in a published paper titled "Psychodrama Shock Therapy." Working with a patient in a state of remission, he returned her on the stage to a psychotic state, her worst fear. "Psychodrama Shock Therapy" was, however, a broader term for Moreno. Under it he subsumed both apotropaic psychodramas and others which were directed to scenes of extreme intensity. He employed what he called psychodramatic shock to achieve catharsis in cases of schizophrenia, manic-depression and psychoneurosis for the principal purpose, as he wrote, of "gaining insight into the patient's social atom, effecting recall and perfecting diagnoses."

It is two years later before there is recorded an apotropaic scene in a psychodrama with a non-psychotic protagonist. Moreno uses a partial script of the drama to illustrate "The Function of the Social Investigator in Experimental Psychodrama"—"experimental psychodrama" in this context meaning the use of classical psychodrama in providing controlled experiments in the social sciences. Only incidentally he remarks that "in this [apotropaic] scene, William [the protagonist], has achieved a certain catharsis . . . it is the *sine qua non* for the removal of that fear."

Though none of the earlier scripts were published, starting in 1944 Moreno made occasional use of apotropaic scenes in dramas where the protagonists felt beset by obsessive anxieties. Several years later, when Zerka Toeman was professionally qualified and began to direct psychodramas at The Psychodramatic Institute in New York City, she staged such scenes to stimulate cathartic release whenever they were indicated by the protagonists' problem.

The manifest power of carefully directed apotropaic psychodrama sessions is now widely known in the profession and to their direction two cautionary caveats may be attached. The first is the need to thoroughly de-role the protagonist. The importance of effective de-roling cannot be over emphasized. The following case provides one example of inconclusiveness:

A woman, sharing responsibility with her sister for a seriously ill, aged mother is the protagonist. She and her sister, without a former history of such feelings, are strongly hostile, at odds over their mother's care. The protagonist living at home does not want the mother removed to an institution. The other, living and engaged away from home, wants the mother institutionalized. The protagonist believes her sister shirks filial duties. The other calls the protagonist "neurotic" and "obsessed to keep mother under your wing." In her psychodrama, the protagonist was directed to confront the "worst possible development." She enacted a scene finding her mother suddenly dead. She felt and displayed extreme emotion and experienced catharsis. After her session, she met with her sister and amicably agreed that the mother be moved to a nursing home. This was accomplished, but the hostility between the sisters, recessing briefly, soon centered on a new grievance and became as intense as before. The erstwhile protagonist, holding to the fantasy that her mother has died, refused, to the sister's bitter resentment, to visit the mother in her new setting.

The second caveat attaches to psychodrama *a deux*. For these, sharing is necessarily limited. Nor can the *a deux* protagonist have a welcoming return into a group with its sharing and support, analgesia for vestigial pain, its existential mode a bridge to life in the workaday world. The protagonist coming through an apotropaic experience is often especially in need of the therapeutic balm uniquely provided by the group. Without it being available, the *a deux* director can only offer more of his self.

* * * *

The Moreno Scripts: Anyone working with the Moreno canon must contend with the problem of the scripts.

A valid distinction may be made between the less fully-formed psychodramatic encounters that J. L. Moreno directed before 1936 and what may be called *clinical psychodrama* that he began to practice after that date and as it is practiced today. There are accounts of the earlier efforts, but the first recorded and published script appeared in *Sociometry*, Vol. I, dated July-October, 1937.

In 1936, Moreno was granted a license by the State of New York to

open a mental hospital called Beacon Hill Sanitarium located on the present site of the Moreno Institute in Beacon, New York. Shortly after receiving patients at the Sanitarium, students came to observe and learn the method that was first known as "Inter-personal Therapy", later as psychodrama. Among the first who came to observe and learn, and bring students with her, was Helen H. Jennings of Teachers College, Columbia University. As Moreno staged a psychodrama, one of her group would take notes which became the raw material for published scripts.

At his leisure, Moreno would review notes taken on a number of psychodramas adding or deleting as he saw fit, then passing them on for typing to, "among others, Joseph Sargent and Mrs. McEvoy who served for a while as part-time secretary. At some sessions, when no volunteer note-taker was present, Moreno would try to recall the drama and make his own notes for a typist.

Note-taking was put on a more regular basis when some who had come to Beacon as patients were discharged but stayed on at the institution for therapeutic employment. One or another was assigned to attend sessions in the theatre and take notes. They alternated in the task with Ernest Fantl, M.D., who was Assistant Physician on the hospital staff. The individual interests of various note-takers is reflected in what they recorded. For many of the therapeutic employees, their emphasis was on the dramatic aspects of the session; Fantel's interest was in the medical-psychiatric aspects. An inconsistency in the scripts was unavoidable.

Moreno's final script, *Psychodrama of a Marriage* appeared in the journal, *Group Psychotherapy,* Vol. XIX, (1966), eight years before his death. Over a period of 30 years a large number of different people served as rapporteurs for Moreno with the consequence that the scripts are of vastly different fidelity and completeness. Until 1944, the scripts are virtually all dialog, having only occasional and fragmentary descriptions of action on the stage—an unaccountable omission in the recording of a modality with action its first principle. In the collaboration of Zerka Toeman and Moreno, it was soon realized that a vital dimension had been missing and, in adding it, what happened in a psychodrama became more comprehensible to the reader.

Zerka Toeman became an employee in 1942. An important part of her assignment was to be in attendance in the theatre and take notes. For the first time, Moreno had an assistant who could write in shorthand. He also had one who saw the importance of having the action described if a reader was to understand what went on during a psychodrama. The combination of a sharp eye and a fast hand made for a distinct change in the scripts. That was revealed initially in *Sociometry,* Vol. VII, (1944) the psychodrama of a military trainee whose work suffered because he was troubled

over the problem of whether to be married in wartime. Its description became a pattern. Referred to Moreno by a superior officer, the trainee's drama is scripted in a published article on role analysis. For the student of Moreno's method it has the historical importance of being the paradigm, illuminating what is done on the stage, as well as what is said, in a psychodrama.

Zerka Toeman, subsequently Mrs. Moreno, was amanuensis to J. L. Moreno as long as he lived, but well before their marriage in 1949, she had also become a full collaborator. Her extended functions affected the note-taking. Trained as an auxiliary ego, she was often acting in the dramas. The shorthand notebook had to be put down as she moved to the stage and someone else was hastily recruited to take notes, or she later filled the gaps with her own recollections.

In 1949, the Morenos bought two wire recorders, then later tape recorders, and the notes on which scripts were based were put together in a different way. Greater fidelity was achieved in what could be heard and taping relieved the note-taker of recording dialog. Fuller descriptions of the action could be written. Mrs. Moreno was the transcriber of the tapes as they were supplemented with notes on the action. By 1954, professionally qualified, Mrs. Moreno was herself directing and the action notes were taken by Moreno when he was present, by staff or students when he was absent.

In 1968, the mental hospital was closed and Beacon became exclusively a training center. It was the same year in which Moreno gave up his own work as a psychodrama director. In the 32 years of the hospital's existence, virtually every psychodrama that he directed was noted.

Three films of Moreno working are in the Institute library. A movie camera was bought in 1948, but it soon disappeared, not to be replaced. Remaining extant is the screening of *Introduction to Psychodrama* in which Moreno demonstrates directorial techniques. Video equipment was installed in 1973 as a training aide. Moreno's directing psychodrama is preserved on two films both dated 1964: *Psychodrama and Group Psychotherapy in Action* and *Psychodrama of a Marriage*.

This latter film will be of especial interest to the researcher working with the scripts. As noted above, a script of this psychodrama was published in 1966. It is a copy of the film's sound track, reproduced on tape and typed for publication. Reading the script and viewing the film will reveal how much of what is occurring in a psychodrama is lost in a verbatim record. Movement, voice tones, facial expressions, body language and other non-verbalized happenings—all of which may be of greater significance than what is articulated—are not knowable even in this, the most faithful of the published scripts.

Zerka Moreno's careful estimate is that Moreno directed approximately 1,500 psychodramas and on each one some notes were taken. She estimates further that for some 150 of these dramas, the notes were transcribed and typescripts made. Moreno decided, with a view to their publication, which notes to have transcribed. But of these, only a limited number were ultimately published. (The manuscripts of unpublished scripts are now in Boston, Mass., as part of the Moreno Collection at the Francis Countway Memorial Library.)

Decisions on which dramas to have notes put into transcripts were made on Moreno's judgement of what was contemporaneously of the most consequence in disseminating understanding and acceptance of his method. He was concerned to make known the importance and effectiveness of role reversal, both for therapy and for applications. Many scripts illustrate the utility of reversing roles. As scientific questions arose on tele and empathy, he selected scripts which documented the theories he expounded in articles. As momentous events of the day occurred, he has scripted his direction of sociodramas centered on the Eichmann trial, the Harlem riots, the Presidential assassination, and such events. As various challenges of the method came to his attention, he selected notes for transcription which provided examples for his ripostes. As he experimented with new directional techniques he found fruitful, he chose some to be scripted.

But because it was never his central purpose to publish scripts tracing the historical development of the psychodramatic method from its elemental beginnings to the state in which he left it, the researcher cannot follow that evolution in the printed material. More of that development may be discerned in the Boston manuscripts, but significant lacunae remain.

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A CASE OF FOLIE A DEUX IN TWIN SISTERS AND ITS TREATMENT IN A DAY HOSPITAL SETTING

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TWIN SISTERS with a rare psychotic disorder known as folie a deux came to our community day hospital. Although the staff was familiar with the treatment of other psychoses, we had not seen this particular shared disorder and the dependency problems which accompanied it before. A special approach had to be devised. We used a thorough consideration of the presenting symptoms and complaints as well as the determined etiology in developing a treatment plan. We decided that a holistic use of our psychological, sociological and biological services was best suited for the treatment of these women and their resulting rapid and successful recovery attested to this. The reader is presented with a brief explanation of folie a deux, some intake information, treatment plan formulation and the actual course of treatment including examples of significant changes which took place in the therapy. This case study is presented not only to permit the reader a view into the clinical features and history of folie a deux but also to suggest a possible model for the rapid and effective management of cases in which this rare disorder is present.

Folie a deux, a rare psychotic condition first described by Lasegue and Falret in 1887, is characterized by a transference and sharing of common behavior and delusional ideations, usually paranoid, between two or more individuals (Freedman and Kaplan, pp. 1151–1153). It is not so rare as to be unobserved, however, and a psychotherapist in private practice may treat several examples of this disorder during his career. Folies of course are seen more commonly in mental hospitals.

Often found between sisters, folies develop usually in families and involve close relatives who tend to live in more or less exclusive contact with one another for long periods of time, although this condition may also surface in any individuals whose similar pathogenicity and close proximity permit the "infectious" association (Haberlaudt, pp. 325–343). In order for a diagnosis of folie a deux to be made, several important conditions must be met:

First, the two members must have had intimate association with one another and, as a result, have a common delusional system. Also, these

members would have to support each other's delusional claims without question, each accepting what the other states as fact. There tends to be one member who is more intelligent or at least more dominant whose core psychosis is the one around which the folie centers but this is not always the case (Freyhan, pp. 191–195).

The epidemiology of folie a deux indicates that it is found more often among the poor, underprivileged and less educated, but there appears to be no limitations to this disease's occurrence culturally or ethically and it is found in all strata of cultures (Soni and Rockley, pp. 230–235). Folies of three major types are described by De Montyl (1959) and are called:

a. Folie simultanee in which common psychotic symptoms erupt at the same time in intimate individuals but appear not to have been induced in one by the other.

b. Folie imposee in which one member, the more dominant seems to induce the symptoms in the more passive member.

c. Folie communique in which hereditary predisposition may play a significant role and in which both members adopt symptoms, specifically paranoid ideations from one another (pp. 18–23).

This paper examines one case of folie a deux (a folie imposee) and its treatment in a day hospital community. The usual course of treatment for folie imposee is the separation of the two members following which the passive partner is a little easier to treat. The dominant member is treated as a case of functional psychosis with medication and other appropriate therapies in an inpatient setting and usually requires a considerable amount of time before management of the psychosis is effective. In our experience, an effective, speedy and integrative outpatient treatment of both members of a folie imposee type of folie a deux was effected utilizing the total program of our day hospital.

Case Report

Joan and Jane (fictitious names) are twin sisters who were referred to the day hospital from our outpatient mental health clinic where they had been sent following a brief hospitalization at the local state hospital. The attractive 21 year old black women arrived at the program with the following complaints: Joan said she was afraid of other people and was terrified of her family in particular. She was moderately anxious, was conceptually disorganized, showed confused thinking, expressed feelings of guilt and evidenced vegetative signs of depression. Walking rigidly, she had other signs of motor retardation. She sat comfortably but occasionally would stand up and walk around nervously. Quite suspicious of the other patients, Joan acted withdrawn and tended to cling physically to Jane,

often holding her hand. Her affect was blunted and she stared straight ahead most of the time, making only infrequent eye contact. Her dress and hair style were similar to Jane's. Except for a small mole above Joan's upper lip and that Jane was slightly heavier, the two girls appeared identical.

Jane was also anxious and even more withdrawn than Joan. She evidenced corresponding elevations in conceptual disorganization, guilt feelings, body rigidity, staring and depression. Jane had active suicidal feelings and reported disturbances of sleep and appetite.

Both complained of feeling stupid, uneducated and worthless. Neither of them had finished high school and Jane as well as Joan felt ashamed of this fact.

Joan acted as spokesperson for the two girls and always referred to herself as "we". There was no effort to be personal or individual and the two hung together throughout the first few sessions.

Both Joan and Jane had just returned from their only mental hospitalization at a local state institution following a psychotic episode with similar symptoms and common delusions. Joan said these symptoms might have been chemically induced by breathing chlorodane used to exterminate roaches in their home. However, in intake, it became clear that the present problem had existed since age 10 when Joan and Jane began to move from house to house in an effort to escape from their father. The father, an alcoholic, had physically abused the children, had raped an older sister of the twins, Marie, and had attempted unsuccessfully at one point to rape Joan and Jane. The family made ten moves in as many years and the twins had difficulty keeping up relationships with friends in new locations and were forced to seek each other out as constant companions.

Family Constellation

The family consisted of: the mother, a talkative, argumentative woman who seemed genuinely concerned about her children though overly protective of them. She was outgoing, of apparently average to above average intelligence and had no history of emotional illness. The mother and the grandmother were responsible for teaching the female children that men were "dirty" and "evil" and couldn't be trusted. Joan attributed much of her reluctance to date men to this persistant message and not to any difficulties which the family had with the father.

The father was described as a "loving, considerate and intelligent man" when not drinking but was vicious, abusive and explosive when intoxicated. During his frequent drunkenness, he would beat up his wife and other children. These beatings were never severe but were frightening to

the entire family. The father used aliases. Frank was his real name, but he also referred to himself as Joseph and Robert. He apparently had quite different personality dimensions accompanying each name and the mother felt that he had a "split personality".

The mother and father divorced one year after his leaving the home. The father was murdered one year ago by an acquaintance at his own birthday party. The family rejoiced at his death at first. Later the twins jointly felt guilty about their initial reaction.

The older sister, Marie, now age 23, was an A student in school but at home exhibited a volatile temper. She had been raped by the father when she was 12. Both twins reported feeling afraid of Marie especially when she was angry with them.

The younger sister, Katy (now age 8) was a "problem child" who did poorly in school and was a discipline problem at home and in school. Joan described Katy as "tempermental and moody."

The youngest child in the family was a brother, Albert (age 7) who was apparently intelligent, a good student and was the mother's favorite. Jane said that Albert was spoiled and Joan concurred that he "always has to have his own way". Joan and Jane liked Albert, Katy on the other hand, was frequently jealous of the attention he received from mother.

Most of the time the family avoided contact with the twins and their lives were for the most part exclusive from the others.

All of the members of the family lived together and were supported on welfare throughout our working with them.

Treatment

Two sessions following the intake interview, a schedule of treatment for each of the women was discussed in staff meeting. In view of the diagnosis of folie a deux and especially folie imposee we decided it was important to:

1. Maintain the medication which they received while at the state hospital in order to reduce accompanying anxiety and reduce psychotic symptoms. Prolixin, 25 mg., B.I.D. and Cogentin, 2 mg., T.I.D. were initially given to both patients. Medications were changed later to reenforce the sense of separateness for the two sisters.

2. Separate the twins as much as possible while at the day hospital through the use of behavioral techniques to keep them from influencing each other's thinking. Specifically:

   a. Hand holding would be discouraged; frequent embracing or holding onto each other would also be interrupted.

b. Sitting next to one another in warm up and wrap up groups would not be allowed.

3. Provide each woman with separate and individual support to aid her in the loss of the other member of the folie a deux and that to achieve this we would:

a. Place each girl in separate therapy groups, art therapy and community living groups. Joan was placed in group A, Jane in B.

b. Assign separate therapists to them. Our occupational therapist worked with Jane and I worked with Joan for 1:1. Our art therapist worked with either one when an assigned therapist was absent.

c. Encourage group support of each girl as an individual and not as a twin.

d. Require that they dress differently and wear different hair-do's so we could easily tell them apart.

e. Encourage different and less psychotic patients to form separate friendships with them. These other patients would nurture development of relationships outside of the folie. A well integrated woman by the name of Wilma was attracted to Joan and an older woman, Gloria, chose to spend time with Jane. (It turned out that Gloria was not a helpful companion because she reminded Jane of her mother. Therefore, another patient, Florence, was approached. She succeeded in developing a close and supportive friendship with Jane.)

4. Identify the more dominant and intelligent member and be aware of her influence on the more submissive. It became clear that Joan was the primary member of the folie. Jane only took over an influential role when Joan showed signs of improvement.

5. Confront delusional material in individual as well as in group and family sessions.

6. Avoid intellectually oriented therapy in view of the rigid and "armored" nature of the patients and use instead: Gestalt therapy to get to emotional material, bioenergetics for establishing renewed contact with the body (Lowen, pp. 43–47) and with surroundings and group psychotherapy and psychodrama for group support and social interaction. Psychodrama was especially productive in aiding Joan in owning delusional projections and undoing retroflected anger (Moreno, 1972, pp. 179–184).

7. Go to the home and organize separate schedules for each sister while outside of the program.

8. Involve the family in the treatment process through family therapy and through the group and their support of the behavioral measures used in the home.

Results and Verbatim of a Psychodrama Session

The maintenance of medication helped to initially reduce anxiety in both women and to moderate psychotic symptoms. However, they both exhibited a few psychotic and depressive signs that continued through most of the early stages of therapy. In group and in psychodrama, both repeatedly confronted key familial figures. Previously retroflected feelings such as anger were released toward the restrictive and domineering grandmother, the mother and various aunts and uncles. Guilt for the father's death was diminished and both sisters returned to premorbid state after only two months.

The schedule of treatment was as follows: 1:1 sessions were provided on an unstructured "need" basis, psychodrama was held for two hours each week, and other groups totalled six hours of therapy group, two hours of family group and 18 hours of other activity therapies per week. Each of them attended most of the groups provided and there was never any resistance evidenced by truancy. When we had family therapy, the mother usually attended and was an active participant throughout treatment. Other family members refused to be involved and were only contacted outside of the program by our social worker. They never interfered (to our knowledge) with the home schedule of treatment.

Several of the group therapy and psychodrama sessions toward the middle of therapy are of particular interest in that some of the key delusional defenses were altered by Joan and both sisters were able to break down a lot of body rigidity. Jane also took one last attempt at suicide in what appeared to be an effort to thwart Joan's therapy, draw attention to herself and preserve the folie. Jane was then facilitated to experience her "death" in fantasy and thereby learn how unwilling she was to die.

In the following psychodrama session, Joan volunteered to participate after a warmup session about fear. She explained that she was "terrified" of her grandmother and that she would like to confront this frightening woman in the role play. Joan had not been chosen for psychodrama before but on this occasion the group selected her. After much gentle preparation and some explanation of what she would be doing and of the purpose of video taping, I asked Joan to select one patient who reminded her of her grandmother. She chose Sandy, a short, dark-haired, very paranoid and intellectually defended woman to play the part. Joan briefed Sandy on how the grandmother acted, gave her some of the grandmother's favorite phrases and instructed Sandy on the attitudinal stance to take during the enactment. A gentle motherly woman played Joan's double (Auxiliary ego) and was instructed to express what she felt was happening inside of Joan, especially at times when Joan was silent (Moreno, 1953, p. 83). Joan

was told that she could say "yes" or "no" to accurate or inaccurate auxiliary ego statements respectively.

The beginning of the session came slowly and with great care taken not to propel Joan into an emotionally overtaxing situation. Other patients, including Jane looked on. After several minutes Joan, hands clutched rigidly in her lap, eyes staring straight ahead and jaw clenched, expressed her fear.

Joan: You want to cut us up in pieces. You want to hurt us (she begins to tremble).

"Grandma": No I don't deary, I love you. I raised you from a little girl.

Joan: You raised us for a while, but you don't love us.

Therapist: Joan. Could you try using *me* instead of *us* to see how that feels . . . to speak for yourself?

Joan: (nods) O.K. . . . I know you don't love me; you want to kill us!

Therapist: Kill *me?*

Joan: (nods) You want to kill me! (She leans forward and wrings her hands. I think "She may want to wring grandma's neck").

Double: I'm so scared right now.

Joan: Yes. (She begins to shake)

Therapist: Can you tell your grandmother how scared you are of her? (I want Joan to stay with the process of her feelings and experience them fully.)

Joan: I'm so scared of you. . . . You showed us pictures of cut up people and you want to cut us up. . . . but I won't let you.

Therapist: Your grandmother wants to cut you up?

Joan: Yes. We just want you to leave us alone. (Here Joan looks glassy. I become aware that when she uses "we", she looks especially dazed.)

Therapist: *I* just want you. . . .

Joan: (Looking suddenly more contactful) I want you to leave *me* alone.

Double: I know you don't really want to hurt me. You're probably a very nice lady. (My guess is that the double is getting scared here of all this talk of "cutting up".)

Joan: No! (She corrects) She does! She wants to rape us. . . . I mean *me* (I nod) and kill me.

"Grandma": Now Joan, you know I love you. I just want to protect you, that's all. It's those men out there that want to hurt you.

Joan: No they don't! . . . It's you!

Therapist: (I want Joan to experience being grandma; to own that part of her that is the internalized version of the grandmother.) Joan, would you mind changing seats with "grandma"? (She does.) What I'd like you to try is for you to *be* grandma now and let Sandy play you, O.K.?

Joan: I think so. Do you mean I'm going to be my granny and I gotta tell Sandy about Joan?

Therapist: That's partly right. What I mean is how about Sandy playing you . . . being "Joan" in that chair.

Joan: (Looking out of contact again) O.K. (Turns toward Sandy and stares, but with her body sitting more erect in the chair.)

Therapist: You look foggy and spacey to me right now. What are you thinking? (She looks at me with a puzzled expression.)

Joan: I'm thinking that I don't want to cut nobody up.

Therapist: So how about saying that to "Joan" over there (Sandy.)

Joan: I don't want to cut you up. But you must not go out with those dirty black men. Black is dirty. They just want to hurt you. (Joan looks even larger in the chair now.)

Therapist: Wait a minute "grandma" (Joan) I'm confused. . . . How come you don't like black men?

Joan: Because I'm white (a gasp goes up in the group. This is the first anybody has heard of this.) . . . and the only good thing about Joan is that she has my blood in her veins. (Turns to Sandy) You are worthless otherwise. You can't read. You can't write worth a damn (her voice becomes stronger, angry, and scathing. Her body becomes more supple). You're no damn good, just like the rest of your worthless family. . . . just like your father! . . . You'll never amount to nuthin'.

Sandy playing Joan: Now grandma. . . . That's not so. . . . (She gets stuck here and doesn't know what to say. I look at Joan. She looks strong and comfortable.)

Therapist: Joan, how does it feel to be grandma?

Joan: (Looking more bright eyed) Scary . . . and kind of . . . I don't know . . . O.K.

Therapist: O.K.?

Joan: Uh . . . Yeah. Like she's real powerful. (I nod and let her sit with the feeling of power for a minute. She remains silent.)

Therapist: Would you mind changing chairs?

Joan: Sure. (Switches again)

Therapist: Do you like the power that granny has?

Joan: Yeah. Not the way she uses it though. She's really mean. She tells me I'm no good . . . Like I feel most of the time.

Therapist: (I think of two things to say. One of them will direct her awareness toward how the grandmother's message of "no good" has become Joan's message. I chose to say the other.) She really "cuts you up" with her words!

Joan: (Leans forward immediately, buries her head in her hands and weeps wrackingly.)

Double: I hurt so much!

Joan: (Nods and cries.)

Therapist: (Moves forward and kneels near her chair.) Joan, if you could let your hurt talk for you, what would it say?

Joan: I'm not sure whether she actually threatened to kill us or not. I don't know. Maybe I made it up. I don't think she did. Maybe I'm crazy. (Looks scared) I'm no good. She's right. I'm no good. (Cries very heavily now.)

Therapist: You *feel* like you're no good!

Joan: Yes. (Sobs heavily, her fists clenched tightly against her head, her body very much alive. After a minute Joan yells down at the floor.) Goddamn it! . . . Goddamn it! I don't want to be no good for the rest of my life. I don't want it no more! . . . Grandma. . . . (She looks up at Sandy in the "grandma" chair) . . . Don't tell me I'm no good.

"Grandma": (Looks at me for a clue)

Therapist: Play it the way Joan did.

"Grandma": You are black, deary . . . And black is dirty! You'll never amount to nothin'.

Joan: (Screams) Stop it! (More heavy crying.) I tried to please you. I did everything you told me to do. You're wrong about me. (She screams out the next lines angrily) You're a bitch. You goddamn bitch. (She begins to foam as she spits out her words.) I hate you. I hate you for what you've done to us. You kept us afraid of everyone all the time. You told us not to trust nobody (Said mockingly) . . . We had nobody but each other. We stayed at home. Had to watch T.V. Never went nowhere. (To me.) We stayed in the house for two years once without coming out.

Therapist: (Nods understandingly.)

Joan: (Back to "Grandma") You are horrible! (Screams) I hate you. (Here her whole body becomes animated. She shakes her fists at "Grandma" and her legs are pushed back under the chair as if to spring.)

Therapist: Are you aware of your hands?

Joan: Yeah. (To "Grandma".) I'd like to punch you out. (There is a short silence during which Joan relaxes back into her chair, and just breathes easily and rapidly. After a while she smiles, winks at me and wipes her face.)

Therapist: Feels good, huh?

Joan: Yeah. . . . (Smiles and blows her nose) . . . Woof, I feel a lot better. (Her face is radiant and her eyes bright.)

The session ran another 45 minutes with Joan enumerating instances where grandma had "cut her up" verbally and instilled a mistrust of men. She occasionally got quite angry and at one point beat on a cushion to demonstrate how intensely she felt. At the end of the session Joan was relaxed, loose and smiling. When asked if she was fearful of her grandmother at that point, she replied, "Nope. She can't screw me up no more." (This use of "screw me" came up frequently in subsequent work that Joan did and later was discovered to be the basis for the projected delusion that the grandmother wanted to rape her.)

While this session did not permanently change Joan's delusions it was the first step in a more effective process.

Jane who was rigidly watching the psychodrama excused herself near the end to go to the ladies' room. She returned to announce that "I just took my pills." She cried and told Joan that she didn't want to hurt her any more and just wanted to die. Of course, Joan became hysterical, blamed herself for Jane's suicidal gesture and they both started for each other, arms outstretched, and professed mutual alliance and unity forever. I got between them and sat them each down at opposite ends of a cafeteria table. I expressed my anger at Jane for this "cheap display of attention getting" and interpreted that she "messed up Joan's work nicely." The group was equally disappointed in Joan's wanting to cling to Jane again and several members took sides to support and/or confront each of the sisters separately. I told Jane that if she wanted attention, she'd have to get it in more appropriate ways and I called the ambulance to take her to our emergency room for gastric lavage. I also told her she could expect a hospitalization for this.

Jane was hospitalized for two days. Joan received support both inside and outside the program from patients and staff. When Jane returned to the program, Joan told her she loved her but did not approve of the suicidal gesture. This was the strongest sign of separation we had seen to date and it proved to be an important turning point. It was interesting that when the dominant member of the folie had made significant progress, the submissive member did not easily improve as might be suggested in the literature (Potash and Brunnell, 1973, 1974). Instead Jane attempted to regenerate the folie, to return Joan to her dominant and psychotic position. I imagine that the eventual dramatic improvement in both members occurred as a result of our not removing Jane entirely from contact with Joan but by allowing Jane to witness some of Joan's significant movements in therapy. This was made possible in the tremendously supportive atmosphere of the milieu setting.

In subsequent therapy sessions both Joan and Jane learned how to "act

black" and accept their blackness. Joan could joke with staff and patients and referred to us occasionally as "whitey".

The milieu group was essential during and between the continuing psychotherapy. It provided peer support and reality testing. It was a place where Joan could check out her imagined unacceptibility and paranoid fear of others. It provided a source of potential friends and some sense of commonality with people with similar though not the same fears.

By the third month both agreed to dress and fix their hair differently. Accompanying this we began to notice changes in facial expressions and details which the sisters had mimicked in each other formerly.

Jane gave up her suicidal thinking by the end of the third month but only after a great deal of catharsis and owning of alienated aspects of her own personality. (Jane had denied that she was angry with anyone prior to this time, for example.) In one Gestalt therapy session Jane was encouraged to imagine herself to have committed suicide and to play dead. As she lay on the floor and was questioned about how it felt to be dead and she was repulsed by the feelings. Insight came when she realized that she was "already dead" in a lot of ways and sobbed out her wishes to change things and improve her life (the first sign of investment in *life*.) She soon reclaimed the part of her that was enraged by the stagnation her life had become and afterward showed great progress.

Realistic friendships with other patients developed by 3½ months for Joan, and both volunteered to be apart even during times of the program schedule when we had not restricted them. Paranoid delusions occasionally returned but steadily decreased in intensity and frequency and were extinguished in Jane after 3½ months and in Joan after 4 months.

As time went on Jane expressed a great deal of satisfaction regarding her new found individuality. She even occasionally showed envy or contempt for Joan and was able to say this to her.

In occupational and art therapies, separate talents began to emerge with Joan showing remarkable sketching and painting skills and with Jane demonstrating better abstracting capabilities.

Followups at home by our social worker and consultation with the mother in family group insured that environmental separation and other behavioral restrictions were continued while outside of the program. (As mentioned earlier, the mother attended most sessions of family group. She was also quite cooperative with home behavioral measures and carried out suggested behavior modification techniques without any difficulty or resistance.) In the family groups, Joan and Jane each confronted mother about her attitudes regarding men, sexuality, and achievement. Mother admitted that she often reenforced the things that grandmother said (and had taught her as a child) but that she no longer believed many of

these messages. She also admitted that men could be "good or bad" and that "you have to judge a person by who they are" and not act on prejudice. The daughters both expressed relief at hearing the mother's new attitudes and negotiated dating schedules with her. (Joan developed a close relationship with Ted, a white patient at the program and mother was able to approve the dating. She expressed some initial fears about Joan's dating but subsequently accepted it. This was an especially important area of reparenting for Joan and it gave her a great deal of confidence about herself as a person and acceptance of herself as a woman.) The mother also worked through her own guilt feelings for not "raising the children properly"; she was eventually able to accept how difficult her role of mother was when the father was alive. Joan and Jane grew much closer to mother in the therapy but not in any unhealthy dependent way. Joan left therapy on the 7th month and Jane left a week later. At the time of discharge they both reported no depressive feelings, no hallucinations or delusions, nor did they evidence any sign of the folie a deux with which they came to us. Both were optimistic about the future and had separate plans. At the present time (8 months post discharge) Joan, who already completed a remedial literacy program, is attending a technical school for computer operation and Jane is taking courses to improve her reading capabilities and gain general knowledge of other adult education subjects. Joan and Jane both have other friends. Joan is still dating. Jane has not yet begun to date but she expresses an interest. Jane is also working part time and does not indicate any interest in pursuing her sister's goals. There is no evidence of depression or psychosis in either women at the time of the writing of this case study.

Both women overcame psychosis and depression, became brighter, optimistic, more alert, better focused and without any indication of the original unhealthy dependency after a total of only 7 months of outpatient milieu therapy and both women are presently off of all medication.

It is my guess that the speed with which this case was treated was at least in part if not greatly due to the holistic nature of milieu therapy. Support from other patients, a chance for new friendships, emotion evoking therapy and creative activities and therapies have all been instrumental in undoing the pathology which maintained this folie a deux of over 10 years duration.

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PSYCHODRAMA WITH AN ALCOHOL ABUSER POPULATION

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Alcoholism and the problems associated with heavy alcohol consumption among Navy personnel have received increasing attention over the past several years (Schuckit, 1974; Kolb et al, 1975, and Cahalan, 1975). One recent report (1975) suggests that the percentage of "problem drinkers" in the U.S. Navy may be as high as 38 percent. (Cahalan and Cisin). One response by the Navy to the problem of alcohol abuse has been the development of specialized programs designed to treat alcohol abusers (Kolb et. al, 1975). One of these treatment programs is conducted at Alcohol Rehabilitation Centers (ARCs) in which alcohol abusers receive multimodality treatment by Navy and civilian personnel knowledgable in the field of alcohol abuse treatment. The backbone of this treatment program are alcoholism counselors who are recovered alcoholics, group counselors, and Alcoholics Anonymous. The ARCs also emphasize various genres of therapeutic methods, one of which is psychodrama.

Psychodrama, as a therapeutic method, has been applied to a variety of treatment populations and settings, among which are drug abusers (Deeths, 1970), police education and training (Barocas, 1972), children (Irwin, 1972), and psychiatric patients (Warner, 1972). While its use with alcoholics is not new, empirical research up to now has been scarce. Published reports which have indicated that psychodrama is an effective treatment modality with the alcohol abuser (Blume, 1971; Van Meulenbrouck, 1972; Blume et. al., 1968; Weiner, 1967) have generally been descriptive. However, these reports mention that psychodrama seems to provide a framework in which new behaviors and approaches can be expanded. Psychodrama, with its emphasis on role playing, affords the alcohol abuser population an opportunity to replace old nonproductive attitudes and behaviors with more growthful living styles. Within the therapeutic session, many of these new behaviors can be developed so as to become part of the productive repertoire of the patient population.

The ARC program is considered a successful program in that it has been returning large percentages (78%) of alcohol abusers to effective duty (effectiveness defined as being on active duty or having received a favor-

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Opinions expressed herein are those of the authors and do not necessarily reflect the position of the Department of the Navy.

able discharge and having a positive recommendation for reenlistment at six months following treatment) (Kolb et. al., 1975). Since psychodrama is a part of the total treatment program at ARC and the role of this treatment modality is not fully understood empirically, this report is concerned with examining those personality traits among alcohol abusers in treatment which are affected by participation in psychodrama as a therapeutic experience.

Method

Subjects

Subjects were 101 patients who received treatment for alcohol abuse at the Navy's Alcohol Rehabilitation Center, San Diego, between September 1975 and December 1975. Demographic variables which characterize those in treatment who received psychodrama and those who did not receive psychodrama may be found in Table 1. Mean ages of those in the psychodrama and non-psychodrama groups were 28.5 years and 27.4 years respectively. This difference is not significant; also no differences were obtained between the two groups on the following dimensions: time in service, pay grade, sex and marital status.

Treatment

The Alcohol Rehabilitation Center is a 75-bed residential facility in which the patients receive multi-modality treatment by alcoholism counselors who are recovered alcoholics with a minimum of two years of sobriety. The primary focus is on group counseling and Alcoholics Anonymous. Individual counseling, gestalt therapy, transactional analysis, psychodrama and lectures on the medical and legal aspects of alcoholism are also provided. The treatment typically lasts from six to eight weeks at which time the patients are returned to their previous work assignments.

Subjects were referred to the Center because alcohol abuse had interferred with their work performance and/or conduct. The referral was ordered by the subject's Commanding Officer at the recommendation of a physician. Prior to treatment, diagnosis of addictive, habitual or episodic drinking was made by a medical officer at the rehabilitation center, employing Navy Department guidelines for the clinical recognition of drug abuse.

Subjects were included in this study if they completed the treatment program and pre-and post-treatment testing packages were complete. Subjects were referred to the psychodrama phase at the discretion of the

subject's group counselor. ARC San Diego has seven ongoing counseling groups, and two patients from each group are selected into the psychodrama tract, which consists of four weekly three hour psychodramas. The psychodramas are typically group-centered; however, protagonist-centered psychodramas are pursued as the occasion arises. The difference between these two forms of psychodrama is that group-centered psychodrama has as its primary concern the theme of the group and specific issues relating to that theme. In a group-centered psychodrama, a protagonist is selected because he best represents that group's theme and issues. The protagonist-centered psychodrama, as developed by Moreno, (1972, 1975, 1975) has as its primary concern the protagonist or patient, and his specific therapeutic issue. The group aids in working with the protagonist as role players and observers, and through him participate in a therapeutic experience as the issues of the protagonist's session affect their own lives.

During the psychodrama, patients not involved in the psychodrama tract were involved in small group therapy. With this exception, treatment was identical for both groups.

Test Instruments

Upon admission to ARC, patients were administered the Comrey Personality Scales, a short form of the MMPI (the Mini Mult), and the State Trait Anxiety Inventory, A-State Scale. These tests were readministered prior to a patient's discharge from the program. Prior to discharge from treatment, a post-treatment prognosis for each patient was determined by the ARC staff.

Comrey personality Scales—The Comrey Personality Scales (1970) are a self-report, multiple choice questionnaire that generates ten scores: Trust vs Defensiveness (T), Orderliness vs Lack of Compulsion (0), Social Conformity vs Rebelliousness (C), Activity vs Lack of Energy (A), Emotional Stability vs Neuroticism (S), Extraversion vs Introversion (E), Masculinity vs Femininity (M), Empathy vs Egocentrism (E), Validity Check (V), and Response Bias (R).

Mini-Mult—The Mini Mult (Kincannon, 1968) is a short form of the Minnesota Multiphasic Personality Inventory (MMPI). It was designed to provide objective assessment for major personality characteristics that affect personal and social adjustment. It yields three validity and eight clinical scales: L, F, K (the validity scales); Hypochondriasis (Hs), Depression (D), Hysteria (Hy), Psychopathic Deviate (Pd), Paranoia (Pa), Psychasthenia (Pt), Schizophrenia (Sc), and Hypomania (Ma).

State-Trait Anxiety Inventory, A-State Scale—The State-Trait Inventory (STAI) is a measure of State-Trait Anxiety (Spielberger, 1970). Only

the State Anxiety Scale (A-State Scale) was employed in this study. State Anxiety refers to a transitory emotional state that varies in intensity and fluctuates over time. It is characterized by subjective feelings of tension and apprehension. The level of A-State tends to be high in circumstances that are perceived to be threatening.

Prognosis

Prior to discharge, the ARC staff met and discussed each patient completing treatment. Based upon consensual agreement, a prognosis for post treatment disposition of excellent, good, fair or poor was given and entered on the patient's medical record.

Data Analysis

Differences between the two treatment groups were assessed by t-tests for independent means and chi squares.

Results

Demographic Characteristics

Demographic variables which characterize those in treatment for alcohol abuse who received psychodrama and did not receive psychodrama may be found in Table 1. No significant differences were obtained on any of the variables.

Comrey Personality Scale

Pre-treatment scores indicate that the group which received psychodrama scored significantly different on five of the ten Comrey scales (see Table 2). Those who received psychodrama scored significantly lower on Response Bias ($p < .05$), indicating that this group was less concerned with giving socially desirable answers or having themselves appear to be "nice" people. Those individuals who received psychodrama also scored significantly lower on the scales that measure Trust ($p < .01$), Activity ($p < .05$), Emotional Stability ($p < .01$), and Extroversion ($p < .05$).

Post-treatment Comrey Scores indicated that there were no significant differences between the groups subsequent to treatment.

Pre/post-treatment change scores for the psychodrama group indicated that during the course of treatment, they became significantly more trusting ($p < .001$), more active ($p < .05$), more emotionally stable ($p <$

Table 1

Demographic Characteristics of Psychodrama Group (N = 36) And Non-Psychodrama Group (N = 65) Participants

	Psychodrama Group		Non-Psychodrama Group		
	Number	Mean	Number	Mean	X^2
Age (in years)		28.5		27.4	
17–20	1		10		
21–25	13		19		
26–35	13		28		
over 35	9		8		
	36		65		6.22 (ns)
Time in Service (in years)		7.8		7.2	
0–2	8		12		
3–4	3		13		
5–6	9		13		
8+	16		27		
Total	36		65		3.23 (ns)
Pay Grade					
Enlisted E1–E3	10		24		
Enlisted E4–E6	19		34		
Enlisted E7–E9	4		5		
Officer O1–O6	3		2		
Total	36		65		2.18 (ns)
Sex					
Male	34		64		
Female	2		1		
Total	36		65		1.30 (ns)
Marital Status					
Married	10		25		
Single	17		26		
Sep/Div	6		4		
Widowed	3		10		
Total	36		65		4.53 (ns)

ns = not significant.

.001), and more extroverted ($p < .01$). Similar findings were evident for pre/post-treatment change scores for the non-psychodrama group, who became significantly more trusting ($p < .001$), more emotionally stable ($p < .001$), and more extroverted ($p < .05$) than before treatment. One pre/post-treatment change score significantly differentiated the psychodrama from the non-psychodrama group: the psychodrama group changed significantly more on the measure of Activity ($p < .05$) than did the non-psychodrama group.

Table 2

Pre/Post-Treatment Comrey Scores for Psychodrama (N = 36) and NonPsychodrama (N = 65) Participants

	Pre-Treatment				Post-Treatment						Pre/Post-Treatment Change Score		Pre/Post-Treatment Change Score Difference
	Psychodrama		Non-Psychodrama		Psychodrama		Non-Psychodrama		Pre-Treatment	Post-Treatment	Psychodrama	Non-Psychodrama	
Scales	Mean	SD	Mean	SD	Mean	SD	Mean	SD	t	t	t	t	t
Validity	14.38	5.93	16.82	6.70	16.89	6.95	17.66	6.37	−0.88	−0.53	−1.62	−0.72	1.37
Response Bias	44.46	8.33	48.79	7.77	46.63	6.94	48.68	7.01	−2.56*	−1.38	−1.19	0.08	1.43
Trust	72.30	13.01	79.85	11.93	85.94	12.39	87.45	11.79	−2.87**	−0.58	−4.49***	−3.58***	1.90
Orderliness	90.46	12.97	93.08	13.19	90.11	12.95	93.19	15.36	−0.96	−1.04	0.11	−0.04	−0.44
Compulsiveness	88.43	12.34	88.55	13.88	90.31	12.44	91.57	12.17	−0.04	−0.48	−0.63	−1.30	−0.44
Activity	84.03	16.25	91.48	14.90	93.43	13.56	95.55	14.84	−2.27*	−0.71	−2.63*	−1.53	2.00*
Emotional Stability	74.24	17.27	83.45	15.28	93.71	16.80	95.40	16.25	−2.67**	−0.48	−4.78***	−4.23***	1.71
Extroversion	66.57	21.47	77.79	21.91	81.49	21.17	86.23	20.45	−2.49*	−1.06	−2.93**	−2.33*	1.20
Masculinity	80.70	13.47	84.51	12.67	82.46	11.56	84.06	10.96	−1.39	−0.66	−0.59	0.21	1.35
Empathy	88.05	14.98	89.92	16.80	90.71	12.66	91.94	14.85	−0.57	−0.42	−0.81	−0.71	0.51

* $p < .05$.
** $p < .01$.
*** $p < .001$.

Table 3

Pre/Post-Treatment Mini Mult Raw Scale Scores and State-Trait Anxiety Measure Scores For Psychodrama (N = 36) and Non Psychodrama (N = 65) Groups

	Pre-Treatment				Post-Treatment						Pre/Post-Treatment Change Score		Pre/Post-Treatment Change Score Difference
	Psychodrama		Non-Psychodrama		Psychodrama		Non-Psychodrama		Pre-Treatment	Post-Treatment	Psychodrama	Non-Psychodrama	
Scales	Mean	SD	Mean	SD	Mean	SD	Mean	SD	t	t	t	t	t
L	7.30	1.84	7.02	2.10	6.97	1.56	7.23	1.67	0.69	−0.76	0.81	−0.62	0.90
F	17.54	3.11	18.25	3.58	15.85	2.71	16.66	2.81	−1.04	−1.38	2.43*	2.77**	0.03
K	12.78	2.22	13.43	2.40	14.46	2.43	13.39	2.72	−1.36	1.97	−3.01	.09	−2.71**
Hs	17.05	2.45	16.85	2.58	15.31	3.36	15.48	2.85	.38	−.25	2.46*	2.82**	.31
D	28.54	4.62	27.89	4.14	26.77	4.00	26.13	2.52	.70	.84	1.72	2.89**	−.10
Hy	30.51	2.67	30.39	2.69	30.77	2.72	29.66	3.06	.22	1.82	−0.40	1.41	−1.07
Pd	24.08	2.80	23.85	2.95	22.23	2.79	22.13	2.39	.39	.18	2.77**	3.59***	.11
Pa	18.30	2.77	17.48	2.87	16.17	2.50	16.32	2.60	1.40	−.28	3.38**	.55	1.50
Pt	21.14	5.65	18.88	5.73	16.26	5.50	16.31	5.69	1.91	−0.04	3.66***	2.52*	1.56
Sc	34.00	5.92	33.41	5.77	28.97	6.07	30.77	7.32	0.48	−1.29	3.51***	2.23*	1.61
Ma	19.38	2.50	19.06	2.49	17.46	2.76	18.34	2.16	0.62	−1.61	3.04**	1.74	1.80
State-Trait Anxiety Measure	51.73	12.18	47.28	11.37	36.80	13.19	35.47	10.09	1.80	1.51	4.91***	6.15***	1.71

* $p < .05$.
** $p < .01$.
*** $p < .001$.

Mini Mult

No significant differences were found between the groups, either pre-treatment or post-treatment, on any of the scales (see Table 3). Pre/post-treatment change scores for the psychodrama group indicated that they significantly decreased hypochondrical tendencies ($p < .05$), psychopathic deviance ($p < .05$), paranoia ($p < .01$), anxiety and obsessive tendencies ($p < .001$), schizophrenic ideation ($p < .001$), and hypomania ($p < .01$).

An analysis of pre/post-treatment change scores for the non-psychodrama group indicated that over treatment they significantly decreased their scores in the F Scale ($p < .01$), and on the scales that measure hypochondriasis ($p < .01$), depression ($p < .01$), psychopathic deviance ($p < .001$), anxiety and obsessive thinking ($p < .05$), and schizophrenic ideation ($p < .05$).

Analysis of psychodrama/non-psychodrama, pre/post-treatment change score differences indicated that the psychodrama group changed significantly more on the K scale ($p < .01$), in the direction of becoming more defensive and controlled than the non-psychodrama group.

State-Trait Anxiety Measure

The psychodrama and non-psychodrama groups did not score significantly different either pre-treatment or post-treatment on this measure (see Table 3). However, analysis of the pre/post-treatment change scores within each group indicated that the psychodrama and the non-psychodrama groups decreased their anxiety significantly ($p < .001$ for both groups). Analysis of pre/post-treatment change score differences between the two groups yielded no significant difference.

Post-Treatment Prognosis

No significant "between group" differences were demonstrated with this variable (see Table 4).

Matched Pre-Treatment Comrey Personality Scale

Since five pre-treatment Comrey Scale Scores significantly differentiated the psychodrama and non-psychodrama groups, two additional comparisons with these groups were made to determine how much change occurred between them over treatment when they were matched on

Table 4

Number of Post-Treatment Prognosis Ratings For Psychodrama (N = 34) and Non Psychodrama (N = 61) Groups

Prognosis	Psychodrama	Non Psychodrama	X^2
Excellent	2	1	
Good	14	31	
Fair	13	19	
Poor	5	10	
Total	34	61	2.04 (ns)

ns = not significant.

pre-treatment Comrey scores. Hence a sub-sample of non-psychodrama (n=15) participants was matched to the psychodrama group (n=36) and a sub-sample of the psychodrama participants (n=15) was matched to the non-psychodrama group's (n=65) pre-treatment Comrey scores. Results of the former match are presented in Table 5. Although the Validity scale significantly ($p < .05$) differentiated the two pre-treatment populations, both t-scores are within the validity range for this scale established by Comrey (1970); the remaining scale scores demonstrated no statistical difference. However, post-treatment Comrey scores indicated that the Psychodrama group was significantly more trusting ($p < .05$), active ($p < .05$), and emotionally stable ($p < .05$) subsequent to treatment than the sub-population of non-psychodrama participants.

Results of the matched sub-sample of psychodrama participants to the non-psychodrama participants' pre-treatment Comrey scores are presented in Table 6. No statistical difference between the two groups is noted in either pre- or post-treatment scores.

Discussion

The major finding of this study is that although pre-treatment Comrey scores demonstrated that the patients in the psychodrama group possessed significantly different personality profiles, (i.e., scored lower on Response Bias, Trust, Activity, Emotional Stability and Extroversion) than patients in the non-psychodrama group, nevertheless post-treatment Comrey scores demonstrated that there were no significant differences between the two groups. Another important set of findings was that when a sub-sample of non-psychodrama participants was matched to the psychodrama group's pre-treatment Comrey scores, post-treatment results indicated that the psychodrama group was significantly more trusting, active, and emotionally stable than the non-

Table 5

Pre/Post-Treatment Comrey Scores for Psychodrama (N = 36) and a sub-sample of Non-Psychodrama (N = 15) Participants Matched to the Psychodrama Group's Pre-Treatment Scale Scores

	Pre-Treatment				Post-Treatment					
Comrey Scales	Psychodrama Mean	SD	Non-Psychodrama Mean	SD	Psychodrama Mean	SD	Non-Psychodrama Mean	SD	Pre-Treatment t	Post-Treatment t
Validity	14.38	5.93	18.93	7.66	16.89	6.95	20.27	7.94	−2.24*	−1.49
Response Bias	44.46	8.33	45.65	8.42	46.63	6.94	46.53	7.62	−0.46	0.15
Trust	72.30	13.01	74.07	13.31	85.94	12.39	78.67	10.92	−0.43	1.94*
Orderliness	90.46	12.97	87.93	15.99	90.11	12.95	87.40	16.50	0.58	0.61
Compulsiveness	88.43	12.34	84.60	10.61	90.31	12.44	87.20	9.68	1.03	0.85
Activity	84.03	16.25	82.20	10.62	93.43	13.56	85.27	8.96	0.39	2.10*
Emotional Stability	74.24	17.27	74.40	17.85	93.71	16.80	84.27	18.83	−0.03	1.73*
Extroversion	66.57	21.47	63.93	14.62	81.49	21.17	79.40	15.91	0.43	0.34
Masculinity	80.70	13.47	83.20	7.21	82.46	11.56	84.60	9.95	−0.67	−0.61
Empathy	88.05	14.98	84.00	21.61	90.71	12.66	85.80	15.83	0.75	1.15

* $p < .05$.

Table 6

Pre/Post-Treatment Comrey Scores for Non Psychodrama (N = 65) and a sub-sample of Psychodrama (N = 15) Participants Matched to the Non Psychodrama Group's Pre-Treatment Scale Scores

	Pre-Treatment				Post-Treatment					
Comrey Scales	Psychodrama Mean	SD	Non-Psychodrama Mean	SD	Psychodrama Mean	SD	Non-Psychodrama Mean	SD	Pre-Treatment t	Post-Treatment t
Validity	16.27	7.07	16.82	6.70	16.71	7.52	17.66	6.37	−0.28	−0.48
Response Bias	48.73	7.81	48.79	7.77	49.86	8.08	48.68	7.01	−0.03	0.56
Trust	77.73	8.15	79.85	11.93	91.29	10.48	87.45	11.79	−0.65	1.15
Orderliness	96.00	13.70	93.08	13.19	92.71	14.14	93.19	15.36	0.76	−0.11
Compulsiveness	90.73	10.01	88.55	13.88	93.14	10.87	91.57	12.17	0.57	0.44
Activity	87.87	12.53	91.48	14.90	96.86	14.74	95.55	14.84	−0.86	0.31
Emotional Stability	84.93	15.48	83.45	15.28	101.79	14.24	95.40	16.25	0.33	1.39*
Extroversion	73.20	16.74	77.79	21.91	89.21	18.95	86.23	20.45	−0.43	0.51
Masculinity	80.40	12.03	84.51	12.67	85.14	10.27	84.06	10.96	−1.13	0.33
Empathy	90.00	16.37	89.92	16.80	95.86	16.37	91.94	14.85	0.02	0.89

psychodrama sub-sample. Also, when a sub-sample of psychodrama participants was matched to the non-psychodrama group's pre-treatment Comrey scores, the post-treatment trend was in the direction of the psychodrama sub-sample being more trusting, active, emotionally stable, extroverted and empathic. These facts, added to the finding that there were no significant differences between the two groups on post-treatment prognosis ratings, suggests that psychodrama therapy with those in the psychodrama groups contributed, at least, to their "catching-up" emotionally and in personality development to those individuals who did not receive psychodrama.

Traditional psychodrama theory and technique may account for these positive increases as measured by the Comrey. One of the major factors in psychodrama is that as psychodrama progresses, it elicits a high level of trust and sharing among group members (Van Meulenbrouck, 1972; Weiner, 1967). The psychological investment in the controlled atmosphere of psychodrama encourages the development of risk-taking skills through which participants can find a means of releasing themselves from old rigid attitudes and roles, which have been dysfunctional, and replacing these non-productive attitudes and roles with new and more productive ones. Such a process allows a participant to become more honest and genuine. Also, the need to actively participate in psychodrama as either its star or a role player demands that the participants take risks, become responsible for their actions and as a consequence, experience the here and now success of the issue that is being dramatized.

By the very nature of the psychodrama process, one cannot remain isolated from the action. Even if one "seems" to be a non-participant, silent group member, his destructive life patterns are audibly and visually presented before him, via the roles taken by his fellow group members. The impact and consequences of that psychodrama presentation are equally his, as the other group members. To remain in his shell of fear and isolation is very difficult. Growth may take place in spite of himself.

Van Meulenbrouck (1972) mentions that two of the strongest denominators describing the dynamics of many alcoholics are passivity and denial. Psychodrama provides an "ideal vehicle" for reversing both of these. Decreases in passivity and denial would seem to allow for an increase in activity and emotional stability, especially since an important aspect of psychodrama treatment (Blume, et al., 1968) is helping the alcohol abuser to understand the motivation behind his drinking and the way alcohol use/abuse fits into his patterns of interpersonal behavior. There is some support for this theoretical position in the fact that the psychodrama group obtained a significantly greater change score on the Activity scale of the Comrey and the K scale of the Mini Mult implying,

for them, a greater movement toward more activity and away from denial. Lastly, the psychodrama director, the group, and other auxiliaries permit the protagonist and all group members to help each other, (Blume et al., 1968; Weiner, 1967) which when combined with the aspects of psychodrama already mentioned, would seem to account especially for the increase on the Extroversion scale of the Comrey.

Significant pre/post-treatment change scores on the Comrey, Mini Mult and the Anxiety Measure for patients in both the psychodrama and non-psychodrama groups were consistent with significant change scores for patients in the Navy's Alcohol Rehabilitation Program as a whole and as reported elsewhere (Bucky, 1975; Bucky et al., 1975). Additional studies are needed in explaining the role of psychodrama in the rehabilitation of alcohol abusers in treatment. Such studies are currently underway at the Navy's Alcohol Rehabilitation Center; however, if this role is to be understood, research from a variety of alcohol treatment facilities is indicated.

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CLAIMED AND DISCLAIMED ACTION IN PSYCHODRAMA

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The aim of this paper is to explore a new concept in the context of a relatively older situation. The new concept is that of "claimed action" which Schafer (1973) introduced into the psychoanalytic theory. The old situation is psychodrama. Schafer (1973) introduced the concept of disclaimed action indicating that although all human behavior is intentional or goal-directed, we sometimes "claim" credit for our actions and other times we "disclaim" credit for our actions. We either take responsibility for our actions or we delude ourselves into thinking that someone or something is responsible instead of ourselves. This might be another person, God, fate, luck, the system, a part of our psyche, a part of our body, etc.

Examples of disclaimed action are evident in speech. For example, "It was only a dream," can imply that the dreamer does not recognize that we are the creators of our dreams. Of course, "It is only a dream" can also be an expression of relief, that is: "I am glad it was only a dream and not reality." However, when "It was only a dream" means that the dreamer is not thereby responsible in anyway, then it is clearly an example of disclaimed action. Likewise, "Things will work out," when that statement implies that we are not in control of our destiny, is an example of disclaimed action. Of course, the same statement as an expression of hope is not necessarily disclaimed action. In these and other examples of disclaimed action, it is important to take into account the sense of the statement. A statement reflects disclaimed action only when there is some attempt to displace responsibility away from the speaker.

Disclaimed action can have important positive effects. For example, disclaimed action sometimes eases the stress of daily living or makes the speaker more socially appropriate. "It slipped my mind" puts the blame on mind and saves the speaker the discomfort of saying "I forgot our meeting" or "My meeting with you was not a high priority."

Disclaimed and claimed action represent two different styles of verbalizing and feeling about responsibility for behavior. They may be viewed as being on a continuum from a passive position in respect to one's action (disclaimed action) to the other extreme in which one is in an active position in respect to one's action (claimed action).

A caution is in order. Claimed action does not represent a morally superior or psychologically more adaptive style of relating to one's action.

While it is true that most people who get into trouble with themselves and with others err on the side of blindly disclaiming their action, it is true that disclaimed action can also be personally and socially adaptive. Using psychodramatic techniques to study claimed and disclaimed action can give people great perspective and insight and thereby greater freedom in exploring both claimed and disclaimed action.

Schafer (1978) expanded the concept of disclaimed action and pointed out that our familiar locations for failure to exercise self-control are excuses that deflect responsibility from the self and fragment the self into useless divisions. For example, "I was unable to control myself" or "The impulse overwhelmed me."

In a similar vein, the existential psychotherapists write about man's responsibility and how he creates himself rather than being created by external forces. "Man is not a ready-made being; man will become what he makes of himself and nothing more. Man constructs himself through his choices, because he has the freedom to make vital choices, above all the freedom to choose between an 'inauthentic' and an 'authentic' modality of existence. Authentic existence is the modality in which a man assumes the responsibility of his own existence." (Sahakian, 1976: 426).

The goal of more authentic existence, can be related to a model of responsibility, i.e., moving from disclaimed action to claimed action. This will first come in the form of insight, but then must turn into action. When I use the term "insight," I am referring to the term that Greenberg (1968:92) speaks of when he says: "The catharsis can lead directly to insight and the consequent re-organization of some aspect of the psychodramatic patient's world seems obvious when one thinks of the technical employment of this psychological term, the most widely used being that insight refers to new understanding or to a restructuring of the perceptual field."

Using the continuum of disclaimed to claimed action provides a direction for change. It also provides a mode of assessing therapeutic progress with a psychotherapeutic format and within the person's life.

New Exercises

Experimenting with the concept of disclaimed activity in the context of Psychodrama led to a new exercise. At an appropriate time in the action, (usually when there is a loss of direction or when insights about disclaimed action might be useful) the director stops the action and addresses the audience asking if the present action is claimed or disclaimed, or where it might fall on the continuum of claimed and disclaimed action.

The director then asks the protagonist to step aside and to view the action that will follow. This is the mirror technique.

The director asks for a volunteer from the audience to mirror for the protagonist and to present "strict" claimed action in the situation that was developed by the protagonist. "Strict" claimed action would represent claimed action at the most extreme position on the continuum of claimed-disclaimed action. "Strict" disclaimed action would represent disclaimed action at the most extreme other end of the continuum. Following that, the director asks for another volunteer from the audience to mirror for the protagonist and to present "strict" disclaimed action within the same context.

The protagonist is asked to judge the two mirror presentations of strict claimed and strict disclaimed action. The protagonist will then be given the opportunity to reenact the scene utilizing the mirrored action in an attempt to find a better solution to his problem.

The protagonist sometimes rejects these new alternatives. When this occurs, he is encouraged to try out the new possibility of claimed action even if it seems incorrect or uncomfortable. The protagonist might want to try out both possibilities and then combine the two of them. He may dislike the entire approach and return to his previous methods. The ideal situation would be one in which the protagonist recognizes how he has disclaimed his action. This insight often comes in a sudden flash. He will then be able to reenact the scene claiming responsibility for what he was previously not able to claim responsibility for in the past.

Blatner (1973) talks about the concept of the divided double in which one or more auxiliaries are assigned to play a specific role or part of the protagonist's psyche. It frees the protagonist to clarify his feelings about other complementary attitudes. This is similar to the technique suggested here. The caution in the divided double and in the current exercise is that the protagonist must understand that he is an integrated whole and that these are merely different ways in which he thinks. They are not actually different parts of the mind.

Role Training

To facilitate the audience's ability to see disclaimed action and to be able to spontaneously invent "strict" claimed and disclaimed action, the group has to be taught how to distinguish the two modes of action. This is done through warmup techniques in which the director sets the scene and selects persons to present both claimed and disclaimed action. The director should choose incidents which will be meaningful to the group and then instruct the members in their contrasting roles. After the presenta-

tion of both actions, the actions should be discussed to see if the group understood the differences. Then another situation should be used with other members playing the roles of the "strict" claimer or disclaimer. Recognizing the difficulty of the concept, it is best used with an on-going group and should be presented in several sessions. The warmup part of the time is spent sharing instances from the group's lives in which members recognized their use of disclaimed action.

A few examples might clarify the concept and the techniques. A student who has cheated on an exam might represent his action in this way. "I just couldn't help it. My eyes were wandering and I just saw the right answer on another student's paper. Anybody would have done the same thing." The student here is putting the responsibility for his cheating on his "wandering eyes" and on what "anybody" would have done. Claimed action in this situation would sound something like this: "I started to look around to see other people's papers. When I saw that someone next to me had an obviously correct answer, I copied it." Here the student takes the responsibility for the "looking" and for the copying.

Another example would be a person explaining why he had been late for a meeting. Disclaiming the action the person might say, "I couldn't get here on time because the traffic held me up and the parking places were all taken." The responsibility here is shunted off to the "traffic" and those thoughtless drivers who took up all of the parking places. Claiming responsibility in such a situation need differ only in recognizing that the speaker might have anticipated both the traffic and the parking problems: "I didn't leave enough time to deal with the traffic and I did not leave time for parking."

Note, from the examples, that claimed action is not necessarily more or less dramatic than is disclaimed action; neither is it more or less "moral" than disclaimed action. However, note that in the examples above, like in the next example, claimed action is more likely to clear the air of confusion and point to a clearer discussion of issues. For example, a woman, talking to a marriage counselor about how disappointed she is in her sex life, might say, "He works nights and I work days. There is just no time for sex anymore." This is disclaimed action. An example of claimed action in the same situation would be something like, "I don't enjoy sex enough to make time for it."

The director should provide participants with specific roles until they are sufficiently familiar with the concept to invent them independently or to find examples in their everyday life.

Teaching this concept of claimed and disclaimed action will also serve the purpose of giving the audience something specific to focus on in their observation of the psychodrama. Although the audience is ideally supposed to be involved in the psychodrama, members may tend to fade out

if the pace of the action is slow, or if the participants are tired, or if they do not relate easily to the subject of the presentation. Having a tool with which to delve into the thinking styles of the protagonist and the auxiliaries would facilitate the audience in giving its attention to the action.

Since the audience is such an important component of psychodrama, it is useful to help the audience study itself during and after the psychodrama. Schauer (1952) suggests that the protagonist be ignored and the focus be on the audience as the principal patient. There is probably no need or benefit, but rather the potential of harm in ignoring the protagonist; however, a great deal of attention can be paid to the audience by the director and an audience analyst. Claimed and disclaimed action is but one of many different techniques that could be introduced to the audience to aid them in their concentration and to help them get more personal benefit from the psychodrama.

Conclusion

Concepts having to do with action and the role of action as performed or as represented internally are especially compatible with psychodramatic techniques. Schafer's concept of claimed action represents not only a contribution by one of psychoanalytic theory's outstanding theorists but also represents a greater awareness within psychoanalytic theory of the problem of "action." This holds out promise for continued cross-fertilization between psychodrama and psychoanalytic theory.

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PSYCHODRAMA IN TEACHER EDUCATION

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Continued research in the area has been unable to isolate the factors that guarantee successful teaching. One of the problems with demonstrating teacher effectiveness is that the criteria change to meet changing societal expectations. What is regarded as satisfactory by one generation is sometimes considered unsatisfactory by the next one. In this modern period of rapid social change, a desirable characteristic for teachers is that of flexibility—an ability to adapt with appropriateness to changing conditions.

Teacher educators are being asked to give more attention to who the teacher is rather than what the teacher does because personality characteristics are more enduring than teaching methods and approaches. Methods need to be adapted for such variables as age, grade level, ability, socio-economic environment, and the like. The skill of teaching seems to depend on this ability to match teaching skills and competencies to the situation and to learn from experience (Medley, 1973). Without minimizing skills and methods, this approach makes more demands on the teacher's personal resources.

Another reason which should encourage teacher training programs to emphasize the personal qualities of teachers has been the discovery that the personal relations between the teacher and pupils, together with the socio-emotional classroom climate that results from them, have important effects on learning, recall, and future attitudes to learning. For both teacher and pupils the emotional life in the classroom is always influential and sometimes formative.

Despite these trends teacher education institutions have not generally established serious and competent programs centering on the development of the teacher as a person. Lectures and discussions are often included as a course segment. Some consider the need to have been met in child-centered courses such as Child Development which purport to encourage sensitivity and empathy in the teacher through the imparting of knowledge about the child. However, it is a timeless axiom in education that experiential learning is the most enduring. Peck and Tucker (1973) comment aptly:

> Direct involvement in the role to be learned or close approximations (e.g., sensitivity training labs or classroom simulation labs) produce the desired behavior more effectively than remote or abstract experiences such as lectures on instructional theory. (p. 943)

But experiential opportunities for personal growth of pre-service teachers are rare. A number of reasons can be advanced for this.

Traditionally, teacher-training programs have not included the affective education of the trainee. Secondly, the proponents of this new approach, because they have come from varied therapeutic backgrounds and have used a variety of personal growth methods, have given the impression of disorder and goal-lessness. Thirdly, little evidence has been produced to date linking the personal growth experiences of teachers with learning gains in the children they teach. Fourthly, there is a suspicion of the "groupy-feelies" whom administrators and many faculty members associate with personal growth programs and the much publicized and supposedly harmful effects of group experiences.

Yet, despite the severe problems of definition, method, design, and control that hampers the between-studies comparison of personal growth research, the weight of evidence points to positive effects for growth group participants. Foulds (1970), Watkins, Nell, and Breed (1975), Ware and Barr (1977) and Reddy and Beers (1977) report significant positive changes towards self-actualization. Finando (1970) and Klemke (1977) found positive changes in self-concept for group participants. Careful analyses by Smith (1975) and Cooper (1977) of the relatively large adverse effects reported by Lieberman, Yalom, and Miles (1972) support the overall beneficial results of such experiences.

Such results do not influence teacher education unless they can be translated into pupil benefits. Research is now beginning to find such benefits. Rogers (1957) encouraged facilitators to develop the qualities of empathy, congruence, and positive regard and Carkhuff (1969) operationalized these to train counselors. Aspy (1969) used the Carkhuff model to train teachers with positive practical results in pupil academic achievement (1969) and functioning (1972).

Fuller, Brown, and Peck (1967), in their research with prospective teachers, found that the teachers did not involve themselves deeply with the needs of their pupils until their own security needs were met. The researchers attempted to increase the coping abilities of trainee teachers through a program of counseling, feedback and instruction which centered on self-awareness. A later study (Fuller, Parsons, and Watkins, 1973) into the expressed concerns of pre-service and in-service teachers found the former to be more concerned about benefit to self, and the latter more concerned about benefit to pupils. The implication is that the teacher-preparation curriculum should focus on the personal development of the teacher trainee at the beginning of the program if it is to be congruent with what appears to be a linear development towards pupil-centered teaching.

Combs (1969) found that teachers identified by principals and curriculum co-ordinators as most successful, differed from the least successful in the following ways: they showed a greater degree of sensitivity to students' feelings, could see things from the child's point of view, had a more accepting and positive perception of themselves and others, saw the purpose of teaching as facilitating rather than controlling, and regarded process as more important than product. In a very real sense, these distinguishing characteristics are features of the teacher's person not the teacher's methods.

It was with these considerations that the writers searched for an adequate and appropriate personal-growth producing experience for teacher trainees. We were faced with the challenges posed by Mininger:

> How to prepare teachers to understand the emotional life of their charges and use this perception to enhance the teaching-learning process; how to help teachers to recognize and deal more effectively with their own feelings and reactions, even to utilize their empathy to become increasingly sensitive and responsive. (Fuller, Brown, & Peck, 1967, p. 2)

In many respects Psychodrama seemed to be ideal. It was structured and defined, so lent itself to between-studies comparisons. It claimed to promote spontaneity enabling the individual to meet the old with novelty and the new with adequacy, so was operationally central to the flexibility goal. Literature gave ample testimony to its success in enabling people in a variety of situations to examine, clarify, redefine, and practice their life roles. It was expected that individuals would increase in awareness and sensitivity to themselves and others.

A course unit entitled, *Psychodrama Growth Group,* was offered in 1974 at Churchlands College, Western Australia as an elective in the Diploma of Teaching. It was conducted in conjunction with the Western Australia Institute of Psychodrama established as the first psychodrama center in Australia by Max and Lynette Clayton. The course unit had equal credit with other units and consisted of a semester of weekly sessions comprising two hours of psychodrama and one hour of group theory. Grades were awarded on the theoretical section. The writers had commenced psychodrama training and were able to take groups under supervision from 1975. During 1975 and 1976 about 20 groups were held involving over 200 students. This represented about 16% of the teacher trainees in the School of Teacher Education over this period. An analysis of student concerns and a preliminary evaluation of the program were made at the end of 1976.

Concerns as expressed in the psychodrama sessions were grouped

Table 1

Means, Standard Deviations, and Chi Square Results Based on Participants Perceived Personal Changes

	Mean	*SD*	X^2	*p*
Awareness of feelings	1.90	.85	35.57	<.001
Expression of feelings	1.64	1.22	10.92	<.02
Sense of identity	1.48	1.28	13.40	<.01
Self acceptance	1.29	1.54	9.94	<.02
Self confidence	1.18	1.39	30.47	<.001
Spontaneity	1.35	.91	37.18	<.001

under the headings of family relations (33%), peer relations (23%), intrapersonal conflicts (19%), group issues (13%) and professional/career issues (11%). The major concerns of these pre-service teachers were personal rather than professional, a finding which supported those of Fuller et al., (1967, 1973).

For a first-phase evaluation of the program it was decided to have the 210 past participants evaluate the course on a Likert-type, self-report questionnaire. The experimental nature of the program and the relative inexperience of the facilitators suggested that the initial evaluatory phase should center on curriculum improvement. The basic question was, "What did the consumers think they got from the course?" It is a question that not every student gets an opportunity to answer. Among other things, the anonymous questionnaire asked respondents to indicate the nature of changes they saw in their behavior as it effected their personal lives, their dealings with others, and their professional lives which they attributed to the psychodrama experience. The change scale centered on zero for no change and ranged through *slight, moderate,* and *marked,* to a (+3) for positive change, and to a (−3) for negative change.

The response rate to the questionnaire was 81%. Means, standard deviations, and chi square results based on participant perceived changes are shown in Table 1 for personal changes, Table 2 for changes in dealing

Table 2

Means, Standard Deviations, and Chi Square Results Based on Participants Perceived Changes in Dealing With Other People

	Mean	*SD*	X^2	*p*
Awareness of others' feelings	2.14	.71	60.79	<.001
Being oneself	1.24	1.21	16.16	<.01
Genuinely expressing feeling	1.61	1.27	9.70	<.05
Accepting others' response to above	1.33	1.24	12.23	<.01

Table 3

Means, Standard Deviations, and Chi Square Results Based on Participants Perceived Changes in Professional Life

	Mean	*SD*	X^2	*p*
Awareness of children's feelings	1.54	.97	16.20	$<.01$
Acting personally not as a stereotype teacher	1.40	1.04	10.17	$<.02$
Seeing children as persons	1.42	1.38	3.43	NS
Using action methods in teaching	1.20	1.13	17.89	$<.001$

with others, and Table 3 for changes in professional life. As there were few negative changes reported, it was necessary to collapse cells for the chi square comparison viz., all positives constituted one cell; all negatives plus no-change tallies were incorporated in the other. The chi square analysis compared the ratings made with those that could be expected by chance.

There are, of course, serious limitations in a self-report study. What cannot be questioned is the very positive participant response. This course unit was also rated very positively against other units in the Diploma program, $x^2(5) = 329.38$, $p < .001$. Regarding its future inclusion, 23% thought it should be compulsory and 75% wanted it encouraged.

Not unexpectedly, participants saw it as making less change to their professional than to their personal lives. They recorded very significant changes in sensitivity to feelings, spontaneity, and self-confidence. We are unable to verify this or generalize from it in any way, but are encouraged to move into phase two of the evaluation which will involve searching for verifiable effects of the program. Suitable instruments are currently being piloted.

At a later time it will be necessary to follow participants into the school milieu. In the final analysis, psychodrama as a growth experience will only be accepted by pragmatic teacher educators if it can show positive carry-over to pupils. Our initial experimentation with the method and its possibilities for teacher education suggests promise in this direction.

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THE EFFECTIVENESS OF AN INSERVICE TRAINING PROGRAM IN ROLE PLAYING ON ELEMENTARY CLASSROOM TEACHERS

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The purpose of this paper is to evaluate whether an inservice training program in role playing which included a workshop and weekly consultation periods is an effective training model for helping teachers gain a better knowledge and understanding of the role playing technique and for promoting a more "skillful" use of role playing in the classroom. As the literature suggests, role playing and sociodrama (Moreno, 1946) offer numerous advantages and benefits for the field of education, in general, and more specifically for the elementary and secondary classroom teacher. As Stanford and Roark (1974) (see, also, Roark & Stanford, 1975) noted, role playing and action methods can make the following important contributions to students' development; through role playing, students are helped to develop self-understanding and awareness of their own feelings, to release feelings safely, to develop empathy for and insight into other people, to try out new behavior and experiment with new roles, to learn and practice new social skills, and to develop skills of group problem solving, to improve psychomotor skills, to foster creativity and imagination, and to enhance subject matter learning. Similar lists of advantages of role playing in the classroom can be found in a number of useful sources on role playing, such as Chesler and Fox (1966), Dinkmeyer (1970, 1973), Dreikurs, Grunwald, and Pepper (1971), Furness (1976), Grambs (1968), Hawley (1975), Klein (1956), and Shaftel and Shaftel (1967).

More recently, several authors strongly suggested the appropriateness of the role playing technique in the classroom. They noticed the students' growing discontent with their passive role in the learning process and their rejection of the traditional methods of classroom learning in which the major portion of the classroom activity has been centered around the teacher (Champagne & Hines, 1971; Hawley, 1975; Hopkins, 1970; Michels & Hatcher, 1972; Stanford, 1974). As Michels and Hatcher (1972) pointed out, "sociodrama can fill an important role and serve the useful

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purpose of helping to solve current educational problems and promote educational objectives" (pp. 151–152).

Shaftel and Shaftel (1967), in their comprehensive text on role playing, reviewed numerous studies and reports which seem to suggest that role playing is used by teachers in the classroom, especially in the teaching of social studies. A review of the more recent literature also points in that direction. Teachers use role playing for many different purposes, such as for teaching subject matter, i.e., social studies (Appleberry & Field, 1974), history (Dumas, 1970) and chemistry (Plati, 1970), in courses such as family living and drama (Mekeel, 1970) and as a major methodology in courses in humanities (Strauss & Dufour, 1970). Role playing is also used by teachers for dealing with behavior problems, tensions and conflicts in the classroom (Blake, 1974; Crystal, 1969; Furness, 1977; Stanford & Stanford, 1974) and for teaching interpersonal relationship skills (Harlan, 1970; Lear, 1970).

However, with all the advantages that the role playing methodology has for the classroom teacher and the empirical evidence of its use, it is suggested that role playing is not that widely used by teachers (Chesler & Fox, 1966; Grambs, 1968; Hawley, 1975; Riessman, 1964; Roark & Stanford, 1975).

Several authors noted that the major reason for that infrequent use is a lack of real knowledge and understanding of the role playing methodology by classroom teachers (Chesler & Fox, 1966; Dinkmeyer, 1973; Hawley, 1975; Roark & Stanford, 1975).

Grambs (1968) felt that role playing requires a teacher who is sensitive to the feelings of the group and is able to accept any direction it may take. The teacher must also be comfortable with ambiguity and uncertainty (which many are not).

Hawley (1975) added that teachers may avoid role playing because they do not want to waste precious class time in "playing" when they could have used it on having a serious discussion. He also noted that some teachers may fear the possibilities of unleashing emotional forces by their students which they feel inadequate to deal with.

Some authors pointed out that teachers may even be resistant to the use of role playing for fear that one might "accuse" them of trying to introduce mental health materials or programs into schools (Chesler & Fox, 1966; Grambs, 1968; Riesman, 1964).

According to Stanford (1974), teachers have not discovered the exciting potential of role playing because they probably have never seen role playing work really well, or they have tried it and failed miserably in their early attempts. Her analysis of teachers' performance during role playing led her to conclude that there are six major problems that teachers face

when they attempt to use role playing in the classroom. These problems include (a) students who are not well acquainted and comfortable with one another, (b) inhibitions and self-consciousness of students about moving and touching which is especially true for the older students at the junior high, (c) students' lack of necessary skills, (d) students who have not properly warmed up before the role playing activities, (e) passivity of the classroom teacher, and (f) the tendency to expect role playing to be entertaining rather than a serious learning endeavor.

As Stanford pointed out, these problems can be overcome through proper training and preparation of teachers, a view that is obviously shared by those authors who address their textbooks on role playing to an audience of teachers (i.e., Chesler & Fox, 1966; Furness, 1976; Hawley, 1975; Shaftel & Shaftel, 1967 and others).

However, it should also be noted that there is very little empirical evidence to demonstrate that training of teachers in role playing is effective in overcoming the kind of problems and difficulties they have in using this strategy.

It is the purpose of this paper to evaluate whether an inservice training program in role playing offered to elementary classroom teachers is useful in producing a better knowledge and understanding of that technique and in building the basic skills necessary for directing successful role playing sessions in the classroom.

The paper is based on a larger study which attempted to evaluate the effectiveness of a role playing intervention on students' behavior and attitudes. That study included an inservice teacher training program as one of its major components. Only that component will be evaluated in the present report.

Procedure

Several months before the study was conducted, this researcher was involved in the development of instructional materials for training teachers in role playing. The materials included a teacher training manual titled "Role playing as a Method for Teaching Social Skills".* The manual included a detailed explanation of a variety of role playing activities and techniques and an outline of suggested steps to be taken during the implementation of a role playing session. Several major publications on role playing (Chesler & Fox, 1966; Dinkmeyer, 1970, 1973; Grambs, 1968; Klein, 1956; Corsini & Cardone, 1966; Lehman, 1971; Lippitt, 1958;

* The manual was duplicated in a limited number of copies and used only for purposes of this study.

Lippitt & Hubbell, 1956; Maier, 1952; Moreno, 1946) were used in the preparation of the manual. Included in the manual were 32 unfinished problem stories that were adapted mainly from Chesler and Fox (1966), Dinkmeyer (1970, 1973), and Shaftel and Shaftel (1967). Also prepared were name tags, pictures and short briefings to the actors. The materials were packaged in folders and later distributed to the participating teachers.

Following the stage of material development and of their piloting in several classrooms, the main project began. This project was conducted in grades three through five in 65 classrooms in two school districts in a midwestern state. Half of the classrooms were randomly assigned to the experimental condition and half to the control condition, making a total of 32 experimental classrooms and 33 control classrooms. All 31** experimental teachers were then involved in a role playing training program which included a workshop and consultation sessions. The workshop lasted two hours and was given to teachers who met in groups of six to 10, after school hours. The major purposes of that workshop were: (a) to train the teachers in a variety of methods and techniques of role playing, (b) to help teachers through demonstrations and group discussions to overcome any fears and reluctance of using role playing with their students, and (c) to familiarize them with the manual, the stories and the materials. Much emphasis was given on teacher involvement through active participation.

After the workshop which was only the first step in the teacher training, the researcher met with the teachers on a weekly or bi-weekly basis for about 15–20 minutes each during the 10 weeks of the program. These meetings took place during recess, lunch, or after school hours. Their purpose was (a) to answer teacher's questions and solve problems which they encountered during the role playing sessions, (b) to use it as an opportunity to fill in missing links in the knowledge and understanding of role playing and its techniques, and (c) to find out whether teachers implemented the role playing sessions as directed.

The role playing project lasted 10 weeks. During that period, the 31 experimental teachers were directed to implement two weekly role playing sessions of about 30–40 minutes each in their classrooms. No training in role playing was given to the control teachers nor did they receive any materials. They also were not instructed to use role playing with their students. In order to evaluate the performance of the experimental teachers during the 10 weeks of the program (some information on teachers' performance was secured during the consultation periods), each teacher was asked to fill out a Lesson Activities and Evaluation form.

**One teacher was in charge of two classrooms.

This form was divided into two parts. In Part A, the teachers checked the steps and activities they followed during that particular session as well as the story used. In the second part, they evaluated their students' involvement, interest, social relationships, and type of solutions to the problems. One additional purpose of this form was that it served as a guide for the teachers during the role playing sessions (reminding them of the steps and activities that can be applied). Further information about the teachers' attitudes toward role playing and the program were secured through a questionnaire administered at the end of the project.

Results

In this section, findings related to the teacher's performance and their attitudes toward role playing will be presented in order to evaluate the usefulness of the teacher training component of the project.

A. Classroom implementation

Table 1 shows the percent and number of teachers who used the different role playing steps and the percent and number of sessions in which these steps were followed. As can be seen, all teachers reported that they followed in many of the sessions the basic steps that were outlined to them in the workshop, the manual and the consultation sessions. Steps which were followed during most or all of the sessions included: explaining the role playing situation (setting the scene), explaining the audience role, the dramatic enactment and discussion. Other steps were not always followed. For example, warm-ups were used mostly during the early part of the program and were skipped during the later sessions. The steps of "presentation of the problem" and "explaining participant roles" were used whenever the teacher used a problem story. However, when a pantomime was used, there was no need for these two steps. Reenactment was used quite infrequently. Also, only 75% of the teachers "found" time to summarize the session.

B. Use of special techniques

Table 2 shows the percent and the number of teachers and the mean percent and number of sessions in which teachers used the various role playing techniques in which they were trained. The average number of techniques used was 4.36 (SD = 1.26), i.e., most teachers tried between three and six special techniques during the program. However, figures also reveal that several techniques were more widely implemented than others. For example, the most preferred formats were the consultant and

Table 1

Percent and Number of Teachers Who Used Each Step and Percent and Number of Sessions (Means) in Which Steps Were Implemented (Data for Combined Districts)*

Step or Activity	Percent Teachers	No. Teachers	Percent of Sessions	Number of Sessions
Steps				
1. Warm-ups	100	31	49.6	6.96
2. Presentation of the Problem Story	100	31	54.4	7.64
3. Explanation of the Situation	100	31	75.4	10.58
4. Explaining Participant Roles	100	31	60.9	8.56
5. Explaining Audience Roles			(84.8)	(12.00)
a. Audience Acted as Consultants	87.1	27	28.9	4.00
b. Audience listened and/or took notes	100	31	55.9	8.00
6. Dramatic Enactment			(108.5)**	(15.35)
a. Pantomime	100	31	42.0	5.90
b. Role Play story ending	100	31	43.7	6.12
c. Acting from Seat	25.8	8	11.0	1.63
d. Alternative-Writing Ending of Story	74.1	23	11.8	1.70
7. Discussion			(102.5)***	(14.29)
a. Large group	100	31	73.3	10.29
b. Small group	87.1	27	21.4	3.0
c. Dyads	25.8	8	7.8	1.0
8. Reenactment	61.2	19	18.5	2.57
9. Summary	74.2	23	56.0	9.04

* Mean number of role playing sessions for all 31 teachers = 14.03. SD = 3.02.
** More than 100%, as some teachers used more than one activity per session.
*** More than 100%, as some teachers used more than one type of discussion per session.

multiple enactments. Next were the role reversal and multiple role players. The less popular techniques were the soliloquy, the doubling the new role and the auxiliary chair, all were tried by only about one-third of the teachers, and implemented on the average of 1.5 sessions during the program.

C. Teachers' reception of the program

At the end of the project, each of the participating teachers filled out a questionnaire in which he/she were asked to evaluate the program. Table 3 presents the responses to several key questions in that questionnaire. The figures presented in this table suggest that the teachers were very positive about the program. The majority of them indicated that they

Table 2

Percent and Number of Teachers Using Special Techniques and Percent and Number (Means) of Sessions in Which Techniques Were Used
(Mean Number of Techniques 4.36 SD = 1.26)

Techniques	Percent Teachers	No. Teachers	Percent of Sessions	No. Sessions
1. Role Reversal[1]	58.4	18	14.8	2.22
2. Soliloquy Technique[2]	32.2	10	9.6	1.30
3. Doubling Technique[3]	29.0	9	10.4	1.55
4. The Consultant[4]	87.0	27	20.9	3.00
5. Multiple Role Players[5]	67.7	21	23.1	3.19
6. Multiple Enactment[6]	83.3	26	19.1	2.73
7. The New Role[7]	35.4	11	17.6	2.45
8. Auxiliary Chair[8]	41.9	13	9.6	1.38

[1] Role Reversal—a technique in which role players exchange their roles to get a better understanding of the other point of view.
[2] The Soliloquy—a technique in which the player turns to the audience and states openly what he is thinking or feeling but is not saying or expressing in the dialogue.
[3] Double Technique—a volunteer acts as the player's double expressing the ideas and feelings that he imagines the character has but is not expressing openly.
[4] The Consultant—a group member is assigned as a consultant to the actor helping him with his role.
[5] Multiple Role Players—two or three children play a character together and help each other in the enactment and in working out a solution to the problem.
[6] Multiple Enactment—the scene is enacted again with different players.
[7] The New Role—the teacher is encouraged to step in the scene with a new invented role (father, teacher, sister, etc.) in order to add some new insight or help to find a solution.
[8] Auxiliary Chair—role playing done with chairs to present the various characters or behaviors to be analyzed. The director stands behind the chair to facilitate the projection of feelings, words, and thoughts into the chair.

learned and benefited much from the workshop as well as from the program which offered them the opportunity to practice the skills of directing role playing sessions. Most teachers found the manual which they used in the classroom of great help. The figures also revealed that all of the teachers plan to use role playing in the future; two-thirds plan to do so very often. Almost all teachers recognized that the role playing lessons were very motivating to their students. However, only one-fourth of the teachers noted that the program had strong effect on their students. Following are a few comments which teachers made on the questionnaire: "I had read about role playing but didn't know about setting the program up." "It was a good review of what I knew, and taught me many techniques I didn't know." "By asking for multiple solutions, non-serious answers are soon forgotten and more practical and sincere answers given." "It was encouraging to hear the interaction that had taken place in using the same stories and the different approaches used with each." "The more involved the students became, the more they could talk about

Table 3

Teacher Evaluation of the Program (Percents) N = 31

	I knew most of it before	To a certain degree	Useful Very Useful Extremely Useful
A. Was the workshop on role playing useful and helpful for you?	3.2	22.6	74.2
	Some	Quite a Lot	
B. How much have you learned and benefited from the total program?	37.9	62.1	
	Some	Of Great Help	Extremely Helpful
C. Was the manual helpful and useful	6.5	35.5	58.0
	From time to time	Quite often A lot	
D. Will you use role playing in your classroom next year?	35.5	64.5	
	Some	Quite a lot A lot	
E. How much were your students interested and involved?	9.7	90.3	
	A little	Some	Quite a lot A lot
F. How much did your students benefit from the program?	3.2	70.9	25.9

the problem. The majority of the students have trouble acting out roles." "I would have liked to have seen a role playing situation presented but with children."

Discussion

The purpose of this paper was to evaluate the effectiveness of an inservice teacher training program on role playing. As the review of the literature indicated, role playing is not widely used as a teaching technique in the classroom. The main reasons suggested for its infrequent use were: lack of knowledge and understanding of role playing, difficulties in implementation, and reluctance to cope with feelings or emotions in the classroom.

Findings from this study suggest that training of teachers in role playing is necessary in order to teach the necessary skills and develop a better

understanding of this methodology. Teacher responses to the questionnaire revealed that they had some training in role playing before the project, but that they were lacking basic skills of conducting role playing sessions. For most of them, the workshop and the consultation periods offered an opportunity to learn more about role playing. Furthermore, the project gave them an opportunity to practice and improve their skills under supervision (consultation periods). It should be noted that during the 10-week project, the teachers implemented on the average 14 sessions of 30–40 minutes each. The majority carried out between 11–17 sessions or 1.1 to 1.7 sessions per week. Five teachers implemented between 18–20 sessions or about two sessions per week, while only five of the whole group carried out about 10 sessions or one session on the average per week.

Based on teacher responses to the Lesson Activities form and from comments made during the consultation periods, it may be concluded that most of them understood the need of following carefully a sequence of planned steps during each session. Two of the steps were always followed, the dramatic enactment and the discussion step. The dramatic enactment included usually the acting out of a pantomime and the acting out of a problem story ending. Acting from the seat was rarely used and so was the alternative of writing an end to a problem story.

A group discussion always followed the enactment step. It is interesting that teachers used the traditional format of conducting a classroom discussion; that is, a whole group discussion. Only during few sessions did they conduct a discussion in small groups. Discussions in dyads were rarely used.

Several other steps were also frequently used. For example, teachers seemed to recognize the importance of involving the audience by assigning them some type of responsibility. In about one-fourth of the sessions, members of the audience acted as consultants. In most of the sessions, however, they were instructed to look for certain things or to take notes. While there is evidence that the teachers recognized the need to involve the audience, the importance of audience involvement needs to be much more stressed in future training programs. Teachers explained the situation (or set up the scene), especially during pantomimes and role plays in 75% of the sessions. Warm-ups were used early in the program and skipped in later sessions. The reenactment step was infrequently carried out. As several pointed out, the major seven steps took up most of the time they were ready to spend for a session and so they did not encourage additional enactments of the scene. Also, not all of the teachers recognized the importance of offering a brief summary of the major points and of the solutions suggested during the session.

The number of different role playing techniques tried out by the teachers during the 10 weeks of the program was very encouraging. On the average, teachers used 4.36 (SD = 1.26) different role playing techniques out of the eight presented to them in the workshop and the manual. However, it is also interesting to note that several techniques were probably easier and better received than others. The most widely used ones were the consultant, multiple enactments, role reversal, and multiple role players. Two of the techniques, the soliloquy and the doubling, may have been too complicated and sophisticated, especially for the younger students and were, therefore, used by less than one-third of the teachers on an average of 1.5 sessions during the program. It is also interesting that the techniques which required active participation of the teacher during the enactment step, i.e., the new role and the auxiliary chair, were "tried out" by only 35–40%. It seems that many teachers still did not feel free to perform in front of their students. As Weckler noted in her introduction (Furness, 1976), teachers in our educational system are not only discouraged from disclosing the basic aspects of their own humaness, but are also often discouraged from being openly emotionally expressive in the classroom. This, then, is one area where further training and encouragement are needed in order to make role playing work more effectively.

Teachers' evaluation of the program turned out to be very positive. Almost all of them pointed out that the program was an important learning experience. On the question whether they plan to use role playing in the future, all gave a positive answer. Two-thirds even stated that they plan to use role playing very often the following year.

The teacher training manual was highly appreciated by the teachers. From comments made, it may be concluded that most of them did not have books on role playing at home, nor were books on role playing available in the school library.

Findings from this study suggest that a short inservice training program which includes a workshop plus weekly brief consultation periods is an effective model for training teachers to use role playing. The inservice program was beneficial in helping teachers to gain a better knowledge and understanding of the different techniques, methods and steps required in directing role playing sessions. Their performance in the classroom proved that teachers can become effective and willing users of role playing.

As to the impact of the program on students' behavior and attitudes, it should be mentioned that the results of the statistical analyses did not turn out to be significant, although several were in the predicted direction. It is the belief of this researcher that if the intervention had lasted over several more weeks, its impact may have been more noted.

Conclusions and Suggestions

1. Findings from this study suggest that elementary classroom teachers do not have an adequate training in role playing. Furthermore, from responses given by teachers, it may be concluded that role playing sessions are rarely conducted in the classroom.

2. An inservice training program in role playing, which includes a workshop, and followed by weekly brief consultation periods, are useful in building the necessary knowledge, understanding and skills needed for directing role playing sessions in the classroom. Through this type of inservice training, some of the problems that teachers seem to have with role playing such as lack of basic knowledge, bad experience and unfavorable attitudes can be reduced.

3. It is suggested that inservice training programs in role playing be offered to teachers in several workshops during the year. Trained school psychologists and counselors should have a major responsibility in conducting these workshops. Furthermore, because psychologists and counselors are available in the school building, they would serve as consultants to teachers whenever questions or problems arise. They could also demonstrate the uses of role playing with students to the classroom teachers.

4. In light of the many advantages of role playing in education, colleges and universities involved in teacher education should include several sessions on role playing as an important component in their methods and/or classroom management courses.

5. Training programs of elementary classroom teachers should focus on the value of role playing as a teaching strategy and not on role playing as a therapeutic approach. Techniques such as doubling and the soliloquy may, therefore, not be appropriate.

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SOCIOMETRY SECTION

Editorial
MANY SOCIOMETRIES

JOE W. HART

The phenomena of the 70's in the area of Morenian and Morenian-influenced therapy has been the development of many different types of applications of sociometric processes—"many sociometries".

At the end of the last decade (or perhaps shortly before) the world of sociometry was neatly divided into two areas: 1. Coastal/psychology/very informal/clinical oriented and 2. Interior/sociology, rural sociology or social psychology/academic/research oriented.

Most practitioners apparently accepted the conveniences of this arrangement. Partially as a result of this apathy, the pace of the development of sociometry moderated. Sociometry entered a dark age. For a few years some Morenians would have felt strange about including sociometry presentations at the ASGPP conventions. Ultimately, the *International Journal of Sociometry* was reduced to the *International Handbook of Sociometry*. The Handbook quietly became a special sociometry section of the journal you are now reading. The interests, economics, and directions of Moreno's followers were not such as to continue the support of this publishing activity. Sociometry was kept alive by a handful of caretakers working independently, often in isolation, and by graduate students working on masters' and doctors' theses.

A big opportunity for the revival of sociometry came with the First International Congress of Sociometry in Baden, Austria in 1968. There, the pioneers and the second generation sociometrists excitedly mingled—freely and spontaneously—perhaps for the first and last time.

Sociometrists such as Mary Northway, John McKinney, Kurt Back, J. L. and Zerka Moreno, Charles Loomis, Jim Enneis, Joe Hart, Ellen Siroka, Anne Ancelin-Schutzenberger, Bob Siroka, and many others including the students of Merl Bonney, Leslie Zeleny, and Mary Evans were there. These sociometrists were joined by a large number of outstanding sociometrists from the Balkan countries. Instead of ushering in a new era of development in sociometry, the Congress seemed to mark the end of an age.

The creative expression we call sociometry had been dammed up for too long. Already new channels were being cut by the research and clinical application activities of people "outside" the sociometry fraternity—people who did not identify themselves as sociometrists. Many of these individuals were relatively unaware of Moreno or his contributions. Many of these individuals "learned"—"were exposed to"—sociometry from third, fourth, or fifth-hand sources. They worked in diverse fields such as anthropology, communications, parapsychology, economics, business administration, humanistic psychology, nursing, public school administration, organizational development (OD), and psychiatry. Moreno's prophecy of a governmental department of sociometry has come true. In response to this widespread, diversified interest in sociometry-like phenomena, the U. S. government, through the National Institute of Education, set up a network division (in fact the first sociometry department in a U. S. government agency, but ironically no one inside or outside of government has recognized it as such). Despite these scholars' lack of "grounding" in the traditional literature of sociometry, their achievements were astounding. *The dynamic power of sociometry could not be denied or weakened.*

Today, these diverse groups not only work without contact with the traditionalists, they often are unaware of the existence and activities of each other. To some degree, this is attributable to the fact that each group developed its own vocabulary. Today, several words used as substitutes for the term "sociometry" are: Social networking, Support systems networks, Interpersonal communications, Team development, Social acceptability studies, Linkages, Identification of nexus individuals, Relationship therapy, Contacts/contacting.

In response to, interaction with, and in interface with, these developments more traditional sociometrists have begun to make sharper distinctions between different content areas—approaches in our field, and develop newer, more dynamic, more time economical, and more relevant sociometries. At this time, this editor feels the following sociometries exist.

1. *Stage sociometry.* Use of sociometry as (a) a warm-up for or (b)

drama facilitation within or (c) closure technique after a psychodrama session. Common techniques are social atom work, role diagrams, and public choosing activities (construction of group sociograms without meeting criteria of privacy/confidentiality—done appropriately in the context of a clinical group exploration). Unfortunately, many psychodramatists do not proceed very far beyond this area in their study and efforts to develop as a professional practitioner. They become sociometry drop-outs upon graduation from kindergarten.

2. *Institutional sociometry.* This academic area has given us 90% of our empirical research in sociometry. Basic values of the practitioners using this approach are (a) the data gathered via the use of the sociometric questionnaire will always be used for the benefit of group members—usually through a group restructuralization process, (b) confidentiality of sociometric responses, and (c) a view of sociometry as a future-oriented research method. Institutional sociometry is used in education, business, sports, the military, advertising, economics, family research, social work, youth programs, population studies, and in prisons.

3. *Perceptual sociometry.* Emphasis is on studying group members' ability to predict the reactions (choices) they will receive from others in the group. Perceptual sociometry has had a strong influence on the more mathematical sociometry of the sociologists from 1956–1978 (the years of their publication of the journal, *Sociometry*). This is, perhaps, the least developed area of sociometry. Little was done after a few pioneer studies were completed by Katz et. al. The work and research of Warren Bonney (brother of Merle Bonney) shows promise and should be followed closely. He is interested in developing ways of studying "deep level" reasons for sociometric choice declarations.

4. *Community sociometry.* From Moreno's and Jennings' early studies to F.D.R.'s resettlement projects (see studies conducted by C. Loomis, et. al.) to Clare Danielson's Intimate Communities, to my own and Alan Wickersty's explorations with the use of sociometry to predict elections, to my staff's and students' use of sociometry to develop "real neighborhoods" in a 16,000 population model city neighborhood in the Texarkana, U.S.A. project 1969–1973, *community sociometry* has been an enduring and productive "special" area of sociometric investigation. As an aside, the reader might be interested in knowing that Johnny Cash was raised in a sociometrically formed community. Watch for a forthcoming article on Johnny Cash by this author and Hannah Weiner.

5. *Clinical sociometry.* The emphasis of clinical sociometry is on (a) the "why" of choices and, (b) the effect of choices. Past and current activities in this area have centered around the study of: psychotic

behavior, sexual impotency, family system analysis, alcoholism and drug abuse, criminal populations, interpersonal conflict, fear of success, accident proneness, heartbreak, death, loneliness, child abuse, cancer victims.

6. *Pop sociometry.* Popularized studies of loneliness, jealousy, isolation, fear of rejection, making contact (with opposite sex), sex and personal appeal, risk taking, and the development of support system networks, are examples of pop sociometry. In most issues of *Playboy, Penthouse, Woman Today, Saturday Review,* or the Sunday supplement of the local newspaper at least one article classifiable as pop sociometry can be found. These popularized articles have replaced the "test your personality" articles of past decades.

7. *Action Sociometry.* This specialization, which I demonstrated at the International Group Psychotherapy Congress in 1977, uses sociometric research results as the empirical base for developing relevant, scientifically grounded therapeutic training, and workshop procedures (called exercises). These may be used as psychodrama warm-ups, encounter group activities, teaching devices, or as basic therapeutic processes. One of the major philosophical contributions of action sociometry is that the mere act of allowing/asking subjects to make sociometric choices has great motivational and therapeutic value. See Hart and Nath article, this issue, and article by Jane Nance and Al Wright (GP, 1977).

8. *Cosmic sociometry.* Sociometry is seen as a research model that can be used to help researchers in various parapsychology areas design better ways of studying psychic phenomena. During the Summer of 1977, this author and a number of IBM executives/researchers interested in the interface of electronics research and parapsychology investigations met weekly to explore possible uses of the sociometric research model as an aid in their investigations. Outcomes of these interactions have been the development of action sociometric techniques for:

(a) working with groups of terminally ill cancer patients to create a cosmic social network (social atom work for the "hereafter");

(b) development of the F-group (futures-group) technique to foretell the future (for a description of this process, see *Saturday Review,* June 9, 1979, pp. 6–7);

(c) development of the concept of "Futurism as Therapy" (presentation made at the National AHP meeting, Princeton, N.J., August, 1979).

9. *Somatic sociometry.* (Who is the matter with me?). This approach is based on the assumptions that:

(a) all phenomena, ideas, feelings, thoughts, actions etc. have a sociometric referent;

(b) that aches, pains, and psychosomatic illnesses are manifestations of dysfunctional and/or inappropriate interpersonal relationships;

(c) that the body is a sociogram and the sociobodygram (SBG) is a process for somatic sociometric measurement; and,

(d) that social grounding (developing an awareness of our sociometric reference points) is facilitative of all medical and/or psychological treatment activities.

10. *Social networking*. This is the broadest of the newer areas of sociometry (or of research areas drawing upon, and interfacing with, sociometry). Because of the diversity and vitality of this area of investigation, we invited Barbara Mueller, an outstanding specialist in social networking to be a guest editor for this issue of GPPS for the purpose of gathering together a set of representative articles in this area—or at least in one portion of this area. Hope you, our readers, enjoy this special section on social networking.

If those of us who have worked to keep sociometry alive, and have made our own modest contributions to its development wish to keep our area of interest growing we must (1) become aware of the explosion of interest in sociometry under many other names (2) become conversant with and skillful in using the "many sociometries" springing up around us and (3) by remaining sociometrically expansive invite other leaders/researchers/practitioners into our social atom. We have a choice. We can be sociometrically expansive and retain (or regain?) our leadership or we can be exclusive-rejective of these "upstarts" and sit in the bleachers in the #1 box reserved for "Moreno disciplines", "ASGPP", etc. and watch the game be played by those who "study networks", "treat relationships", and teach others to "improve their interpersonal relationships." At the beginning of this, the new decade, it is within our power to determine what our response will be. What is the answer? *In what manner will we, the sociometric traditionalists, survive?*

MEASUREMENT, SOCIOMETRY, AND SOME DEVELOPMENTAL IMPLICATIONS

DIANE MILCIC-GRAHAM

This article presents descriptions and examples of some empirical links between social and cognitive behavior. A brief sketch of selected sociometric techniques tied to developmental theory is presented. From this follows a subsequent proposal for an interactional analysis of social and cognitive behaviors. J. L. Moreno and J. Piaget's works provide the supporting theories for the empirical assessment of the interaction of these behaviors.

Definition of Sociometry

The domain sampled by sociometry may be defined by sociology. Sociology, broadly considered, can be thought of as a science of human relations. Therefore, theoretically, there could be a myriad number of variables which the domain of sociometry could include. Ideally, a sociometric technique might encompass a measure of reciprocal impressions of group members, an individual choosing another and the other in turn choosing. The choice is a function of both the person's relationship to the social environment and of the social environment's relationship to the person. For the purposes of this paper, sociometry is utilized to sample the domain of sociology, the study of social behavior in group relations. It is considered to be a technique which attempts to quantify an aspect of social behavior.

Some Measures of Sociometry

Methods of measuring in sociometry can be categorized according to the kind of information desired. The value of the method is the degree to which it maps some aspect of human relations in a group accurately and its feasibility of administration to larger groups. Four examples of measuring social status are provided as follows:

(1) The sociogram shows the intrapersonal relations of the group, and the interpersonal relations of members of the group. Of the four examples, it gives the most information concerning social status of group members. The greatest disadvantage of this method is the time required to construct the sociogram.

(2) A second technique is that of ranking people from most-liked to

least-liked. As in the sociogram (like method one), each group member is considered. However, this method has the added benefit of having a less tedious scoring procedure. Frequencies for each social position are tallied. Then, depending on the research questions, the analysis can proceed in several directions. A major disadvantage of this method is that it is questionable if social ranking is at all socially significant or empirically valid after the lower and upper extremes are considered.

(3) A third alternative is to measure only the two extremes—an assessment of the most-liked and least-liked members of the group. Scores for an individual group member consist of the summation of times chosen in either category. Those individuals who are not chosen are assigned to a separate category. A score of zero represents being chosen equally in the liked and not-liked categories. The disadvantage of this technique is that it does not reflect the reciprocal impressions of group members.

(4) Fourth, each person may be asked to choose either the most popular person in the group or the least popular. In this type of assessment, only one end of the continuum (popular or not popular) is represented in the analysis. This sort of either-or choice limits selection and represents certain disadvantages. While this method is the most feasible to administer to larger groups, it yields the least accurate mapping of the variability of intra-group relationships, e.g., it represents only one social grouping.

Whatever method of measuring sociometric status is used, the end result describes a social phenomenon of the particular group being studied. As is characteristic of behavior assessments, there are advantages and disadvantages to each method. One method gives a more comprehensive mapping of the social relationships. Another method has greater feasibility of administration with larger groups. The information obtained from each sociometric assessment gives the group facilitator (teacher, therapist, researcher, etc.) and group members information on the social status of individual members. While this type of information is contextually important, further information can be obtained by studying social behavior in relation to other aspects of behavior. Several researchers (Rubin, 1973; Chandler, 1977; Piaget, 1970; Johnson, 1975; Alvy, 1968) have considered the relationship of social behavior to cognitive developmental variables. This sample of research supports the position that the integration of cognitive and social development is important for the study of human behavior.

Developmental Assessment

Sociometry from the philosophical point of view outlined by J. L.

Moreno (1941/1977) proposed that social systems be represented in process. Moreno suggested that social sciences have too long been concerned with end results at the expense of the social movement for the result. Moreno maintained that: "A study of human interrelations proceeding forward from their status nascendi (concept of the moment), instead of proceeding backward from their end-product, has great theoretical advantages" (p. 9). This perspective also posits some basic notions in developmental psychology on cognitive growth.

In order to specify sociometry's potential role in social-psychological research, developmental theory can advantageously be introduced. Jean Piaget's theory of development lends itself to the consideration of the social influences of cognitive development. Piaget (1958, 1959, 1960) focused his research questions on the intellectual development of children. He studied various schemes of thought (i.e., classification, conservation, seriation, volume, relational comprehension, etc.) from preschool through adolescence. The results of his numerous studies showed that certain notions could be traced as a progressive understanding, e.g. stages of development. Although Piaget had not empirically researched social development, he surmised that development necessarily includes biological, social, and cognitive interactions (Piaget, 1971).

According to Piagetian genetic epistemology, one theoretical link between social and cognitive interactions is the construct of decentration. The newborn infant is not decentered; the infant is egocentric and responds in a nondifferentiated manner to the world. The world is viewed as action and is the result of the child's action. Through progressive interaction, spatial objectivism of the world is accomplished. The self is located by successive approximations in the world of objects. As intellectual development progresses, the early egocentrism diminishes. The focus of thought changes to equilibrate for the self as an independent part of the world. This is a continual process from the first interactions to the last. Decentration is the process of moving from one reference system to another. The potential for decentration is effected and affected by the social environment. Although a person may be able to reason from premises other than his/her own, the consequences of acting out the behavior in a social context play an important role in this process. There are, then, instances in which social interactions may not only provide an impetus for cognitive understanding, but may at other times thwart cognitive understanding. A brief article by Z. T. Moreno (1975) underscores the necessity of understanding role-playing from both cognitive and social dimensions. Cognitive differentiation of the world interacts with and is not independent of social development from this frame of reference.

Research Implications

As referenced above, J. L. Moreno and J. Piaget have both emphasized the import of cognitive and social growth as progressive, parallel, and complimentary development. Ideally, research utilizing their theoretical foundations would trace a child's socio-cognitive behavior throughout development. Measures of sociometric status and stage of intellectual development would reflect socio-cognitive behavior and its significance. While longitudinal research yields the most empirically valid information about human development, it often lacks practicality and/or possibility to implement. Modifications of longitudinal designs can be utilized to obtain more quickly relevant information on the progressive development of human behavior.

Recommendations for alternative research designs to assess these behaviors might conceivably account for the developmental level of the individual through his/her progressive performance. The design might well be sensitive to the social structure the individual is a member of and his/her role in the structure. Tasks in problem-solving ability documented for its developmental validity could be used for the assessment of cognitive developmental level (Elkind, 1961, 1962). An assessment of social behavior could well include a measure of the relation of the group to the individual. Assessments of these behaviors could be conducted over a period of educational (social, psychological, cognitive, etc.) training. The analysis then could consist of testing for measureable changes in the different behaviors (i.e., the interaction effect of the variables).

Implications for the Social Sciences

Historically, the social sciences have aged through theoretical views representing a gamut of systems from strict empiricism to phenomenology. A critical analysis of different approaches shows that each theory in its own way attempted to deal with the age-old epistemological dilemma, the relationship between the subject and object (Gibbs, 1978). Recently, there has been a resurgence of interest in theory and in research dealing with the dialectic of individual and social development (Riegel, 1976; Achenbach, 1978).

Sociometry has a definite place in the integration of social and cognitive research. It can provide a measure of an individual's social status in relation to his/her performance at a particular period in development. This paper centers on the dialectic of the socio-cognitive dimension. It provides an avenue to define and differentiate one aspect of the subject-object epistemological dilemma. Hopefully, more research of this sort will

be forthcoming and will provide empirically valid data for the building of socio-cognitive theories.

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STUDYING ACTION SOCIOMETRY: AN ELEMENT IN THE PERSONAL GROWTH OF THE THERAPIST

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The field of Sociometry deals with the study of interpersonal relations in a group and the structure of the group at the same time. The purpose of Sociometry is to provide new ways of looking for answers. Action Sociometry addresses itself to the cultivation of the initiative and enthusiasm of individual group members to make choices that may be utilized in helping members design or reconstruct their futures. I believe that the therapist who has experienced and utilizes sociometric techniques in his practice will enhance his client's potential for therapeutic growth.

The preparation of competent group psychotherapists has been a concern of sensitive professionals as early as the late forties. At that time Dr. Samuel Hadden (1963) published a paper entitled, "The Use of a Therapy Group in Teaching Psychotherapy," presenting his views regarding the teaching of medical students. Today educators continue to search for and incorporate methodologies and techniques that enrich the armamentarium of the therapist. One such methodology—Sociometry—can significantly enhance professional performance. An understanding of this choice process and its impact as (1) a prime motivating force and (2) a creative growth facilitator can lead to enrichment of the quality of interactions among group participants and provide a sound base for all future personal growth.

A person grows only when he is committed to a belief in his capacity to grow. Growth is more than enrichment; growth blossoms from within. It is a life-long endeavor encompassing more than theoretical concepts and constructs. In growing, one allows himself to experience spontaneity, thus enabling himself to fully utilize his creative resources. It is this spontaneity that propels the individual toward an adequate response to a new situation or a new response to an old situation (Moreno, 1953:42). It is the catalytic element of the spontaneity-creativity dyad, the governing principle of sociometry, manifested in human beings and their relationships (Moreno, 1953).

Recognizing spontaneity as the precursor of creativity the sociometrically oriented therapist (1) focuses on positives and (2) identifies useful, constructive, self-perpetuating elements in the therapy situations of which he is a part.

He invites others to make contributions and identifies what really "is".

He deals with actuality. Only with this attitude will the therapist be successful in promoting candid, open exchange that encompasses a variety of points of view.

Spontaneous therapists appear more able to utilize themselves maximally and to trust their own innate capabilities. The projection of an attitude of confidence in, respect for, and appreciation of the individual is often reciprocal and helps create an atmosphere of trust, support and well-being, a milieu in which the client's potential for "risk-taking" is maximized. The expressed appreciation of others and their unique contributions is consistent with creative behavior and fosters the development and use of one's capacity for accomplishment and change. Creative group leadership involves (1) aiding clients in developing alternatives, (2) enriching identified possibilities, and (3) managing consequences, goals which may be experienced through action sociometric techniques such as role-playing, role-reversal, surplus reality, etc.

Acknowledging that group psychotherapy is based on the dynamics of interaction and the therapist is of importance because of his influence on the group process and milieu, it appears that the therapist's personal sociometric responsiveness is a vital factor in facilitating group growth. Dr. Grotjahn in his discussion of "Qualities of the Group Therapist" writes: "The contact between therapist and patient is probably the most important vehicle in therapy" (1971:757). There is evidence in current literature that irresponsible leadership can hurt clients. Dr. Allen Bergin of Brigham Young University and his associates have identified about a dozen studies that they considered well enough designed and carefully controlled to permit a fair assessment of the effects of therapy. The studies included various types of therapy and nearly 1,000 subjects—delinquent youth, disturbed teenagers, college students, outpatients with neuroses and hospitalized patients with schizophrenia. The effects of psychotherapy were summarized as follows:

Untreated Groups		Therapy Groups
40%	Improved	65%
55%	Unchanged	25%
5%	Deteriorated	10%

Assessment of these subjects showed that therapy helped an additional 25 percent but harmed another five percent of patients. Dr. Bergin suggests that the key factor in determining the outcome of therapy seems to be the quality of the therapist (1975). He found therapists who are psychologically healthy and have the capacity to form deep, trusting relationships with others appear to achieve more positive therapeutic

results. Therapists whose recorded sessions showed high levels of empathy, warmth and genuine concern had much better results than therapists who lacked these qualities.

Qualities attributable to the "good" therapist, as evidenced in a long term study by David Ricks and associates, include:

1. an interest in the more disturbed client
2. capacity to be affectionate
3. willingness to give time and effort to "sicker" clients
4. less concern about inner personality dynamics when improvement can be achieved by direct action and
5. personal follow-up with spontaneous visits by former clients

In contrast, the more ineffective therapist:

1. looks for "easy cases"
2. is easily depressed when confronted by a particularly unpromising client
3. likes details of case histories, fantasies and deep exploration of the personality and
4. becomes frustrated when clients have difficulty providing detailed descriptions (Bergin, 1975).

Therapists do not necessarily need to be paragons of mental health to be effective. Rather, acquaintance with one's own somatisms, anxieties and fears may provide him the basis for a kind of maturity similar to what the child attributes to his parents. More important, in the therapeutic alliance, the therapist must not fear his fears. Martin Grotjahn (1971) identifies the mature therapist as he who has learned how to deal with the inner and outer reality of himself. He is a student among people (his clients) who want to learn how to live.

The sociometrically oriented therapist is sensitive to the process of affiliation and analyzes the patterns of affiliative choice within his group to determine (1) the interpersonal relations of each group member and (2) the organizational structure of the group itself.

With a knowledge of action sociometry the therapist can introduce methodologies for clients to exercise sociometric choice—accept or reject persons according to objective criteria (which, incidently, is a characteristic of mature individuals). Since relationships are what therapy is all about, the sociometrically oriented therapist is able to guide clients in the use of choice, a prime motivating factor and optional ways of choosing so as to create new social atoms and sociometric networks. The client, through various action techniques, can design a new future and experience how tomorrow will be different. Changes in group structure contribute to the individual being perceived differently, reacted to differently and allow the individual the option of relating to the new group in an altered way.

A study of sociometry teaches the therapist to protect the client and to have inherent trust in the group. The group situation provides greater emotional and verbal freedom for the therapist, and the group is an effective "supervisor". The therapist who has been exposed to action sociometry and experienced himself working in a spontaneous, creative manner in relation to others will have also had the opportunity to experience others accepting and loving him just for what he is. The same group members who actively promote often painful self-disclosure will also protect the protagonist until he integrates and gains meaningful closure (Grotjahn, 1971). Unconditional acceptance will tend to act as a catalyst and lead the protagonist to develop a new perception of himself, promoting a beneficial effect on his life and life space (Moreno, 1972). Such an experience reasonably could enhance the therapist's empathy and sensitivity to the pain and joy, fear or other multitudinous feelings his clients experience in the growth process.

The group, because of its very nature, is more sensitive than an individual to the personality of the therapist (Berger, 1963). The therapist can role-model behavior in his interactions with group members, which they in turn can emulate and become extensions of himself. Dr. Moreno has noted that "the internal, material structure of the group is only in rare instances visible on the surface of social interaction; and if it is so no one knows for certain that the surface structure is the duplicate of the depth structure" (Moreno, 1953). (The depth structure becomes visible through action-filled situations i.e. sociodrama with its cocommittant social atoms and sociometric networks.)

Adequate training in sociometry for the group therapist should acquaint him with social factors affecting mental and emotional illness. He should be knowledgeable of action techniques effective in exploring the development and maintenance of affiliative relationships and understand the dynamics of interpersonal choice and its relationship to personal growth (Stein, 1963). Such training is not a matter of the therapist "picking up" some more skills, but rather the laying of a foundation for influencing his viewpoint of man. By viewing man as a social being, functioning in the context of others, one cannot possibly perceive man as a solitary creature. When the psychotherapist is oriented to view man in this manner he avoids the arbitrariness of stance and behavior suggested by Sadler (1969).

> "If one emphasizes as basic states
> of mind anxiety and fear while
> ignoring trust and gratitude, one
> will naturally see man as solitary
> rather than in terms of solidarity"

The development of a therapeutic atmosphere in which individuals can experience the freedom to explore and be themselves with confidence in the support and understanding of other group members is a central goal of the therapist. The growth of the client will be promoted when he functions in a climate of acceptance and trust as he encounters the multiple facets of his human counter-parts in his group experience (Bonney: 1974). The sociometrically oriented therapist appreciates the existence of a process which attracts individuals to one another or repels them (tele) and recognizes this two-way, empathetic phenomenon is the basis of group cohesion, solidarity and stability (Moreno, 1953). Interpersonal attraction and interpersonal respect are essential to a cohesive group. The balance between these two elements will determine the maturity of the group.

The therapist who allows himself to respond to his intuitiveness will more readily restructure his personal role as client's needs alter. He may be called upon to be a facilitator, initiator, catalyst or supporter. Through careful manipulation of the environment he may sociometrically utilize space (territory) by means of role-reversal; time through future projection; and nonverbal communication through gestures, postures and eye-contact as vehicles in the promotion of client self-growth. The therapist's awareness, sensitivity and integrity in structuring growth experiences gains significance when he is aware that leadership style can contribute to negative therapeutic results. Group leaders' styles can be a major cause of group casualties (Bergin: 1975). "Sometimes a group succeeds in spite of the therapist," and when one believes in the innate value of the individual this risk factor appears deplorable (Bonney: 1974).

The sociometrically responsive group therapist who recognizes the choice process as a crucial motivating factor in creative growth, who is open, genuine and willing to guide clients in positive choice experiences and who utilizes action sociometry in spontaneous, creative ways is certainly in a position to enhance client's growth. Action sociometry methods allow the therapist and client to experience: ideas become real, issues become action alternatives and participants develop a greater consciousness and capacity to strive toward self-actualization.

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SOCIOMETRY IN BUSINESS AND INDUSTRY: NEW DEVELOPMENTS IN HISTORICAL PERSPECTIVE

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Part I

INTRODUCTION

A. The effective organization is characterized by (a) an organizational structure or social network and (b) a manner of functioning designed to insure that in all interactions the members will, in terms of their socio-psychological groundings, values, expectations, and hopes, perceive and experience the integrations achieved as supportive of and contributive to becoming the type of person they each want to become.

B. Sociometry is the study of selective affiliation.

C. Life can be viewed as an "uninterrupted sequence of choice".

D. After a period of time, this choice-making activity forms a pattern (on both an individual and on a group basis).

E. This pattern sustains us.

F. Once the group member has developed a pattern, he/she will tend to do everything possible to sustain that pattern (network).

G. Networks and the basic choice patterns can both be changed.

H. A social network change technology exists.

I. It behooves the manager to continuously assess this choice pattern and the social network created by the unfoldment of the pattern.

A rather commonplace observation is that when a group of people come together for even a short time, they organize themselves in some way. This organization is one of the most important strategies used by humans in fulfilling their needs and achieving their goals. This organization occurs because the group members are motivated by a desire for appreciation, a need for recognition, a knowledge of accomplishment, and a feeling that the people in their social atom respect and believe in them. The social atom consists of the individual and the configuration of people to whom a person is emotionally tied. The constellation of this social atom functions as a unit. This means that the worker's primary network may occasionally change in membership but that the external structure will tend to remain consistent over a period of time. For those who cherish the primacy of the group concept the social atom, not the individual, is considered the smallest social unit. (Yablonsky, 1976).

The effective modern organization is characterized by:

1. An organizational structure or a social network
   A. Because of its direct influence and because of the by-products of patterning, this structure is very important
      (1) It sets limits on performance
      (2) Different networks cause workers to behave in different ways
      (3) In terms of corporate health and the achievement of goals and objectives as well as in terms of the emotional well being of the workers, there are what, from a structural view, can be called "bad" and "good" networks.
   B. Networks can be changed
   C. We have the technology to bring about these changes. This technology and the construct that goes with it are particularly valuable for those making OD interventions (See Wessman, 1973).
2. A manner of functioning designed to insure that in all interactions each of the members will, in terms of their socio-psychological groundings, values, expectations and hopes, perceive and experience the interactions as supportive of and contributive to their becoming the type of person he/she wants to be. As Haskell (1975) asserts:

> The choices of . . . spouse, of a business or professional associate, or of close friends may greatly influence the life experience of the individual, his view of the world, and ultimately his self-image. The healthy person, the winner, chooses others who facilitate his expression and stimulate his spontaneity (p. 59).

To facilitate this process of becoming, each person invents, constructs and maintains a social support system that supposedly will fulfill his/her growth needs. The word "supposedly" is used because the degree to which this human network does, in fact, give the person the support and stimulation required, is determined by the level of social skill of the individual. Workers can recruit members for their support system network who are inadequate as support persons or they can develop (or participate in the development) of patterns of interpersonal interaction that are not maximally supportive. The making and maintaining of such a network is a social skill for any worker to have, but for the person in a managerial situation that requires relative isolation from one's peers, this ability to develop sources of support may become the most important factor in one's day-to-day job functioning and in one's career development. The efficacy of one's choices are important determinants of one's

success or failure, happiness or misery (Haskell, 1975, p. 59). For the future manager or for the person managing the "new generation" possession of this skill is absolutely essential. (Stroh, 1971).

SOCIOMETRY IS THE STUDY OF SELECTIVE AFFILIATION. It is concerned with the interpersonal and intergroup relations that are the core subject of the scientific study of all patterns of social behavior (Moreno, 1978). The problem of choice is to be found at the very core of all social science theory. The degree to which a theoretical system attempts to deal with this phenomenon is perhaps one of the most important indicators of the depth and relevance of that system and of the models that are based on its precepts. One of the ways of distinguishing between different theoretical systems is by observing which piece of the choice problem they adopt for their area of emphasis. Sociometry was introduced as a method of study, a therapeutic technique, and as a philosophical position in 1934 with the publication of *Who Shall Survive?* by J. L. Moreno. In that volume, studies dating back into the twenties were reviewed. This means that the sociometrist/manager has access to an accumulation of almost six decades of research using a methodology which makes the study of the choice process, social interaction, group structure and the institutional structure of the organization quantitative, measurable, communicable, verifiable, and generalizable.

Sociometry is the study of the patterns, motives and sociopsychological significance of the choices we make when we select companions for various activities. Primarily sociometry is an assessment technique that asks workers who they would like to associate with in terms of various activities and uses the data obtained to restructure the group for the mutual benefit of those affected by the output of the group and by those who are members of the group. If we borrow a more modern and more informal terminology, we can define sociometry as the scientific measurement of "vibes".

At the level of discussion of personal existence, life can be viewed as an "uninterrupted sequence of choice". Chief among these choices are our selection of associates for various activities. The freedom to exercise this choice has been described as one of the most fundamental human values. The suppression of this freedom may result in a variety of destructive behaviors for both the individual and for the organization. Acceptance and the opportunity to express one's choices with some anticipation of having these choices accepted (not necessarily returned although this is the goal of the chooser) are, more than any other variable, what releases growth forces in the worker. We must continuously choose because:

A. We lose contact with certain others and must "replace" them. This can include geographical changes, promotions, etc.

B. There is a change in our work-social milieu and we need a different set of contacts to provide for our socio-emotional needs.
C. We grow and in the process "leave behind" some of our friends and associates.
D. Changes in responsibilities, roles, and duties may necessitate enlarging our circle of associates (workmates, teammates, friends, and colleagues).
E. Others begin to respond to us differently—they may start choosing, ignoring, or rejecting us and we are "called on" to express our choices.
F. We are in jobs that require such choice making on a more formal basis.
G. People change. If one is separated from an associate for a period of time he/she should not expect the other to remain the same. In fact each time we have a new encounter with an associate we are to a slight degree meeting a "new" person.
H. We may deliberately decide to launch a "self-betterment" program that involves either (a) changing our circle of associates and/or (b) making and concretizing new contacts.

After a period of time this choice-making activity forms a pattern. The individual and those about him may or may not be fully aware of this pattern. Nevertheless, it does exist and provides meaning and lasting value to the life of the worker. It is the primary motivating force. Usually these choices move us in a consistent direction toward a specific goal—but not always. Our choosing patterns can be self destructive for the chooser and counter productive for the organization. There are three ways in which this can occur:

A. All of our choices are not necessarily "wise". We can choose the wrong person at the wrong time for an anticipated specific activity. We may choose only those who, for one reason or another, have no desire to interact with us.
B. We are not always able to accept choice. The degree to which we can extend ourself to "take in" others and the degree to which we can tolerate the risk involved varies from person to person.
C. We do not always have the freedom to choose. The openness of the social system of the organization is the factor that in the main sets the morale and motivation of the group. When the worker is able to exercise choice and has the capability to "choose well" he/she will feel like he/she is a part of the ongoing human experience as it is recapitulated in the work place. The basic motivational appeal of all the ages has been to paint a picture of one's vision of the future. This is true for the salesman, the politician, or the lover. In other

words, anticipation of the future is a motivational force to the extent that the member feels he will experience it with desirable companions and projects himself into the situation envisioned.

This pattern sustains us—we become dependent on it and we view the world in terms of the definitions and perceptions taught us by these in our social atom (e.g. that nucleus of significant others in our environment).

Once the individual has developed a pattern that fits his personality and fulfills his needs, and helps him interact with others as they are involved in their own choice pattern-making process he will do everything possible to sustain that pattern:

A. because the act of making choices and receiving choices and of having one's choices accepted is positively exhilarating. It is the source of one of life's great pleasures and is is a most potent motivating force (Cartwright and Zander, 1968, and Julian, 1966), and

B. the mature self-actualized manager obtains a great deal of his job and professional satisfaction—they fulfill the desire for meaning, accomplishment, and creativity in their work life—through the execution of the organizing function of their role (see Maslow, 1965, pp. 1, 3). They do this when they create a new group that "is their own" that can be viewed as a model or as they work with a collection of individuals of varying abilities, interests, and values and mold them into a group.

Networks can be changed. Managers realize the practical importance of understanding the effects of interpersonal behavior and of the social structure of the management team and of the work group when they attempt to introduce changes and new procedures into the system and encounter resistance or when problems of productivity arise. Unfortunately, the technical planning of work often takes into consideration the best methods to maximize efficiency, minimize cost, keep the union and the EEOC happy and ignores the significance of worker interaction. Altorfer (1977) has studied the development of emotional job fitness in an industrial setting. He observes that there is a need for industrial training to provide assistance and support that goes beyond the distribution of knowledge and skills. Tache' (1978) has made the same point in a discussion of the relationship of stress and human values as these operate in the business world. Knowing more about the social network structure of a work place helps the supervisor make critical judgments that underlie all job performance ratings (Kavanagh, 1972) and places the manager in a much better position to work with the work groups. (Also see discussion by Rothaus, 1965; Meyer, 1965; Thompson, 1970; and Burke, 1972). This is not a suggestion that it is his function or primary function to suppress or

manipulate the group but rather that he may use this information in an effort to integrate the formal and the informal organizations for the benefit of all (Makin, 1962; Haugen, 1964).

A social network change technology exists. (Hart, 1969; 1976). This has been the general theme of this manuscript. More specifically the work of Woodard (1971) should be cited. In a study of the sociometric group restructuralization process Woodard found that group interaction with sociometrically chosen leaders can bring about a change in sociometric status and increase the following perceived group characteristics:

A. Group informality (flexibility)
B. Mutual acquaintanceship, openness to discussion of matters of concern to the group, and ability to anticipate reaction patterns of group members (intimacy)
C. Expansiveness of the group in terms of soliciting new members as appropriate (permeability)
D. Stability of the group
E. Ability of the group to function as a single unit (viscidity).

It behooves the manager to continuously assess this choice pattern and the social network that comes into existence as a product of each member's choices made in conjunction with those of others.

The importance of the manager's ability to effectively utilize these informal group networks is noted by Mayo (1951) who stated that any external attempts to interfere with this social impulse to form groups would lead in some way to management's defeat.

The manager can determine if his assessment of the network in which he operates is up to date by asking himself the following questions:

- Have you studied your choice patterns?
- Who do you choose and why?
- Are those your best possible choices in terms of your personal and work-related human relations goals?
- Are your choices supportive of your career objectives?
- When we choose we choose someone that we perceive will help us become who we (1) think we ought to be (if we are unaware) or (2) want to be (if we are aware and perceptive and socially skillful). What are you becoming? What can you expect to become if you continue your present pattern of social choices?
- Have you studied your total environment in which you work and live?

Consider the questions above in reference to the significant individuals in your life's arena (work, place, home, leisure and civic organizations, and professional groups)—the choice patterns of your subordinates, your peers, your superiors,

your vendors, your colleagues, your clients/customers, your family.

- What interaction patterns—choice patterns—exist in the various groupings that are important in your life?
- Are you aware of the informal groupings in your work place?

Managers and personnel staff members are becoming more aware of the importance of the informal groups which evolve and operate within the larger structure of the formal organization (Soliman, 1972). The basic foundation of sociometry is the axiom that the official (external) organization is different from the sociometric (internal) organization (Moreno, 1953). Sociometrists study the structure and formation of informal groups in the work place and make interpretations and recommendations based on the configurations identified. In this process they are able to ascertain how the informal groupings resemble and differ from the formal organizational structure and how these two configurations can be coordinated (Sensenbrenner, 1955). If the manager fails to make this assessment, he/she cannot have all of the social data that he will need to possess in order to play technical, professional, and managerial roles properly. Each of us lives out our lives as actors—actors in an arena that is peopled by many other interdependent and independent actors each doing their own thing and each participating in the "casting" process through their positive and negative interpersonal choices. Furthermore, the professional futurists tell us that the social maze brightness to operate spontaneously and effectively in even more dizzying arenas consisting of interlocking and overlapping and ever changing interpersonal patterns of a multitude of coinhabitants of our social life space will be the prime prerequisite of the leader and manager of tomorrow's business and industrial organization. (Madden, 1971; Barrett, 1971).

Part II

EARLY STUDIES OF THE USE OF SOCIOMETRY IN BUSINESS AND INDUSTRY

Jacobs (1945) is credited with making one of the first applications of sociometry in industry. He found that sociometric methods had value in a business setting in several ways. They were described as being useful in:

1. measuring morale
2. selecting supervisors, foremen and managers
3. determining informal groups
4. locating social factors influencing production

5. determining how well workers are (socially) adjusting to the work place and to their specific assignments
6. measuring cooperation
7. measuring factors of value in determining merit ratings and bonuses.

Other early studies follow. Browne (1951) used a sociometry-like questionnaire* and other independent measures to study the relationships existing among a group of 24 executives. The data were used to graphically depict (1) the formal organization of the company and (2) interaction patterns. Further analysis of the data on a divisional basis revealed marked differences in the relations existing between the executives in these units. How frequently an executive interacted with others seemed to be correlated with (1) responsibility, (2) authority, (3) delegation of authority.

The author suggested several possible uses of sociometry in industry:

1. in the study of interpersonal relations
2. in the study of communication channels
3. in the study of "methods of performing leadership functions"
4. to identify/suggest needed modifications in personnel relations.

Criswell (1960) examined the use of sociometric choice data in the performance of two functions of personnel administration:

1. placing workers in appropriate jobs
2. placing workers in congenial work groups.

She suggested that the sociometric status an individual achieves in various situations should be viewed by the personnel department as an indication of that persons' social skills and insights needed in (1) administration, (2) liaison, (3) public relations work.**

In a series of three studies of military units plus a sociometric study, Fielder and various associates (1963, 1955, 1958, 1961, 1960) studied the conditions under which efficient utilization of both leader's and members' talents are most likely to occur. They found that:

1. While groups at times may be less efficient than single members

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* The basic premise of the sociometric investigation is that by asking subjects who they would prefer to work with in the future, the investigator is allowing them to participate in a most meaningful way. In expressing their preferences they are participating in the design of the social structure of their future. Obviously, this involvement increases their motivation. We refer to Browne's technique as a sociometry-like test because subjects were asked to indicate the persons they actually DID associate with not who they would LIKE to associate with in the process of carrying out their jobs.

** Criswell's suggestion has been proven to have been a harbinger of the use of group emotional experiences (sociometric, T-Group, and sensitivity training, psycho-dramatic techniques, encounter, TA, and other action approaches) as a major ingredient in in-service training and in the on-going personal and professional development of managers.

working alone "teamwork is essential when the task precludes individuals from independent action."

2. The leader's ability to influence a group and contribute to its productivity and effectiveness depends to a large extent on the cohesiveness of the group.
3. In the uncohesive group, the leader must work harder and spend more time on group maintenance; therefore, little time is left for more direct task-related activity.

Sociometric data can provide important information concerning the determinants and possible approaches to the control of industrial accidents. This is evidenced in two studies—one of school children by Fuller and Baune (1952) and one of steel mill workers by Speroff and Kerr (1952). Both research teams found accident proneness to be negatively related to sociometric status. In the industrial study it was recommended that the frequency of industrial accidents could be reduced through a program designed for the sociometrically unchosen. Such a program would consist of two elements, sociometric reassignment and active counselling.

Herringa (1951) studied group formation in industry and recommended the following "blueprint" for a sociological study of an industry:

1. a general orientation through the personnel and social services departments
2. a written questionnaire for individual workers for the detection of frictions among them
3. systematic sociometric interviews yielding the pattern of sympathies and antipathies in a department
4. report not only to the management, but also to the personnel.

Rogers (1946) studied human problems in industry and was convinced that the most significant contributions to the understanding of the psychological problems of the worker has been made by: (1) J. L. Moreno in the form of sociometric measures, and (2) The Harvard Business School group (Roethlisberger, Dickson, et. al.).

Skibbell (1952) reports the results of two investigations completed in a successful effort to demonstrate the application of sociometric analysis. One of the contributions of this study was the first use of the hierarchy and locometric sociograms. It was concluded that the structure of the human relations in an organization are shaped primarily by the likes and dislikes of persons for other persons. Levels of sociometric status were described as:

1. Supporters (stars): Their influence was felt in all departments and on all floors of the organization they . . . served as subrosa channels of communication, both upward and downward, in the authority

hierarchy of the organization. It can be inferred that management, by constructive interviewing, can use supporters as a focus point of control; as terminals for sounding out established store policies, as informers concerning innovations (p. 116).

2. Outcasts (rejects): It was ascertained that they were predominant in producing conflict with the organization (p. 116).
3. Isolates: . . . need aid in integrating themselves into the organizations. Job satisfaction *not work satisfaction* aids the cause of efficient operation. An isolated individual cannot achieve the same degree of job satisfaction as an individual who is well integrated into the group. Should management institute a program to aid isolates in their integration, a follow-up sociometric study can be used to check the effectiveness of the program (p. 116).
4. Fringers: Fringers were referred to by the personnel department as the "questionables".

Strauss (1952) conducted a study of a local union to determine the effectiveness of direct observation as a source of quasi-sociometric data. He found that such a process could be used to: (1) Measure the consistency in contact and interaction between members and leaders over a series of meetings and (2) Identify cliques, isolates, and other social phenomena.

Van Zelst (1952) described the following as being applications of sociometry that may be usable in the industrial situation:

1. Supervisory selection
2. Buddy work teams
3. Individual therapy
4. Combating race and group prejudices
5. Studies of informal organizations
6. Studies of accident proneness

For success in using this technique it is essential that:

1. Management have a democratic approach to its workers
2. Management recognize the importance of group relations and
3. Management manifest an interest in worker preferences.

Further, it was noted that the sociometric approach must allow social situations to define themselves and allow the participants in the situation to define the nature of their own needs and problems.

The work of Weshler and Associates (1960, 1952) should be noted. They were able to develop multi-relational indices as composite ratios utilizing data on various types of relationships applicable to both individuals and groups: normative, perceived, action, positive, negative.

When workers attempt to conform to the external and internal system of a group when these are in normative opposition, personal conflict is the

result. In a study of life insurance personnel by Wispe (1955) a set of six sociometric questions were used to provide data hopefully usable in the further examination of this phenomenon as it applies to that industry. Salesmen were asked to choose:

1. "an assistant for the day on the debit",
2. a person to present a new sales plan,
3. a house guest for a social evening,
4. persons to whom they would turn for insurance information,
5. the most aggressive man in the district, and
6. the man with the most technical insurance information.

Other studies of interest are included in the reference section of this article.

Part III

VALUES OF THE SOCIOMETRIC TECHNIQUES FOR USE IN BUSINESS AND INDUSTRY

What Does a Sociometric Technique Measure? (Major Variables)

Lindzey (1954) in a classic review of sociometric literature examined "empirical concepts definable in sociometric operations" i.e. ". . . the major variables of psychological interest that sociometry measures have been used to assess or appraise." The variables listed are: Leadership, Minority group prejudice, Social adjustment, Social sensitivity, Social status, Morale, Group structure.

What Does the Sociometric Technique Measure? (Other Variables)

The sociometric technique can be used to measure the following:

1. Role integration
2. Need competence
3. Personal and interpersonal effectiveness
4. Employee task orientation
5. Identification of community/political power structures
6. Leadership ability
7. Importance of various value configurations as status determinants in a given setting
8. Dependence behavior
9. Need autonomy

10. Expression of aggressiveness and assertiveness
11. Degree of group internalization of official norms
12. Functions of slang in shaping group reaction patterns
13. Alienation
14. Race, sex, age or other cleavages
15. Rejection patterns based on race, sex, age or other factors
16. Conformity
17. Intimacy level of the group
18. Balance between peer orientation and self orientation
19. Incidences of scapegoating (second hand rejection)
20. Altruism
21. Overt achievement behavior
22. Determining level of cooperativeness in a group
23. Identification of accident prone workers
24. Effects of rejection
25. Fear of success and fear of failure
26. Selection of the unprejudiced
27. Causes of depression
28. Ego functioning
29. Personal effectiveness
30. Group flexibility
31. Group integration
32. Basis of orientations and self concepts
33. Dissemination patterns of rumors
34. Relationship of shame and self esteem
35. Stages of group/team development
36. Behavior of marginal groups
37. Social responsibility
38. Personal success patterns
39. Social effectiveness
40. Trust
41. Spontaneity and barriers to spontaneity
42. Identification of creative potential
43. Identification of ulterior motives
44. Influence of spatial distribution of workers on various behaviors
45. Tentative identification of alcoholics
46. Tentative identification of violent and suicidal individuals
47. The function of pain in the inner life of the chronic pain patient
48. Public attitudes and opinions (at an incredibly high level of acceptability)
49. Identification of "real neighborhoods" in the community
50. Decision making styles of a group.

What Does A Sociometric Test Measure? (Special Aids for Management)

Sensenbrenner (1955) made an analysis of the feasibility of applying sociometry to industry and concluded sociometry could aid management in accomplishing a variety of tasks. Quoting her (Ibid., pp. 104–5) these are:

1. Effecting a better integration of the informal groups' objectives with those of the formal organization.
2. Introducing change to the work group in such a manner that old relationships are not destroyed.
3. Placing emphasis on those motivational drives which are truly significant to workers reacting as members of a group.
4. Selecting foremen that have displayed leadership qualities on the informal level by being chosen as informal leaders.
5. Helping new supervisors adjust to their jobs in a minimum of time by allowing them to study the informal interpersonal relationships of their new department even before they take active charge.
6. Providing a means whereby minority groups may be peacefully and orderly assimilated into work groups.
7. Increasing the cooperation that gets the job done when the formal organization fails or is faulty.
8. Increasing the teamwork that raises productivity.
9. Allowing individuals to better understand their own working relationships.
10. Accomplishing a more complete tying together of the informal groups to the formal organization.
11. Building more compatible work groups and teams, by fitting the worker to a group just as he is fitted to a job.
12. Permitting a closer analysis of the social situation of the working environment to determine whether the worker is well adjusted to his job.
13. Understanding and using the underground communication system to better put across its messages to the workers.
14. Determining better the state of morale of the groups in the organization.
15. Making possible the partial measurement and control of an individual's morale.
16. Controlling the interactions between individuals and groups in order that social and working harmony is encouraged.
17. Performing the job of managing better by permitting management to have a better fix on how things really are at the informal operative level.

Reliability and Validity of Sociometric Data*

Reliability

Although many sociometrists (Jennings, 1959; Northway, 1952; Lindzey and Borgatta, 1954, 1968; Gronlund, 1959; Bonney, 1960; Bonney and Hampleman, 1962; and Pepinsky, 1949) have questioned whether typical methods used in "determining the reliability" of sociometric techniques apply, certain methods have been employed and have generally indicated reliability until better procedures have been developed to overcome the limitations of utilizing methods developed by psychometric—not sociometric measurement. These have been outlined by Davis (1965), who in the process of completing a more comprehensive study, made a survey of studies to determine the reliability of sociometric instruments. She surveyed four methods for testing the reliability of sociometric devices. They were: (1) Interpretive "reliability", (2) Internal consistency (split half), (3) Equivalent or alternate forms reliability, (4) Test—Retest reliability.

The following points seem to summarize what we know about the reliability of sociometric techniques and sociometric data.

1. The sociometric pattern of a group will stay about the same even though the number of choices specific individuals may give or receive may vary greatly.
2. Reliability is greater with adults than with children.
3. When first, second, and third choices are used, the first choices are more stable than the second choices, the second more stable than the third.
4. The longer the group has been in existence, the more stable the choice pattern.

Validity

In the study mentioned above, Davis, (1965) also surveyed studies to determine the validity of sociometric instruments and discovered that

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* It is felt that to give a complete analysis of the factors involved in the reliability and validity of sociometric data was beyond the scope of this article. Therefore, this section is limited to a very brief comment with regard to this subject. Hopefully the reader with a more specific interest in this area will find the references mentioned valuable as a starting point for any investigation he/she may wish to undertake. The authors also recommend the works of Schaeffer, 1959; Jennings, 1948; McDermott, 1964; Gronlund, 1955, 1958; Gronlund and Holmlund, 1958; Moreno, 1956; Criswell, 1939; Forland and Wrightstone, 1951; Naia, 1959, and Werdelin, 1969.

three different approaches have been made to validate sociometric instruments. They are:

1. To declare the test valid by definition (face validity) if the subjects appear to have been well motivated
2. Compare the sociometric results with the results obtained from measures of related personal and social factors
3. Compare sociometric results with measures of successful group performance.

It was reported that when the last two methods were used there appeared to be "relationships between sociometric status and psychological and sociological factors which might be logically related such as personal and social adjustment, social acceptance and successful performance in groups . . ." and that ". . . relationships between the sociometric status result and the result from personal-social adjustment or social acceptance test . . . usually are indicated by low and positive correlations . . ." and that ". . . when extreme sociometric status groups . . . are compared, the high sociometric status groups generally are rated significantly higher scores than the low group on measures of personality traits which are interpreted as indicating more effective social and personal functioning. (Ibid., pp. 41–42).

Part IV

THE PROMISE OF ACTION SOCIOMETRY AS AN AID TO MANAGEMENT

Action sociometry is a new development,* and may be defined as an actional and experiential method that has as its objective the use of "derived sociometry" (active intervention techniques suggested by sociometric theory and research, but not actually utilizing the original sociometric measuring techniques) as well as more traditional sociometric methods used in a more dynamic-actional way to help group members (1) develop skills in making and maintaining interpersonal relationships, and (2) become more capable of directing their own lives through better understanding of (an application of) the concepts of choice. Action sociometry focuses on helping the group member personally utilize the principles derived from sociometric research. In the words of Haskell (1975):

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* This technique was formally introduced by one of the authors while he was serving as organizer and leader of the sociometry symposium of the 6th International Congress of Group Psychotherapy, Philadelphia, Pennsylvania, July, 1977.

sociometry can provide an instrument which each individual can employ to gain better understanding of his position in the groups in which he functions, his relationship to other people in them, how they relate to each other, and ultimately, whether to stay in them, take the steps necessary to improve his position in them, or abandon them for others in which his needs can be better satisfied (p. 58).

Characteristics of action sociometry are:

1. It is an actional process.
2. The basic sociological/psychological conditions of aloneness and physical isolation are regarded as entry devices into the psyche of the individual and thereby a starting point in making an intervention into the appropriate larger system.
3. Emphasis is placed on anticipation and motivation as the primary forces in change, educational, and therapeutic processes. Anticipating the future in which one is chosen and has one's choices accepted is always motivational to the extent that a person projects oneself into the situation envisioned.
4. Multi-faceted and multi-level choosing are taken into account. An exciting new technique and research tool called hypnosociometry (conducting sociometric investigations of a group while members are in a state of relaxation) is being developed to improve our abilities to work with these phenomena.
5. Is interested in the study of group-to-group choosing.
6. Regards sequential growth as "power" building.
7. Holds as a basic postulate that choosing itself is therapeutic, learning facilitative, and change inductive.

The future development of action sociometry will widen the range of application of sociometric processes in business and other settings. The purpose of this section is to call attention to several provocative possibilities. The reader is asked to withhold judgment and let his imagination soar as he/she examines these suggestions. An invitation is extended to the reader to pursue the leads offered here in the conduction of his/her own affairs and is encouraged to add to what we have done. He/she is urged to use the concepts gained for individual benefit in those ways that will accelerate both personal and professional success. These possibilities are:

1. Tarrab (1977) is involved in a series of projects designed to study *functional leadership*. Inspired by the basic (cultural) systems approach of Levi-Strauss, he has designed a research approach that combines sociometry, Bales process analysis, and systems analysis to study this phenomenon. The central hypothesis of this research is:

> a group in process of establishment represents a system that is an assemblage of relations which are maintained, which evolute and become transformed in a cyclic manner but always according to a general pattern . . . and this independently of things after Durkheim . . . which they tie together (p. 1).

2. Action sociometry should be explored as a tool in contingency management. Sociometry deals with the choices of actors *in situ*. It is a measurement and recording of each group/team member's desired "*future of interaction*" *in a specific situation.** By obtaining a composite time projection the futuristic manager/researcher will be able to identify what contingencies we face in terms of human phenomenon and develop plans for the management of available resources to meet these eventualities.
3. Action sociometry can be a valuable tool in the study of interorganizational linkages for the purpose of identifying the best social pathways for the diffusion of innovations i.e., the use of social networks for diffusion of innovation. (Hart, 1979; Paul, 1976).
4. The use of action sociometry in spotting potential business leaders early (Byham, 1970; Bonney, 1969).
5. The study of sociometric perception and feedback. For example, the study of rejection and sociometric cleavage in the workplace would be an important subtopic to be investigated. For illustrative purposes an outline of the content of this subtopic follows:
   - I. Results of fear of rejection
     - A. Impair functioning at work
     - B. Interfere with interpersonal relationships
     - C. Stifle creative expression
     - D. Make one less capable of playing
     - E. Has negative influence on intellectual pursuits
   - II. Fear of rejection is an emotional phenomenon
   - III. You create yourself being rejected.
     Rejection and the preconceived fear of being turned away is what you do to yourself, not what someone else or the world is capable of doing to you.
   - IV. Importance of understanding the significance of the choice process as a beginning in the process of learning to deal with one's fear and experience of rejection.

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* As used in this context a situation as a conceptualization is the product of one's conclusions regarding (1) the effect of moving events, (2) one's acceptance of non-acceptance by significant actors involved in the event, and (3) one's continuity of existence (as an active or as an inactive participant), (4) psychological integrity, and (5) ability to maintain one's self in a future.

6. Action sociometric theory and research as the basis of a new theory of normal personal, leadership, and managerial behavior. Maslow's self actualization theory is stimulating and provocative. Unfortunately it does not readily lend itself to empirical validation. An alternative that would produce a testable theory of normal behavior could be derived from selected works of two individuals, Merl E. Bonney, (1969) and Rudolf Dreikurs, (1971).
7. Action sociometry is a valuable tool for the organizational development (OD) trainer/practitioner. The OD approach aims at organizational climate and a system of beliefs, values and attitudes which determines the way people relate to each other and to authority figures. The emphasis is on openness, authenticity, and confrontation. There is a bias toward the interpersonal and the interactional (Bolembiewski, 1974). However, it is possible for the OD practitioner to follow the easy road, select only one level at which to intervene and rely on comfortable interpersonal-interactional influence strategies appropriate for only one level and more comfortable for the practitioner. When this happens, (A) The OD practitioner may fail to extend the applications of their interventions to intergroup and structural issues, (B) The OD practitioner may have difficulty in dealing with the multiple memberships of the target population, and (C) select an inappropriate level of focus and attempt to apply micro-level interventions to macro-level problems.

As business consulting and the use of human behavioral science technologies have advanced from decade to decade, there has been an increased concern for dealing with more complex problems at higher and higher levels of management. The future step in this process is proposed to be an intervention process combining the technology of action sociometry and OD. Sociometric and action sociometric measures possess a number of qualities that make them of special interest to the OD practitioner. Among these are:

A. Interdisciplinary popularity
B. The development of these measures is not associated with any one discipline
C. Their capacity to represent individuals in interaction within a miniature social system, makes it possible to study the "individual and the environment simultaneously"
D. Are inexpensive and extremely cost effective
E. Can be costed as a part of an operating budget—not necessarily as a part of a "funded" project
F. Are good for use in exploratory and feasibility studies
G. Ease and speed of administration of all these techniques.

8. The principles and techniques of sociometry and action sociometry can be of value for personal use of the manager, professional, and supervisor.
9. Sociometric and action sociometric techniques designed to measure group styles might be used as either a supplement or alternative to the "managerial" grid. Components of this proposed process would be:
   A. A new approach to measuring "focusing power" and *effective cohesion* of the group or team
   B. Identification of the configuration of decision-making styles in a group
   C. Identification of the configuration of the internal creativity styles in a group
   D. Identification of the configuration of learning styles in a group
   E. Examine the interrelationship of focusing power, effective cohesion and these three styles configurations to explicate a *group style profile.*

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TRIANGULATION: PITFALL FOR THE DEVELOPING CHILD

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The term individuation refers to a quality of relationship between people in a family (or other group). In a highly individuated family, boundaries between individuals are clear, yet permeable. Respect for individuality, uniqueness, similarity, and difference, is the ground for true mutuality and thus for cohesiveness and intimacy among family members. In unindividuated families, individual boundaries are not clear. Family members project owned and/or disowned parts of the self onto others. For instance, in an unindividuated family or family subgroup, individuals may experience an enmeshed sense of "we-ness" in which there is not delineation between own and others' feelings. If I'm sad my sense is that the other is also sad. An example of projection of unowned aspects of the self into another would be a marriage in which the myth is that she has feelings and he is rational—she senses and expresses feelings for both; he accepts all responsibility for making decisions. In an individuated family, family members are more similar than in an unindividuated family, in that each is more complete, more aware and accepting of all parts of the self. At the same time in an individuated family, family members are more different because each person's characteristics are perceived with a high degree of accuracy, unclouded by projections of the perceiver's own needs and feelings.

The level of family individuation in a family may be seen to derive from parental self concepts. Parents with clearly differentiated selves have a more realistic perception of self and others and can thus create an atmosphere of empathic acceptance in the family. A parent with a less clear sense of self will be more likely to project own moods and tensions onto a mate or child, responding selectively to those moods and tensions in the other which correspond to the parent's own state, or will tend to be preoccupied with own moods and thus be less responsive to the other. In an individuated family, interpersonal stress is less, both because there exist more realistic perceptions of each individual and because individuals are acknowledged as separate persons. There is less need for certain individuals to be or feel a certain way to meet the personal needs of another individual. A parent, for instance, is less likely to try to meet his

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own needs through identification with a child. When family members are distinct and autonomous, the child enjoys validation in the form of realistic feedback to her expression of feelings and thoughts, and to her behavior. She also has the freedom to expand herself by experimenting with alternative behavioral styles, and equally as important, she can receive constructive feedback from other family members to help her select successful styles. Without an individuated family environment, the lack of empathy for the child's state fails to provide the necessary ground for the child's development of self esteem and a strong self concept. (See Kohut, 1971, 1977).

One family structure which reflects a lower level of individuation often revolves around a method parents can use to avoid stress between them. This process is called triangulation (Anonymous, 1972; Haley, 1967). The term is used here to refer to two types of coalition formation in the family. The first is a type of scapegoating. (Vogel and Bell, 1968; see also Schmidt's, 1968, discussion of the united front family). When there is stress in the marital system, the husband and wife may react by focusing their attention and conversation around their child's problems, thus avoiding dealing with the conflict between them. Another method of dealing with marital stress is for one parent to pull in a child for support, orienting conversation around the faults of the spouse. This cross-generation coalition leaves the spouse in the position of a distanced, dissimilar outsider (see Schattschneider, 1960, for a discussion of the same process in the political sphere). Over time, families develop relatively stable patterns of triangulation (Anonymous, 1972, pp. 123–124). Both forms of triangulation are invalidating to the child because she is related to out of the needs of the parents rather than out of empathy and respect for her own needs. Her own understanding of her behavior is often denied by a parent who defines the child's behavior according to the parent's needs.

Because both types of triangulation are invaliding to the child, both are expected to interfere with the development of her self concept and to restrict her social and emotional development. It is hypothesized that triangulation of a child into the marital system will be negatively related to the child's personal development. By personal development, we refer to the skills and personality structure the child has (or has not) developed that enable her to act effectively in her environment. This includes variables such as ego development, self-acceptance, self-control, and interpersonal effectiveness.

Method

Between October, 1975 and June, 1976, 99 families participated in a

structured 2-hour interview in their homes. We sought a homogeneous population (white, middle class, 2 and 3-child families, with a 15–17 year old girl) in order to minimize extraneous variance. The identified adolescent girl in each family had previously completed Loevinger's sentence completion measure of ego development (Loevinger, 1966; Loevinger and Wessler, 1970), a shortened California Personality Inventory, and a sociometric survey completed by about 3500 freshman and sophomore students in their high school.

Families were contacted first by letter, then by phone; the person making the telephone contacts was not an interviewer; she knew nothing about the status of the adolescent and little about the specific goals of the study. Of 215 families invited, 99 agreed to be interviewed. Families who declined the interview usually gave lack of time or a concern for maintaining their privacy as reasons. There were no significant differences in the group of families which declined the interview, compared with the group which accepted, in age, father's education, mother's education, number of children in the family, religion, or position of the identified adolescent (oldest, middle, or youngest). There was a difference in the functioning of the identified adolescent, as measured by the psychological and sociometric tests. Families who declined had, on the average, adolescents who scored less well on a summary score of these measures ($t=2.30$, $df=216$; $p<.03$, 2-tailed test).

Families participated in a structured home interview. Immediately after the family members had given their written permission for the interview, they completed individually, a 63-item True-False questionnaire about their family. This questionnaire was a shortened version of the Moos Family Environment Scale (Moos, 1974). Answers to the questionnaire are used to construct our measures of scapegoating and cross-generational coalitions.

Measurement of triangulation

Because scapegoating and coalitions are relatively difficult to observe, we constructed indirect measures of each. We expect that in any long term coalition (either a cross-generational coalition or a coalition in which parents distance the adolescent), the allies in the coalition will tend to become similar to one another and more dissimilar from the excluded person. This is because persons in the coalition are more likely to share their perceptions and attitudes with each other, including those about the family. Also, since they define themselves as similar to each other and different from the outsider, they are most likely to accept each other's perceptions and reject the outsider's views. The same process would lead

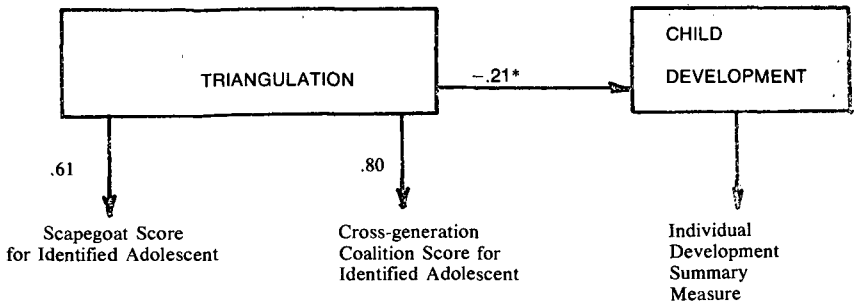
the person triangled "out" to define herself as seeing things differently from the other two. We thus look for evidence of scapegoating and cross-generational coalitions in the perceptual/attitudinal congruence among different pairs of family members.

To test the hypothesis, then, we assumed that the pattern of differences in how family members described the family climate (on the true-false Family Environment Scale) is a manifestation of their perceived closeness or distance from each other. A scapegoated child will be drawn into the position of increased disagreement with the parents as differences between child and parents are focused on and reinforced in this triangulation. When the child is in a cross-generational coalition with one parent, to the exclusion of the other, there is exaggerated agreement between coalition members and exaggerated disagreement between the child and the excluded mate.

To test the hypothesis, three dissimilarity scores were developed: one for the husband-wife dissimilarity (HW), and one for the dissimilarity between the identified adolescent (the one for whom we have psychological data) and each parent (husband-adolescent, HA; wife-adolescent, WA). The dissimilarity scores were found by calculating the proportion of items the two people disagreed on for the Family Environment Scale. Our interest was not in how much family members disagreed or in whether some families had more or less disagreement than other families, but in the *relative* amounts of disagreement between family members. Scapegoating and coalition scores were thus developed using the amount of disagreement between the two parents as a baseline. A *scapegoating score* was calculated for the identified adolescent by finding the dissimilarity of the child from both parents relative to the HW distance; i.e., (HA + WA) / HW. This score thus represents the adolescent's isolation from parents; the more distant she is from both parents relative to the interparent distance, the higher the scapegoating score. A *coalition score* was calculated by finding the imbalance in the child's dissimilarity from the parents relative to the HW dissimilarity (dividing the HW distance into the absolute value of the difference between the two parent-child dissimilarities), i.e. / HA—WA/ / HW. Thus the closer the adolescent is to one parent relative to her distance from the other parent, the higher her coalition score.

Measurement of adolescent functioning

Following a factor analysis of the individual psychological variables, four scales were devised for each adolescent: ego development (Loevinger), sociometric (popularity and mutuality of choices), self ac-



* p = .02

Figure 1. Effect of triangulation into the marital system on child development.

ceptance and sociability (CPI), socialization and self control (CPI). A gross measure of individual development was achieved by summing the adolescent's standard scores on these four individual scales.

Results

The hypothesis, that triangulation (either by scapegoating or cross-generational coalition formation) would be negatively related to child development, was tested by relating the individual development summary measure for the identified adolescent to a triangulation variable constructed of the child's scapegoat and coalition scores (see Figure 1). The results support the triangulation hypothesis. The estimate of the causal effect of triangulation on child development was significant ($p=.02$) in the predicted direction.

Discussion

Support is found for the hypothesis that triangulation of a child into the marital system is detrimental to that child's development. The sample was a group of unlabeled (normal) families. The results point to the importance of understanding the individual as part of the larger system and respecting the power of the family system to impact on the development and growth of the individual. Even an adult, no longer living with the family, is subject to the pull of the triangle (see Boszormenyi-Nagy and Spark, 1973; Framo, 1976). The pull of the family triangle can hamper the individual's attempts at self differentiation and self actualization. The same family

triangle will effect the individual's integration into a therapy group, or any other group, in that the individual will tend to recreate the known, the interpersonal pattern which is comfortable and predictable. This tendency, when the individual is made aware of it, can provide impetus for meaningful personal growth.

The family system aside, triangulation is a dynamic present in all groups. Awareness of this process is an especially important asset for the group therapist. As tension arises between individuals in the group, a strong tendency develops for one person in a conflicting dyad to pull an outsider into a coalition, for group members to focus on something else outside the group, or to scapegoat one of the group members. Highlighting this process for group members will help all maintain clarity about individual identities and interpersonal boundaries.

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PROMOTING SOCIAL COMPETENCE IN EXCEPTIONAL CHILDREN THROUGH PERSPECTIVE TAKING AND SOCIODRAMATIC ACTIVITIES

RUNE J. SIMEONSSON, LYNNE B. MONSON AND JAN BLACHER-DIXON

Although exceptional children may differ widely from each other in terms of etiology and severity of handicaps, they often share the common characteristic of deficient social competence. Evidence for current interest in the social competence of exceptional children is reflected by a substantial growth of attention devoted to this topic in the professional literature. The timeliness of such interest for retarded persons has been indicated by Kleck (1975) and Affleck (1977) who stress that social incompetence has been a concept central to defining mental retardation from a practical as well as an historical standpoint. A recent conference focused on the relevance of social competence to psychopathology (Kent & Rolf, 1979), and Caparulo and Cohen (1977) have stressed the importance of investigating dimensions of language, cognition and social competence in autistic and aphasic children. Furth (1979) and Volpe (1976) have commented on the social awareness deficits of the deaf and the orthopedically handicapped respectively.

An overview of the literature indicates that social competence has been defined in a variety of ways and equated with a variety of behaviors. Simeonsson (1978) identifies five major approaches—social maturity, vocational adjustment, adaptive behavior, instrumental competence and interpersonal competence—in a review examining definitions and assessments of social competence in the developmentally disabled.

In this paper, the interpersonal competence approach to defining socially competent behavior will be considered, with a review of some of the essential skills involved. For example, O'Malley (1977) has suggested that social contracts are critical for developing interpersonal competence. Weinstein's (1973) theory of interpersonal competence emphasizes three components of socially competent behavior: (a) to be able to take the role of the other in social situations; (b) to have a range of interpersonal tactics; and (c) to be able to implement these tactics when appropriate. In this context, it is clear that skills such as taking the role of another and communicating effectively are important. These skills have been investigated in social-cognitive research (Shantz, 1975) and include the dimensions of role-taking, empathy, moral judgment, and referential communication.

Merging Weinstein's theory with research on social-cognitive skills provides specific ways in which to operationalize the assessment of interpersonal competence in exceptional children. Perspective-taking tasks, for example, can be used to assess how handicapped children establish identities in social encounters.

Social Cognitive Skills in Exceptional Children

Research on perspective-taking and other skills associated with the development of social cognition in exceptional children have emerged in the recent literature. There are at least three types of studies representative of such research which are relevant to this consideration of perspective-taking:

1. Exceptional children have, in general, been found to be deficient in role-taking ability. In a series of studies with mildly and moderately retarded children and adults, Affleck (1975a; 1975b; 1976) has found that role-taking ability was associated with more mature interpersonal tactics and appropriate interpersonal skills. Chandler (1973) and his associates (Chandler, Greenspan, & Barenboim, 1974) have documented deficits in the role-taking skills of delinquent as well as emotionally disturbed children. Children with sensory handicaps such as the deaf (Bleasing[1]) and those with motor handicaps (Volpe, 1976) have also been found to have less mature perspective-taking skills than their non-handicapped peers.

2. Perspective-taking may also be related to communicative effectiveness in children. In a series of studies, Longhurst (1974) demonstrated that the retarded child's ability to communicate is not simply a function of vocabulary or IQ, but of perspective-taking ability as well. Employing a speaker-listener paradigm for referential communication, Longhurst (1972) found that mentally retarded adolescents could follow their own instructions but were inadequate in their communication to others. The retarded adolescents thus demonstrated their failure to take into account the listener's needs, despite the fact that they had demonstrated the possession of appropriate communication skills.
3. Deficient perspective-taking may also be expressed in the failure of exceptional children and youth to take into account the intents and consequences in moral judgment tasks. In recent research on moral

1. Blaesing, L. *Perceptual, affective, and cognitive perspective-taking in deaf and hearing children.* Unpublished doctoral dissertation, University of North Carolina, Chapel Hill, 1978.

judgment, Foye and Simeonsson (1979) found that the moral judgment of the retarded adolescents and adults was similar to that of first graders but characterized by individual variability. Hence, some retarded individuals are "competent" and some are not in making moral judgments involving differential intent and consequence.

Adolescents who are delinquent or characterized by behavioral pathology have also been found to demonstrate immaturity in judging intents and consequences. In a study comparing the moral judgment of psychopathic, neurotic and subcultural delinquent males and a group of matched nondelinquent adolescents, the psychopathic group was found to be reasoning at less mature levels than the other three groups (Jurkovic & Prentice, 1977). Psychopathic and neurotic delinquents also displayed less reciprocal role-taking than the controls and subculturals. Although the findings support the interpretation that the psychopathic delinquent is deficient in assessing the perspectives of others as well as making judgments of moral behavior, variability across groups indicates that delinquency should not be seen as a unitary syndrome in this regard.

The above research findings indicate that deficient social cognitive skills is one characteristic of exceptional children. The fact that not all children lack effective interpersonal skills suggests that factors such as social experience (Volpe, 1976; Newman and Doby, 1973) may account for individual variability in these domains. This conclusion suggests that specific interventions to enhance perspective-taking behavior could be a potentially effective strategy for the development of socially competent behavior. Some of these interventions have been demonstrated; others need further exploration. The major evidence supporting intervention to promote social competence comes from experimental studies and from clinical reports.

Promoting Social Competence

The following sections will demonstrate, in general terms, how certain experimental or therapeutic procedures can promote the development of socially competent behavior. One procedure is the experimental manipulation of perspective-taking through which subjects recognize that other people have views or perspectives different from their own, thus learning to "take the role of another." A second procedure involves the use of sociodramatic activities, in which subjects are given the opportunity to "play" different roles in order to learn appropriate behavior, improve interpersonal relationships, and enhance personality development.

Perspective-taking Activities

In a recent experimental study (Blacher-Dixon and Simeonsson, 1978), retarded children of comparable intelligence and age were grouped according to high, intermediate or low role-taking ability. An experimental task, in which children were required to adopt perspectives or viewpoints different from their own, i.e., to "stand in the shoes of another person," was then administered to promote role-taking performance. The procedure was found to be differentially effective, in that the performance of the high and low groups remained unchanged across two testings, whereas the intermediate group improved after the experimental intervention.

A more general type of intervention was carried out by Chandler, Greenspan and Barenboim (1974) with 48 institutionalized emotionally disturbed children who were shown by screening procedures to be deficient in role-taking and communication. One third of the subjects were enrolled in a 10-week training program which used drama and the making of video films as vehicles for teaching role-taking skills; another third were involved in a 10-week training program which used communication games in order to improve their referential communication skills; the last group was the no treatment control group. Subjects in both experimental groups improved significantly in their role-taking ability and subjects who received the communication training showed improvement in their communication skills as well. Of particular significance is the fact that a 12-month follow-up showed that such improvements were associated with improvements in social adjustment. Similar findings on the effectiveness of intervention have also been found with chronically delinquent boys initially deficient in role-taking skills (Chandler, 1973).

A study of institutionalized emotionally disturbed children 8–15 years old (Gelcer, 1978) incorporated both perspective-taking and sociodramatic activities as intervention techniques to increase role-taking and socially competent behaviors. Post-intervention results included improved perspective-taking skills and less maladjustive behavior in school for those children who had participated in the social cognitive intervention as compared to a control group who did not receive the intervention.

Referential communication skills, that is, skills of a speaker to utilize referents which effectively take into account the informational needs of a listener, have also been the focus for intervention with exceptional children. In a study involving deaf children, Hoemann and Farquharson[2]

2. Hoemann, H. W., & Farquharson, S. *Referential communication training of deaf children.* Paper presented at the fifth biennial Southeastern Conference on Human Development, Atlanta, 1978.

demonstrated that the provision of experimental referential communication training improved those skills. The effectiveness of referential communication training has also been demonstrated with mentally retarded children by Mandelkorn and Corman[3] who found that such training seemed particularly effective for situations requiring verbal problem-solving and communication to a listener.

Sociodramatic Activities

The second major strategy to promote social competence is based on the use of sociodramatic activities. The use of sociodramatic activities as a vehicle for social development has been proposed specifically for the mentally retarded (Foster, 1975). A creative dramatics workshop described by Blumberg (1976) was designed to enhance personality and social development of the mentally retarded with an ultimate goal of improving job potential. The advantages of using role play to develop social interaction and appropriate job behavior have been cited by Robinson (1970) from experiences in classes with retarded adolescent girls.

The use of sociodramatic activities as part of a deinstitutionalization program for retarded adults has been described by Klepac (1978) as contributing to successful placements for these clients. The technique allows them to learn to function more effectively and less fearfully in social problem solving situations.

Although the application of sociodramatic activities may seem more appropriate to older children or adults, its effectiveness with severely retarded preschoolers (Strain, 1975) and with behaviorally disordered preschoolers (Strain and Wiegerink, 1976) has also been demonstrated. In both of these studies participation in sociodramatic activities, in which the children assumed various roles of characters in a story, was associated with an increase in observed social play. Among culturally disadvantaged preschool children the amount of sociodramatic play, seen as one index of role-taking ability, has been found to be significantly less than among advantaged children (Rosen, 1974). The provision of instruction and practice in sociodramatic play for forty days resulted in significant improvements in group problem-solving behavior, in problem solving in tasks involving cooperation vs. competition, and in role-taking skills.

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3. Mandelkorn, B., & Corman, L. *The effects of two training models on communication-related abilities and intelligence in young IQ-defined EMRs.* Paper presented at the biennial meeting of the Society for Research in Child Development, Philadelphia, 1973.

Conclusion

The above review has identified some common patterns of delay and/or deficiencies in the social perspective-taking skills of exceptional children and youth across a variety of handicapping conditions. A number of experimental studies have demonstrated the effectiveness of specific perspective-taking training whereas more global interventions in the form of sociodramatic activities have been carried out in therapeutic and educational contexts.

In conclusion, there is clinical as well as empirical support for the enhancement of social competence in exceptional children through sociodramatic activities and perspective-taking training. The methods and procedures reviewed seem relevant and feasible for future applications although additional research is needed to determine the most effective strategy for a given population. In considering the clinical implications of this approach several points need emphasis:

1. Social experience of a passive nature is not sufficient for developing social competence. Exceptional children should *actively* assume the roles of others and *actively* solve various social dilemmas. Unfortunately they may often be sheltered unintentionally or intentionally from such critical, "real world" experiences.
2. Perspective-taking and sociodramatic activities provide means for systematically building social competence skills of exceptional children. The importance of perspective-taking training is based on the premise that "a person cannot take a role for which he has no knowledge of its attributes and expectations." (Volpe, 1976, p. 372). Educational and therapeutic services should provide opportunities in which exceptional children can assume the roles, deal with dilemmas and make the choices which foster socially competent behavior.
3. To optimize these opportunities, there is a need for teachers and therapists to recognize the value of perspective taking not just for exceptional children but also for themselves. In reciprocal perspective-taking, helping professionals need to experience the perspectives of being handicapped along physical as well as psychological dimensions. Teachers and therapists should, through role-playing activities, know something of the experience of having impaired hearing, impaired vision, or other physical handicaps. Along psychological dimensions perspective-taking on the professional's part could contribute to a greater awareness of being dependent, rejected and/or misunderstood. Through such experiences, helping professionals should develop more insight and appreciation of the problems and needs of exceptional children with the result that the full therapeutic value of perspective-taking can be realized for both client and helper.

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SOCIAL NETWORKING

Editorial

Some years ago I noticed an interesting phenomenon among my individual and group clients. Some people would come into treatment with certain presenting problems and issues; they would participate in the therapy process; they would terminate treatment looking and sounding changed; and they would go out into the "real world" and continue to grow. Others would come in with the same issues, participate in therapy in similar ways, and leave therapy looking and sounding equally changed. Yet these people were likely to return with the same issues later and did not maintain their changes within the context of their daily lives.

I began to believe that I was discounting the impact of the world in which my clients spent most of their time. I began to recognize that the kind of support clients did or did not illicit among the members of their network affected the client's ability to sustain changes. In order to work in this new frame of reference, I needed to add assessment of the client's network and strategies for change to my treatment model.

About the same time I developed another concern about therapy as I had been taught it. It seemed that techniques abounded for helping people to separate from others in the interest of autonomy. What I lacked was a large set of interventions to help people move beyond that stage into interdependence. At times, it seems that therapy may increase clients' experience of isolation and alienation if the thrust of treatment does not include a bridge to the clients' life beyond therapy. I now believe that as social animals, we have a basic need to give to each other as well as to get from each other and that the operation of such reciprocity has too long been ignored in therapeutic models.

It is with some excitement that I co-edit the sociometry section of this journal. I appreciate the opportunity to share some perspectives and approaches with you, and I hope that you join me in looking for ways in which our therapeutic work can fit more appropriately into clients' daily experience. With all that we understand about human behavior, it would make sense that we offer guidance as our culture seeks solutions to its fragmentation.

BARBARA MUELLER, PH.D.

THE USE OF NETWORK CONCEPTS IN AN EDUCATIONAL MODEL

BARBARA MUELLER AND PENNY MACELVEEN-HOEHN

As clinicians expand the context within which they view clients from the individual to the group and family to the social network, forms for working in the wider context need to be developed. Certainly, meeting with the whole network is as different from talking about the network as meeting with the whole family is from talking about the family–both in terms of assessment and treatment options. Large scale network interventions require large expenditures of resources, however, and are often not practical.

This article illustrates one way in which the concept of social networks may be taught in a workshop or group setting to help people make both behavioral and intrapsychic changes. Using the context of the social network, clients increase their awareness of personal issues and their options for resolving them.

Network interventions on behalf of schizophrenics, depressives, and nuclear families experiencing a breakdown in their relationships historically occurred by gathering a large portion of the social network (Speck and Attneave, 1973; Rueveni, 1975; Cresswell, 1976; Attneave, 1969). When appropriate, such interventions offer some clear advantages: a clearer understanding of the problem within the wider context of relationships, multiple intervention points, the opportunity to include personnel from other agencies, creative and open problem solving, revitalization of social relationships, validation for the network and its members, and the probability that benefits will be experienced by more than the identified patient (Speck and Attneave, 1973; Erickson, 1977). Clark's studies have also suggested that the patient's use of therapeutic community as a part of her/his network is correlated with patient improvement (1967, 1968).

Others have used the examination of the network and a discussion of its possibilities with client or family members to renew and reactivate ties or to plan major life changes, such as a move upon retirement (Fine, 1975; Attneave, 1977). The authors decided to make use of the network concept in an educational model with a range of participants from neurotic to well.

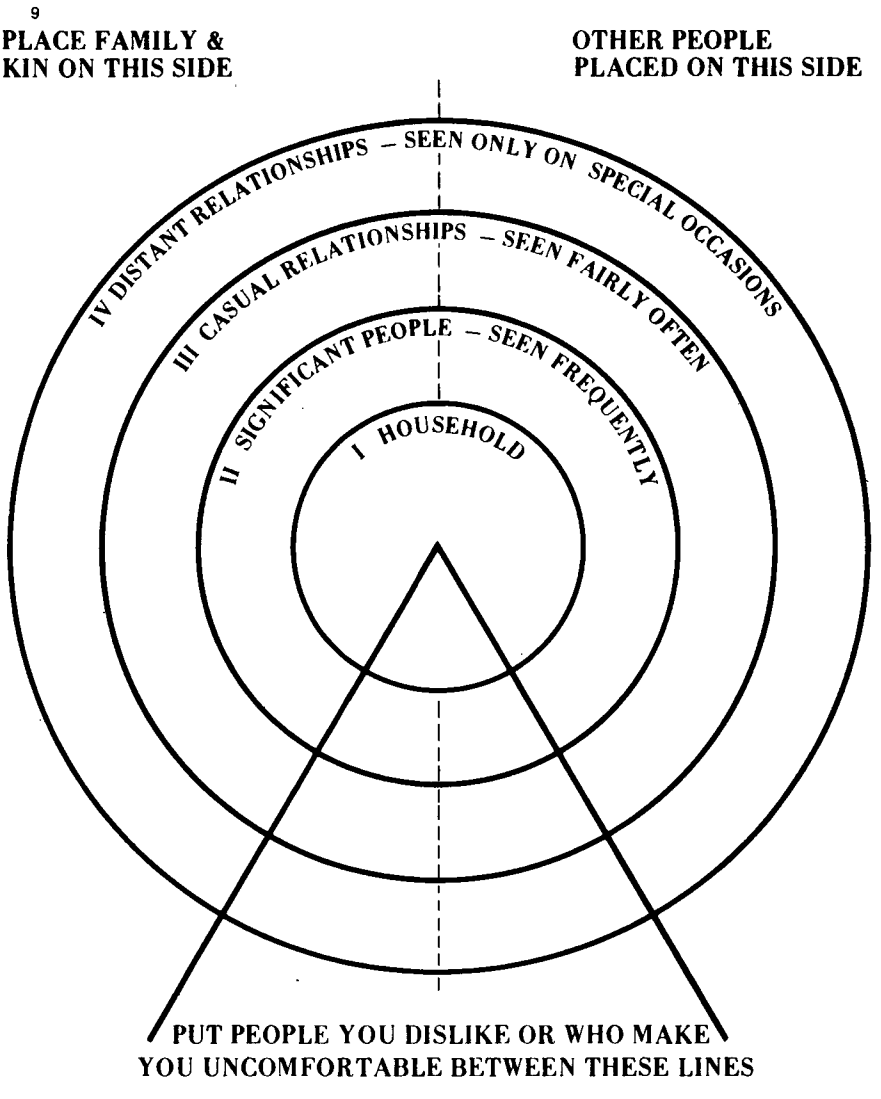
The purpose was to discover if the opportunity to assess one's own network and talk about strategies for change would result in a change in self-reported behaviors with one's network. A workshop was designed, and anecdotal information was collected.

Format

Three sessions, each of three hours duration, comprised each series of workshops. There was a space of one week between the first and second workshops and a space of four or three weeks between the second and third. The time lapse between the last two sessions is greater so that participants have enough time to experiment with new behaviors in regard to their networks. The span was reduced from four to three weeks after feedback from the first group of participants indicated that four weeks also reduced the sense of group cohesiveness that established safety for individuals to share their experiences.

During the first groups, the leaders presented a general description of network theory and practice. Participants were then asked to map their own networks, using a technique and form developed by Attneave (1975). Briefly, participants were asked to list members of their network by the following categories: Household, Close, Casual, and Distant. Participants were assured that no meaning would be attached to the order in which they listed people and that this particular network would be a time/space representation for now and might be different at another time. They were then instructed to put symbols next to each name (squares for men and boys, circles for women and girls, and triangles for pets) and to number the symbols. Most individuals have networks so large that it would be difficult for them to write out each person's name. Symbols are used because they fit on the map more easily. Participants then place the symbols on the appropriate section of the map (Figure 1) and draw lines to connect those people who have contact with each other. After completing their maps, participants were divided into two small groups and invited to share their maps and their feelings as they were drawing them.

The second session began with listing participants' answers when asked what they wanted from their relationships. Although the lists were long and varied, they can be summarized by Weiss' list of relationship aspects that must be present in one's personal network: attachment, social integration, opportunity to nurture, validation, dependable allies, and guidance (1974). The leaders emphasized that individuals may differ in their needs and wants and that the rank order of those needs and wants may change for a given individual over time. Variations in adult development,



family life cycle, life style (including occupation, recreation, personality, and economics), and cyclical change in the need for contact might all be reflected in one's current network. Participants were then divided into small groups to discuss the following questions:

What do you want from your relationships with others that you are not currently finding in your network?
How do you recognize what you need?
Are you getting enough of what you need?
Are you getting too much of anything?
Given where you are headed in the next one or two years, do you have the kinds of people in your network to help you get there? What do you need from people to support your direction? (Permission was also given to be content with one's current network.)

The group was reconvened as a whole and individuals were asked to share any changes they planned to make in their networks and what strategies they might use in the next few weeks to begin those changes.

The third session provided participants with an opportunity to share their own experiences in thinking about and initiating changes in their networks and to learn from the success or problems of other participants' strategies. Participants discussed their thoughts and feelings as they initiated changes in their networks and received validation from the group leaders and each other. Participants again discussed the variations within satisfactory networks and examined the applicability of their new tools for assessment and change to future life developments. The session ended with an evaluation of the workshop by the participants.

Assessment experiences

The simple act of mapping their network appeared to provide important insights for some of the participants. The leaders specifically refrained from suggesting that there was a "right" way to complete the map, and some individuals creatively noted relationship problems by their use of the map. One woman placed her ex-spouse's family (her children's relatives) on the line between kin and non-kin, which also represented their function within her network. She could not quite depend on them for the emotional support and instrumental aid she received from her own relatives, but she could not remove them from her network in the way that she might choose to do with a friend, neighbor, or business associate.

One participant avoided putting any of the symbols inside the close zone. Instead, she placed them on the line between close and casual, which reflected her own sense of keeping people outside of her household at arm's length. Another woman drew two plants inside the household zone. She identified them as two plants in her house that had a particular importance to her. She reported feeling nurtured by them rather than their

meaning being derived by her nurturance of the plants. This particular woman's parents died when she was a young child and the relative who then raised her died when the woman was an adolescent. The plants, it turned out, served as the embodiment of the memory of early nurturing.

For some participants, the number of network members that fit in each zone had importance. A man who reported feeling isolated and alone was surprised to note how many close friends he actually had. He used that information to begin changing how he thought about himself. A woman in her thirties recognized how much of her network was concentrated on the kin side of the map, which helped her understand how she felt both secure and somewhat restricted by a network with so many shared values, experiences, and relationships.

The connecting lines also helped participants identify issues for themselves. A woman who contemplated divorce noticed that most of her closest friends were connected to her husband. After some thought, she recognized that he had brought them into the couple's network and continued to have the primary bond with many of them. She realized that leaving the marriage might actually mean leaving her support network. She decided to develop some friends independent of her husband and to then decide if that would provide enough separation in her life or if she indeed wanted a divorce. A man realized that his network consisted of a number of connected groups of people, many of them professionally related. Of course, leaving any one of the groups meant leaving most of an entire group of friends and associates. The problem of which he was more keenly aware was how difficult he found it to have intimate one-on-one relationships when so much of his time was spent in groups.

Perhaps one of the most useful discoveries participants made was that a wide variety of support was available in their networks. Each member of the network might not be supportive of every part of one's life, but support for nearly any current or new behavior was available somewhere within the network. Several participants noted that their awareness of that phenomenon suggested that they might make major changes in their lives without feeling compelled to disrupt former relationships. They could instead continue to get what support was available for other areas of their lives even if network members disapproved of the more recent changes.

Strategies for change

Participants reported a variety of changes begun as a result of the workshop. Probably the most dramatic was the initiation of new relationships among several men and women who had previously identified themselves as too insecure to meet new people. Since some of the workshop

participants were in counselling with one of the leaders, it was known that these individuals had indeed resisted making new contacts over a period of time. The therapeutic interventions which had been used had not met with success, yet these very individuals came to the third network session boasting of their new acquaintances! When they were asked to explain their hypotheses for the reversal, they each had variations on the same theme. They mentioned that the maps they had constructed the first session were instrumental in changing their mental picture of the world. They could see that they were not isolated and alone, searching for someone to befriend them. Instead they began to view themselves as already surrounded by others, as connected to people. (Some even said to the world or to the universe.) From this frame of reference, it became much easier to initiate new contacts because they felt less alone and more likeable. They maintained that a new contact was not a devastating risk when they were aware of the other people they had to rely on.

For those participants who identified a particular kind of person after which they sought, a number of strategies were successfully employed. Individuals spent time on their own and with others to brainstorm the kinds of places one might be most likely to discover nurturing men or especially bright women. Other participants asked their network for help in locating the kind of person desired. Some took the direct approach of calling someone they had heard of and wanted to meet, most often a business connection or mentor, although not always.

Among the participants who wanted more people inside their close zone, the general agreement was that potential members were already known to the individual and could be found in the casual zone. In order to move closer to the person, what was needed was to spend more time together and to begin the pendulum of reciprocity by either doing something for the other or allowing the other to do something for the individual. Participants recognized that they could make use of their natural style to begin the relationship and then merely needed to maintain the reciprocity. They also saw that a number of their single-stranded relationships (those based on only one shared interest) could easily be expanded to be multi-stranded. Multi-stranded relationships are less vulnerable to loss through natural life changes and provide more richness and closeness within the relationship.

The other noteworthy category of changes was the ways in which participants dealt with network members who appeared in the uncomfortable zone. One mother of an adolescent daughter realized that the girl moves in and out of the uncomfortable zone on her mother's map. She decided that by simply knowing this she could at least stay aware that her relationship with her daughter was not always difficult, although she

might feel that way during those periods. A professional identified one of her colleagues in the close uncomfortable zone as the man who had been her original mentor but now seemed unsupportive of her success. Her strategy was to make her contacts with the man more casual and to stop seeking his approval. Once she had done that, she believed her relationship with him would be more comfortable for her. Another participant in a similar situation simply continued moving the network member out into more distant zones until eventually the member disappeared from his network. Another woman placed her mother in the close uncomfortable zone. Unwilling to take such a severe step as stopping contact, she decided that she needed to find ways to make her relationship with her mother more comfortable. After some thinking, she discovered that the one thing that she and her mother did and enjoyed together was to go shopping. She made a point of structuring as much of the time she spent with her mother in that activity. Over a period of some months she reported that her relationship with her mother had indeed changed. Hypothesizing that sharing an enjoyable activity took care of some of her mother's emotional needs in the relationship, she reported that her mother had become more supportive of both her lifestyle and her career choices, both of which were outside the mother's role expectations.

A variation on that same theme may be found in a woman who reported that she was uncomfortable with her in-laws because the basis of her relationship with them seemed to revolve around talk about her husband. When she was with them, she felt as if she had no particular importance as a human being. After some consideration of the problem, she admitted that their shared interest in her husband was nearly the only thing she had in common with in-laws who had a lifestyle very different from her own. She decided that with that insight she would redefine the discussions of her husband as her in-laws attempts to make contact with her instead of a device to avoid recognizing her existence.

Summary

The educational format of this workshop provided individuals with an opportunity to assess their own networks and to identify both desired changes and plans for implementation. The same technique has been used with clients in a counseling setting to help them plan network changes to support their intrapsychic changes. The approach has also been used in one and two-day workshops, although the participants do not have an opportunity to share their experiences with making changes in such a format.

The effectiveness of the workshop appeared to be the result of a cognitive structure within which participants could think about their relationship picture as a whole. Providing both language and a conceptual framework to discuss their networks allowed participants to organize their previous experiences and to assess their current situations. Clearly, the subject matter was already familiar to participants. Without knowing the language, most people find the concept of networks and their operations quite familiar. The power of the workshop lies in its ability to provide participants with tools to examine and change their own networks. Participants expressed their belief that such tools would continue to be useful to them, and follow-up contact with some of the participants suggested they continued to make use of the material. This use of network theory was, of course, limited by the participant's perception of her/his network. However, it was more practical, less costly, and less cumbersome than a total network gathering. It has been most appropriate as a way of working with networks when a convening of the network was not warranted.

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THERAPEUTIC EFFECTIVENESS OF SOCIAL NETWORK INTERVENTIONS COMPARED TO GROUPS OF 'INTIMATE STRANGERS'

CAROLYN L. ATTNEAVE

Actively promoting network building and integration can be effective in diminishing or preventing fragmentation of families in crisis. Such an approach supports the strengths and resources of the network members as well as the identified patient(s) and lessens the likelihood that the service agency will unwittingly foster an unnecessarily dependent relationship.

In addition, the project described in this article has the advantages of helping client families maintain connections with their roots and of bringing them into a network in which they can be helpers as well as the helped. This kind of network intervention may sometimes be sufficient in that the resources within the network may be able to adequately deal with the presenting problems. At other times, it may be more appropriate to use such an approach in addition to more traditional forms of treatment.*

There are not many shiboleths left in the theory of therapeutic effectiveness, but one of these is the reverence for anonymity and confidentiality that has led to a blind spot with regard to the potential therapeutic effectiveness of working with natural groups, especially those composed of family and other significantly related persons. The unit of intervention has, of course, been debated ad nauseum: individuals; couples, families; intergenerational families: and both natural units, such as classrooms, businesses, and departmental units; or natural collections of family, neighbors, colleagues, friends called social networks. General consensus leaves the battleground to those who must find one single answer, like the size of the Procrustean bed, and allows the majority of therapists to select those units with which they feel both comfortable and effective.

However, especially in the U.S., there has remained a continuing emphasis on the privacy, the individual responsibility for solutions to

*It also makes the child's transition into and out of foster care less jarring because the families are connected.

one's own problems, the protection from misuse of personal information by governmental units, and the suspicion that gossip and less formal behavior will always be destructive.

This has sometimes led family therapists to suspect that those who focus on individuals are settled in so many long range goals and years rather than weeks or months of therapeutic effort, primarily because the weakest link in the system, who has been extruded as a 'patient' becomes responsible for change not only in himself but in the system as well. The alternative, now ideologically reprehensible, is of course the 'adjustment', or manipulation of the individual to accept the system and conform to it. Group psychotherapeutic methods were certainly conceived and brought forth in the atmosphere of preserving individual privacy in one's own world, while sharing one's humanness in the artificially created intimacy of groups of strangers.

This approach to the solution of problems via therapeutic change in the individuals participating has a number of recognizable strengths, as well as some vulnerable weak spots. Some of the more significant elements of can be described briefly.

Among the strengths, is, of course, the freedom from pressure for the individual in the anonymity of groups of strangers. It not only permits one practice in making new relationships; and in approaching people who one has previously not felt at ease in social settings. It also breaks the polite rules, allowing feedback to each person of the discrepancy between intent and effect of actions, words, and patterns of self presentation. While this aspect of group therapy interaction provides some immediate connection of response and reinforcement (both positive and negative) it also separates in time and place the consequences of behavior. This permits trial efforts, experimentation with new roles and encourages attempts at new perceptions of self and others, without the risk of consequences in one's own life space. The immediacy of the feedback also often provides some verification of change before the new patterns are established in an external context, and thus provides an antidote to discouragement and the extinction of effort when the habitual patterns of response from family, friends, work associates and others have not permitted the perception of new aspects of personality or are not flexible enough to respond in kind to changes of behavior. This aspect of positive reinforcement is one of the strengths of the groups therapies—and a very essential piece of all social learning.

The group also provides some checks and balances within its collective experience, so that at least a resemblance of reality testing is available. To some extent the heterogeneity of the group frees the therapist from having to be all things, and all knowing; and permits the multiple foci of each

person's experience not only to be validated, but to be of service to the others in the group in its appropriate time and place.

These elements of group emotional support, of a place and time set aside for practice of new roles and patterns, and of verification of change and reality checks are parts of the tremendous strengths of group therapeutic models. However, a few but increasing number of models are now becoming available for comparison that carry with them many of these strengths, but do not rely on the anonymity and separateness of the artificially composed group. Instead, these therapists work with natural contexts of extended family and social networks of persons who are involved with one another in daily living as well as in the conflict resolution, crisis coping, and problem solving which leads one or more of the natural group to seek outside assistance in the form of a therapeutic intervention.

Only a few persons are bold enough to challenge the sacredness of confidentiality, and to maintain that freeing the natural group from the constraints of its secrets looses energy for problem solving otherwise bound up in maintenance functions.

Ross Speck, Ronald Laing, and Carolyn Attneave, have been outspoken among those recognizing this source of potential creative resources. Especially within contexts of family therapy, the need to develop open clear communication has become a standard operating procedure, although there is always the need to establish the context in which revelations of family skeletons, secret collusions, extra marital affairs, and other typical 'secrets' can be shared without destructive fallout. Perhaps initially it appeared easier to induce a shared collusion of conspiratorial secrecy within the group of strangers than to produce within the natural group the elements of trust and respect that are essential if the energy available from the fission of secrets is to be used in a controlled, constructive manner instead of explosively. However, utilizing the safety of the anonymous group only replicates the problem in a new form and does not accomplish the final therapeutic task of enabling people to accomplish this task in their own life space.

The very strength of the anonymity of the traditional therapeutic group makes it difficult after a very few sessions to reconcile the contrasts between the freedom, the new vocabulary, and the new social conventions of the group life and the patterns of the real worlds of the individual or couples who are its members. Although now generally recognized as a common phenomenon, when the natural sequence of events led members of the group therapy sessions to meet outside of the scheduled times for meals, dates, and even sleeping together, this was considered a breach of contract by the early leaders of the field. Nevertheless, such intimacies and shared "secrets" within and between subsets of the group, no matter

how natural a consequence of its original collusion of secrecy plus its intimate revelations, is disruptive of the illusions of anonymity which gave the therapeutic group some of its initial energy.

Perhaps in short and intensive bursts, the tools of group therapy are effective in the ways originally intended, but groups with a longer life, of months and sometimes years, become part of the warp and woof of the lives of members outside the therapeutic sessions—which may even for some fill a void left by church, synagogue or Sunday School as a gathering of likeminded friends and a leader or two for recharging batteries.

Group interventions, using many of the same techniques as well as new ones of their own, have been evolving from a focus within natural social networks. These interventions facilitate problem solving, energize familiar rituals or develop new ones, and establish the cultural climate that fosters growth in the context where it can continue. The effects seem to be long lasting, and the time span required for active professional involvement in network interventions seems to be relatively short term. A use of the social network as the unit of intervention becomes a natural extension of family therapy, since for most of the mobocentric U. S. population friends fill niches once occupied by extended family members. Even the language of "Aunt", "Uncle", "Sister", "Brother" or "cousin" is often used, whether whimsically in terms of "kissing cousins" or seriously as in the Black community where close friends are spoken of as "going for brothers". Folk wisdom is here many strides ahead of the formal social scientist who has been bogged down with kinship systems and bloodlines or legally sanctioned relationships.

It is both satisfying, and a challenge to work with such a unit of people, who have real problems to solve; who know one another, but who may not have experienced real intimacy: and whose relationships before and after the interventions continue or fade on a realistic life-time continuum. It is a challenge because some of the security of the prosenium arch separating 'theory' from real life must be given up. One not only rehearses for new behaviors, one actually begins to implement them, and the professional is responsible for not a single person's welfare, but of the interacting members of a live system. Nothing can be set aside as "just a game" since its repercussions will always be a part of the collective memory. On the other hand, immediate feedback, and shifts of relationship within real life systems is an even more potent source of reinforcement to sustain change than the dress rehearsal of the synthetic group.

Obviously, rules about individual confidentiality and collusions about secrecy are impossible. However, within the context of the intervention, one of the most dramatic results is usually the dropping out of the rules against admitting that one has known at least part of the secrets all along. Fantasies and ghosts can be replaced with realities, and human beings

confronted with reality can usually deal with it in effective coping ways. Experiencing this in one's own context is one of the most healing experiences that can be provided.

However, bringing this healing about, calls for a very different role at times for the therapist. Except as a model the therapist's acceptance is no longer the most important of the bag of tricks held. Insight must be owned by the group members who will live with it and who become the healing agents in real life as well as in the special sessions. Some therapists find this exceedingly difficult, for their own ego needs and super-ego pressures require them to be more responsible for success even as they are concerned about failure.

Nevertheless, the resources of the group exceed that of any therapeutic individual or team, and often the value of the heterogeneity of social network membership contributes solutions and supports efforts at change that a professional would not dare to attempt or could not possibly provide the human power and time to undertake or see through. Most of the energizing strengths of the synthetically created can be developed in the naturally related group, and the reciprocities as well as the strengths of group energies focused around problem solving for its members are as available in social network intervention as in traditional group and family therapies. The advantages of persistent relationships, or immediate reality testing, and of a much shorter time span of involvement on the part of the therapists, all recommend that serious attention be given to meeting the challenges of using the natural intimacy of social networks, rather than relying solely on the traditional group as the units of intervention. Perhaps one does not replace the other, but each contributes along a continuum of therapeutic methods and technologies. With more experience and more sharing of therapeutic activities using natural groups, criteria for when to use these units and when to use traditional group methods may be more easily discriminated.

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FAMILY REUNION: NETWORKS AND TREATMENT IN A NATIVE AMERICAN COMMUNITY

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An overview of the differences between traditional group psychotherapy and social network approaches provides an opportunity for clinicians to consider the context within which they work. A comparison of the beliefs inherent in each treatment approach and a discussion of the practical differences for both clients and therapists as they experience the alternatives offers a framework for therapists to consider both their current models as well as new areas to explore.

This article, then, establishes the frame of reference for those who use a social network model. It shares the view of the human experience that values the resourcefulness of people and their willingness, indeed their desire, to be givers as well as receivers with their social context.

The Urban Indian Child Resource Center (CRC) in Oakland, California, was the first urban Indian project funded by the National Center on Child Abuse and Neglect (NCCAN).[1] Since it opened in 1975,[2] it has served the special needs of Native American children and their families in the San Francisco Bay Area. During the course of its existence, CRC has developed a unique and effective approach to the treatment of child abuse and neglect in Native American communities. This paper contains a description of the Center's treatment model and an analysis of its innovative approach.

At first glance, it would appear that what goes on at CRC is not much different from other child abuse/neglect or child protective service agen-

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1. This paper is based on research which was carried out at the Urban Indian Child Resource Center between July 1977 and July 1978. The research was funded by the National Center on Child Abuse and Neglect, and I gratefully acknowledge its support. Recognition is also due to LeMyra DeBruyn, Marcia Herivel, Patty LaPlant, Kyle Patterson, and Milton Poola, who assisted in the collection and processing of data.

2. As of October 1978, CRC expanded its activities. New funds were made available for child psychology services and programs for adolescents. This report refers to the original program funded by NCCAN and covers only the period from 1975 to 1978. The model described here continues to form the basis of the Center's work and the new services are being incorporated into the original model.

cies. There is a staff of caseworkers, called Family Representatives, who coordinate and deliver services for client families. The services include counseling, foster placement, court advocacy, referral. There are Homemakers who provide respite childcare and home management services. There are professional consultants who provide medical, psychological, and legal services.

One visible distinction between CRC and other agencies is that it is Indian—controlled with an all Indian direct service staff. However, the difference between CRC and comparable non-Indian programs goes beyond the ethnicity of the personnel. The way the services are rendered, the treatment goals, and the rationale under which CRC operates provide sharp contrasts to the more familiar non-Indian therapeutic model.

The non-Indian model assumes that child abuse/neglect begins and develops within the context of personal pathology and aberrations in individual growth and development. Therefore, treatment in a non-Indian model usually means that individual experts work to change individual clients. The goals of treatment are to help the client to become independent and self-sufficient, to stand on his/her "own two feet". The non-Indian model rarely involves the client's community—that network of family and friends within which the client moves. Individuals from that network may come into the treatment plan, but usually as persons to be adjusted to, separated from, or coped with.

The Indian model, on the other hand, views the problem of child abuse/neglect as due to social processes originating outside the individual and occurring because of institutional pressures exerted by Anglo society on Native American cultural systems. The Indians call these pressures "institutional abuse/neglect". The term institutional abuse/neglect is not original with the Center, of course; but when they use it, it differs somewhat from what others mean when they use the term. Usually the term refers to such things as beating prisoners, doing psychosurgery on inmates in mental hospitals, and neglecting to provide for the aged in nursing homes. Some of the instances of institutional abuse which were practiced against the Indian clients at CRC come under this definition. For example, several report that, when they were caught speaking their native language in boarding school, they were punished by having their mouths washed out with soap.

But experience at the Center indicates a broader definition is in order, namely that major institutions in Anglo society, such as bureaucracies, churches, schools, have set out deliberately to alter or destroy major institutions in Indian society. What is going on, then, is not a case of abuse against an individual who happens to be in a physical institution. Rather, it is a case of social institutions in one culture abusing whole

segments or classes of persons in another society. The particular segment of Indian society which is of concern to the Child Resource Center is the Indian family.

Given the Indian view that Native families have been broken by outside interference, then the solution to the problem is to reconstitute such families as Native families. Therefore, the goal of treatment at CRC is interdependence—to pull people into a mutually reinforcing social network. Treatment is not solely in the hands of experts, but is carried out by many persons from many parts of the network.

Of course, the typical non-Indian treatment model is not without its critics from among the ranks of experts themselves. Concepts such as "network therapy", "supportive systems", "natural helping networks" are beginning to emerge as challenges to the individual expert-individual client paradigm. What is unique about the Indian model is that it developed not as a challenge to the Anglo model, but rather out of Indian traditions and tribal patterns themselves.

Tribal Antecedents

A description of the way families in tribal societies traditionally function, along with a look into the background experience of the parents and grandparents in CRC's client families, can help us understand more about the process of international abuse/neglect and why it is so devastating to Indian families. Such a look can also give specific meaning to such concepts as "cultural patterns" which tend to be misunderstood by Anglo practitioners.

In most tribal situations, young parents are rarely expected to take on the sole responsibility for childrearing. Usually, groups of siblings or cousins live close together—either under the same roof or within easy walking distance of one another. Elders commonly reside with their grownup children and the entire group—parents, aunts, uncles, grandparents, etc.—are considered to share the responsibilities of raising all the children in the extended family. In many tribal languages, the terms used to refer to relatives reflect these close ties. For example, the word in many languages which translates as "aunt" in English, really means "second mother" or "other mother".

It is not unusual for children to move from one nuclear family to another. Sometimes it happens because the child's parents have too few resources; sometimes it happens because "uncle" needs an extra hand, sometimes it is because special ties of affection have developed with "auntie". Children's wishes about where they live or with whom in this extended family circle are usually respected in most tribal traditions.

Young parents, in a tribally based system, can count on getting as much help, support, and advice as they need. They are not usually expected to make all parenting decisions alone; they are rarely expected to make the abrupt transition from nonparent to parent status that is often required of Young Anglo parents. When an Indian baby is born, the parents do not lose their status as child to the grandparents or niece/nephew to their aunts and uncles. These respected elders are there to help without imposing expectations beyond the parents' experience. In turn, the young parents maintain a sense of respect and deference for the experience and wisdom of the elders.

Compare this tribal experience with the expectations in Anglo culture. Young adults usually live separate from their extended families. They make an abrupt change in status when the first baby is born. They are expected to take sole responsibility for the care and character development of their children. This value of individual responsibility makes it easy for non-Indian social workers to view a child who is living with someone other than his/her natural parents as having been abandoned by those parents.

In contrast to Indian parents, Anglos, when they do seek assistance, seek it from experts—the pediatrician, the teacher, the family counselor, or one of the myriad books on parenting. They are not expected to go to their own parents and are often encouraged to follow more "modern" or "scientific" methods than their parents used. The experts, then, have little difficulty in believing that they know better than the parents what is good for a child.

In Anglo culture there is an expectation of change from generation to generation, whereas in most Indian cultures there is an expectation that the generations will repeat themselves. This value that change—progress—is necessary and desirable makes it easy for Anglo teachers and social workers to see the removal of Indian children from their homes as in the best interest of the child, or to view acculturation to a technological way of life as a laudable goal.

What this means is that in Anglo-run schools Indian children have been told through textbooks and by teachers that their ancestors were savages who stood in the way of progress, that their religions were pagan superstitions, that their languages were inadequate for the modern world, that their homes were dirty, squalid, and unsanitary. Anglo teachers and non-Indian foster parents urged them to turn their backs on the "old ways", give up their "superstitions", and instead learn English, become Christians, and strive for success in an Anglo world.

It is in school that many of the children first encounter spanking, harsh commands, expectations beyond their capacity to perform, and punish-

ment for failure. They begin to doubt their abilities, and because they are after all only children, they begin to apply the negative messages coming at them to their perceptions of themselves. The result is a tragically low self-esteem and a lack of a sense of competence.

When Anglo institutions intervene in the traditional tribal patterns, the result too often is the destruction of those patterns. Children are encouraged to denounce their tribal heritage and are frequently separated from family and culture by being placed in Anglo-run boarding schools or non-Indian foster homes. As young adults they are forced, because of reservation poverty, to leave the reservation and migrate to the city. Relocation to the city sometimes creates more problems than it solves and when that happens, the families wind-up as clients at CRC.

The Client Families

An analysis of case histories reveals two basic types of client families at CRC. In the first type, which will be referred to as New Migrants, the parents are at risk of losing their children because they cannot meet their basic physical needs. Usually these families are young, have just arrived from the reservation on urban Relocation, have few salable job skills and virtually no urban survival strategies in their repertoire.

They are in the city because there are no jobs back home. They often have adequate parenting skills which would be sufficient in a supportive environment such as an extended family household. However, alone in the city they are unable to provide shelter, food, medical care, etc. for their children.

They cannot find work because they have had no adequate education or training in reservation schools. Their already lowered self-image suffers further assaults by the repeated failures in the city, and they are left with little sense of competence or worth. They often do not know how to obtain welfare or subsidized medical care, and are very suspicious of all bureaucratic agencies. They are socially isolated and fearful; tragically, they often see their only alternative to be to turn the responsibility for their children over to someone else. The pressures on this type of family are so acute that without assistance the parents could easily fall into a cycle of despondency, alcoholism, and failure, from which it becomes harder and harder to recover.

The second type of family involves parents, usually single mothers, who moved from the reservation when they were children in one of the first Relocation families; thus they represent Second-Generation Migrants. These young parents are the victims of the institutional neglect which their parents encountered when they relocated. That is, their par-

ents (the client children's grandparents) arrived in the city and faced the problems outlined above for New Migrant families. They did not receive the help they needed, and the family gradually dissolved.

Typically the parents in CRC's Second-Generation cases were removed from their own parents and placed in non-Indian foster homes. They often were transferred from home to home, usually in families with resources that placed them not far above the poverty line. The children had begun schooling on the reservation, had very poor command of English, and because of this inadequate preparation suffered a cycle of failure in urban schools.

By the time they came to the Center's attention, they had slipped into street life, and their children, who frequently were the results of adolescent pregnancies, had been taken from them. Because their natal families had been disrupted when they were children, and because they had suffered early in their lives the cultural disruption of the reservation-to-urban shift, they never developed an adequate sense of ethnic or personal identity. Nor did they have an opportunity to develop parenting skills, let alone strategies for responsible self-care.

What The Center Does

In building services for these families CRC caseworkers began by identifying Indian families in the Oakland/San Francisco area who could serve as foster homes for Indian children. These families were organized into what became known as the Family Support Network. It has since developed into a surrogate extended kin group and has taken on functions similar to those found in tribal societies.

Besides providing a source of potential foster homes, members of the Family Support Network also serve as volunteer "host" families to new migrants to the city. They provide the support, advice, and mutual caring that is characteristic of tribal extended families. They come together frequently for potlucks, powwows, feasts, and ceremonies. For the client families at CRC, the Family Support Network provides the basis for the reconstitution of the traditional extended kin group. The Family Representatives and the Homemakers work within this network to help Indian families where the parent-child bond is in jeopardy. In organizing and mobilizing the resources of the Family Support Network, CRC has made excellent use of the grapevine. The Oakland Indian community, like most tribal communities, has a strong and viable informal word-of-the-month communication network. Through this grapevine news travels of events which are important to Indians, of information about jobs, services, and

various opportunities. Messages are sent between relatives or friends; tabs are kept on the comings and goings of families.

There is a tendency for Indians to place more reliance on this face-to-face means of disseminating news than on more formal forms of written communication such as newsletters or mailed notices. Perhaps the preference for the grapevine is linked to the tribal precedent of oral traditions; perhaps the written word is too impersonal to engender trust; or, more likely, perhaps a combination of these factors is at work. In any case, the grapevine is the single most important communication network available to Indians. Messages can flow through it with astounding rapidity.

There are identifiable people in the network who serve as nodes or "switchboards". They seemed to attract information and maintain contact with large numbers of persons to whom to pass it on. The Center has such people on its staff and has made excellent use of their abilities in order to obtain resources for the clients.

Another use which is made of the grapevine is as a social control mechanism. Traditional tribal cultures have often used teasing and shaming as a means to control behavior which did not live up to cultural standards. Fear of being talked about and having one's weakness exposed to public scrutiny is a powerful deterrent. Of course, unfounded rumors and gossip sometimes flow through the grapevine as well as trustworthy pieces of information. Usually the persons at the nodes are able to interpret these and reverse their effect rapidly.

The grapevine is probably not amenable to formal organization. It is the informality of person-to-person links which gives the system its vitality and effectiveness.

For those cases where foster placement is necessary, either because it has been mandated by the courts and child protective services agencies, or because CRC workers have determined that the children in a family need a more secure place to be while their parents are being stabilized, the Center utilizes the Family Support Network and the Indian grapevine to find a suitable home. The Indian Nurses of California, who are the sponsoring board for CRC, have formulated a resolution regarding the placement of Indian children, and the staff follow that resolution in making all placements. The resolution sets up a hierarchy of acceptable placements: first, every effort needs to be made to place a child with relatives; if that fails, the next approach is to seek out a family from the same tribal background; if that fails, the child should be placed in an Indian home with a different tribal background. Only when these avenues yield no suitable home is a non-Indian home to be used and then only under the condition that the foster parents are sensitive to Indian issues and in agreement to maintain strong ties to the Indian community.

There were no licensed Indian homes before CRC was established. Through the Family Support Network, the Family Representatives have identified homes, conducted home studies, and assisted in processing papers. A sufficient number of Indian homes have now been established so that the Center has been able in nearly every case to place children with relatives or same-tribe families.

Having the child returned to his/her natural parents represents the last stage in many family treatment plans. That is, after the parents have successfully stabilized and are securely linked into the system, then concrete plans are made to return the child. The Family Representatives help by advocating for the family in court, preparing the child for the move, and securing the necessary legal assistance. The Homemakers often work with the parents in setting up the household and preparing for the child's return.

Foster placement as arranged and managed at the Center shows how the tribal concepts of shared responsibilities in an interlocking network are carried out in practice. Foster parents and natural parents are brought together *as a unit* for the benefit of the child. Whereas most non-Indian programs separate the two families, this Indian program pulls the units together to form one large family group. Frequently after the child has been returned to the natural parents, the unit continues to function as a family, with visits back and forth, help exchanged, advice given.

In a non-Indian model the child becomes something of a pingpong ball, transferred from one family to another and back again. Furthermore, jealousies often arise between the foster parents and the natural parents. Under CRC's model, there is a much reduced chance that such jealousy will arise, since there is a relationship built into the system which continues regardless of whether or not legal custody of the child shifts.

Much of the work of the Center takes place in and around events such as potlucks, powwows, feasts, and recreation programs. What to an outsider may look like pleasant social gatherings—full of fun and little work—are to CRC staff examples of an important treatment mode. These are occasions for building ethnic identity, solidifying families, gaining spiritual guidance through traditional songs and ceremonies, educating children, and in general breaking through patterns of social isolation.

In structure, such events are nonhierarchical; staff, professionals from other Indian organizations, clients, foster parents, natural parents, children, and adults all participate on an equal footing. In a non-Indian setting, groups, when they are used are either hierarchical—with a defined leader/therapist—or homogenous. Examples of the latter are groups of experts functioning as an interdisciplinary team or groups of clients engaged in "self-help" such as Parents Anonymous. Clients and experts

rarely come together as equals; usually the setting in which they interact is formal and provides for "professional distance". Such an atmosphere does not allow for shared fun or community ritual. But in an Indian program such communal activities are necessary to build the mutually reinforcing network which is the ultimate goal of treatment.

Case Studies

Two composite case studies (i.e., put together from several individual cases so as to highlight commonalities and protect individual identity) have been prepared which can give a complete picture of how all the various parts of the Center are coordinated in a single case plan. One example has been drawn from New Migrant families and one from the Second Generation type.

New Migrant. A newly arrived family was referred to CRC by another Indian social service agency with a request to find suitable foster placement for the children. The family had no housing and the mother needed medical care. The father was unable to find employment and the family was destitute. The Family Representative identified a host family from the Family Support Network to provide temporary shelter. Then services were coordinated with other agencies so that the needed medical care was provided. A search for permanent housing was initiated, and the parents were assisted in contacting the local employment office. When the employment office failed to produce a job, the Indian grapevine was activated and opportunities were uncovered.

The Homemaker helped the family settle into an apartment and assisted the mother in budgeting and shopping. Where necessary, she provided transportation to and from the clinic, and to and from county agencies to obtain such assistance as food stamps, medicare. During these trips she explained much about what to expect from city life, how to use public transportation, etc. The children were helped to settle into school; the younger ones were included in the Native American preschool program.

The family was invited to Center-sponsored potlucks, and through the Family Representative and the Indian family which initially provided them with shelter, they were introduced to many other Indian families. A pattern was established so that if the family subsequently suffered a crisis, they would contact the Center or one of the Family Support Network families for help. This pattern was activated when a death in the family meant that the parents needed to return to the reservation temporarily. Help was found in arranging transportation and in providing care for the children while the parents were gone.

The father has stabilized in his job, and the mother's medical problem is

under control. Eventually, this family served as "host" for another New Migrant family, recently arrived on Relocation.

This case illustrates several elements of the Indian model. The family's initial contact with CRC points up the sense of despair and hopelessness from which many Indian families have learned to view the world. Since they were isolated and without resources, the parents thought that their only alternative was to give their children over to a foster home. Fortunately, they contacted an Indian agency before they contacted County Protective Services.

Another important aspect of this case is the way it illustrates the interdependent nature of the support system. The young family was not exhorted to "make it on its own", but rather was encouraged to remain in the system and ask again for help if it became necessary. This pattern is similar to the tribal expectations of shared responsibilities within the extended kin-group. The fact that the family in turn became a "helper" in the system shows the interrelated strengths of the network.

Second-Generation. A child from a Second-Generation family, who had spent his early years on the streets with his teenage mother, was having severe school problems. His acting-out behavior became so violent that he was to be placed in custody. Due to the linkages which CRC staff had built up with members of the county probation and protective service agencies, an official from the county contacted CRC before the child was incarcerated.

CRC coordinated a family conference where all the members of the family, mostly young relatives of the mother, were present to decide what to do with the child. The family acknowledged that they did not know how to deal with the child at this time and agreed to foster placement. The Family Representative and the Homemaker carefully prepared the child for moving. The Homemaker especially gave loving and individual attention to him. During the times that she picked him up to provide transportation, she spent extra time with him giving him physical affection, listening to him talk about the things that frightened him, encouraging him to confide in her.

Meanwhile, the Family Representative coordinated services with other agencies which included the school, probation office, protective services, psychological services, the Indian survival school, and Indian recreation programs. A suitable foster home was found by using links in the Family Support Network. The Family Representative spent much time in preparing the foster parents for the special needs of this child. Counseling sessions were set up, the boy was readmitted to school and also began attending the Indian survival school on a regular basis. A tutor was engaged through CRC auspices and tutoring took place at the Center.

Throughout all, the Homemaker spent a great deal of time with the boy—encouraging him to seek comfort from her.

The Family Representative coordinated visits between the boy's family and the foster family. Through the Family Support Network potlucks and events, the Family Representative and the Homemaker gradually drew the boy and his family into the Indian community.

At a recent case conference—coordinated by the Family Representative and attended by the school principal, the lawyer for the family, the placement worker for the county, CRC workers—it was acknowledged that there had been great improvement. The boy no longer acts out at school, is involved with team sports, has steadily improved his grades, and seems to be stabilized.

A "weaning" process began when a new Family Representative took over the case. Due to the new worker's fresh insight, it was seen that CRC's direct involvement in the case could be terminated soon. The boy was carefully prepared for the change in workers and is now being seen at gradually lengthening intervals. The boy and both his families—natural and foster—are still active in the Family Support Network, and that link will be maintained. Eventually, the boy may return to his mother and aunts and uncles; in the meantime his family of origin and his foster family have formed an extended family. His Indian identity is enhanced and with it his self-image.

One of the points which this case illustrates is the effectiveness of CRC's prevention techniques. The care that had previously been taken to sensitize non-Indian agency personnel was successful in preventing the removal of this Indian child from his culture. The interlocking nature of the whole CRC approach is also apparent in the ways in which the Family Representative, Homemaker, foster parents, and Family Support Network cooperated in pulling the boy and his family into the community.

Address: Ann Metcalf
Institute for Scientific Analysis
Berkeley, CA

A NOTE ON POETRY IN THE PSYCHODRAMATIC EXPERIENCE

Arthur Lerner*

My primary concern in this brief comment is with "Psychodrama in Four Acts" as an affirmation of life. During a series of training sessions conducted by the Moreno Institute at the University of Connecticut, for mental health professionals, its author was a protagonist. It was her first experience with psychodrama.

As we read the opening lines of the poem "Risk brought me here to center stage" and follow through the course of the poet's psychodramatic experience we go through a series of emotional and intellectual stages reminiscent of Theodore Roethke's poem, "Journey to the Interior." We are told in the note appended to the poem there was a time lapse in which the protagonist experienced "floating through the perceptions, sensations of that experience." In this regard, the poem is the statement and revelation of a dream pattern, with a beginning, a middle and end and a hope for the future.

A skilled person in psychodrama is a skilled artist. Thus, warm-ups, time techniques, fantasy techniques, sharing, closing and a host of other such phenomena can be pinpointed in the poem testifying that psychodrama is an alive art very much in the mainstream of being. The thrust from beginning to end of the poem reveals the anguish and guilt (with the psychodramatist moving the creative process toward a higher state of awareness) until Dad becomes a human being (as do other figures in the past) and the clarity of the closure is revealed in the last stanza.

Finally, it is my belief that Avis Crowe's "Psychodrama in Four Acts & an Epilogue" could only be inspired by a psychodramatist for whom poetry is an important part of the life experience. I regard the poem as part of the energy flow which such a director inspires as a dedicated professional.

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* Dr. Lerner is a poet, Professor of Psychology at Los Angeles City College; Founder and Director of the Poetry Therapy Institute, Encino, California; Director of Poetry Therapy at the Woodview-Calabasas Hospital, Calabasas, California; and editor of *Poetry in the Therapeutic Experience* (1978), Pergamon Press.

PSYCHODRAMA IN FOUR ACTS & AN EPILOGUE

I

Risk brought me here
  to center stage.
I took a halting step
  and chance or two
and was chosen.
I feel affirmed, and eager.
But pleasure quickly
  shifts to pain—
What lies ahead?
  What agony,
What truth will I encounter
  along the way to
wherever you are taking me?
Which mess will I be forced to face—
What windmills will I do battle with?
  Too late for turning back.
My destination's forward,
  even if the way to
Get me there is backwards.
  Take me where you will, then,
but please—be gentle, guide.

II

Setting scenes and time and
  introducing all the players
I'm drifting up and down through
  swirling layers of past
and present, mom and dad and
me, a child/adult loos'd from
my moorings, suddenly afraid.
  Cut adrift from now,
yet acutely aware of all those eyes . . .
  watching, waiting.

Who are these people? Why am I here?
  That's not my mother—or my dad.
Tears begin their rise. I can't.
Where is this going. I can't do it.
What does she want from me?
  Can't do it right.
(Ah, yes—the critic—my constant companion)
  So hard to recall
the me and she and he of
  another lifetime. STOP.
I'm a fussball piece being batted back and forth.

III

No, wait. I hear voices raised,
  anguish untarnished by time . . .
voices linking my today with yesterday,
  in pain. I move
across the frontier of time and space.
The spectator has quietly stepped aside
leaving the actor immersed in
  shimmering moments
of the past relived, but with a new sound.
  My own voice is heard
with words I've kept locked away
  all these years, unleashed.
They startle me, these new sounds
I hurl across the room like poison darts.
Spent, I wrap relief that follows
  all around me.
It seems finished. No?
  No, not yet. Dad wants—needs
to speak. To give me gifts
  he could not give before.
And I could never ask.

IV.

His words come, and fall like
spring rain on the desert.
I receive them and am nourished, though
my eyes perceive a different reality.
I feel joy, but sadness, too, for the
other universe we might have shared.
I bring myself quietly back to joy.
Then, in the stillness of suspended time
my gentle guide invites me
even further back. Dad takes me
on his lap, the hallowed place I
longed for but never had a right to be—
'til now. The final gift,
an offering. I feel a tremor of shock,
a catch of my breath. Deep within
my whole being says YES.
THIS is what I wanted. I could not ask;
you could not give. Now,
holding me in your arms you give
me back the freedom to be me.
It is an incandescent moment.

V.
(EPILOGUE)

I'm jolted back to now.
Suddenly the child on Daddy's lap
becomes middle-aged,
perched awkwardly on legs I hardly know,
acutely aware of having stood naked
in front of strangers.
Trying to hold the moment;
Ecstasy does not last.
I am weary, drained—yet fulfilled.
Full comprehension
will come later. It is enough now just
to feel.

Thomas Wolfe was wrong.
I *did* go home again.
  Not to stay,
  but for a visit—long enough
  to reclaim a vital piece
  of me I'd left behind;
  and bring it back into today
so I can soar headfirst and whole
into tomorrow.

Avis Crowe
May, 1979

Note: This poem was inspired by a particularly profound session in which I was protagonist. The session took place on a Tuesday—the poem was written a week later, after days of floating through the perceptions, sensations of that experience.

NEWS AND NOTES SECTION

Seventh International Congress of Group Psychotherapy

Copenhagen, Denmark
August 3–8, 1980

Congress Theme: The Individual and the Group—Boundaries and Interrelations in Theory and Practice.

Program participation sought. Proposals should be mailed to: Dr. Malcolm Pines, 1 Bickenhall Mansions, Bickenhall St., London WIH 3LF, Great Britain.

Registration Fee: After September 1979, 370 Swiss Francs. After April 15, 1980, 400 Swiss francs. Registration fee should be sent to: Spadille Congress Service, 3 Sonnervej, DK-3100, Hornback, Denmark. Membership in the International Association of Group Psychotherapy: $18 for three years including subscription to the *Congress Newsletter*. Mail to: Dr. Jay W. Fidler, Secretary-Treasurer, I.A.G.P., RD #1, Old York Road, Flemington, New Jersey, USA 08822.

HISTORICAL RECOGNITION

The psychodrama theatre, attached to the student residence at the Moreno Institute in Beacon, N.Y. has been recorded as an historical landmark by the New York State Historical Preservation Office. The designation was accorded because it is the original source of the world-wide practice of psychodrama and group psychotherapy. Training in these methods at the Moreno Institute has been continuous since 1938.

CALL FOR PARTICIPATION
A.S.G.P.P. 38th ANNUAL MEETING
AND TRAINING INSTITUTE
April 17–20, 1980
Barbizon Plaza Hotel, New York City

Now accepting program proposals for 2½ hour demonstration sessions at this meeting. Please send program proposals to:

Ellen Siroka, Ed. D.
Program Chairperson
39 East 20th Street
New York, NY 10003
(212) 260–3860

ZERKA MORENO AWARD

The ASGPP is proud to announce the establishment of the Zerka Moreno Award. This award will be presented at each year's annual meeting to a psychodramatist who has graduated from an approved psychodrama training institute. The recipient of the Zerka Moreno Award will be chosen for distinguished work in making Moreno's psychodrama method more widely accepted. The procedure for applying for this award will be announced late 1979. The first recipient of the Zerka Moreno Award will be announced at the 1980 Annual Meeting.

HOLWELL CENTER FOR PSYCHODRAMA

MARCIA KARP, former Moreno Institute Faculty member, founded the Holwell *Center* for Psychodrama in *EAST DOWN, BARNSTAPLE, DEVON, ENGLAND* in 1974. This year it offers the only diploma course in psychodrama in England.

ZERKA T. MORENO'S TRAVELS—1979

Zerka T. Moreno and Merlyn S. Pitzele have traveled during 1979 to the following places to conduct psychodrama training courses and workshops: El Paso and San Antonio, Texas; West Chester, Pennsylvania; Storrs, Connecticut; Boston, Massachusetts; Asheville, North Carolina; Topeka, Kansas; England; Stockholm and Goteborg, Sweden; Hartola, Finland: Cordoba and Buenos Aires, Argentina.

ST. ELIZABETHS HOSPITAL—MORENO INSTITUTE EXCHANGE PROGRAM

Affiliation Agreement

1. *Purpose.* Saint Elizabeths Hospital (SEH), through its Psychodrama Section and the Moreno Institute of Beacon, New York agree to enter into a joint affiliation for the purpose of exchanging training and specific educational activities for their respective staff and trainees.

2. *Responsibilities of SEH.*

a. SEH will make available psychodrama training experiences to staff and trainees of the Moreno Institute at the Hospital's facilities. All training activities will be directly supervised by personnel of the SEH Psychodrama Section.

b. SEH shall have absolute discretion to accept or reject any trainee for participation in training at SEH. All nominations for training made by the Moreno Institute will be accompanied by a personal letter of intent by the proposed trainee and his or her curriculum vitae.

c. Trainees will participate in regularly scheduled activities at SEH for not more than two weeks.

d. Participation in training under this agreement is non-stipended and all expenses for travel, food, lodging and other personal expenses will be borne by the individual trainee.

3. *Responsibilities of the Moreno Institute.*

a. The Moreno Institute will make available psychodrama training experiences to staff and trainees of SEH at the Institute's facilities. All training activities will be directly supervised by personnel of the Moreno Institute's Psychodrama Section.

b. The Moreno Institute shall have absolute discretion to accept or reject any trainee for participation in training at the Moreno Institute. All nominations for training made by SEH will be accompanied by a personal letter of intent by the proposed trainee and his or her curriculum vitae.

c. Trainees will participate in regularly scheduled activities at the Moreno Institute for no more than two weeks.

d. All expenses for travel, food, lodging and other personal expenses will be borne by the individual trainee and/or staff.

4. *General Provisions.*

a. All trainees at SEH shall be registered with the Hospital Coordinator of Volunteer Services as non-compensated trainee affiliates. As such, trainees shall be considered to have the same status as Hospital employees for the purposes of medical service benefits for work-related injuries and diseases, in accordance with the provisions of the Federal Employee Compensation Act, 5 U.S.C. 8101, *et seq.*

b. Trainee affiliates are obligated to comply with all rules and regulations applicable to the employees of the institution at which training occurs.

c. Liability arising from alleged negligence or wrongful conduct of trainees while engaged in patient care or related activities at SEH will be considered and acted upon in accordance with the provision of the Federal Tort Claims Act, 28 U.S.C. 2671, *et seq.*

d. Saint Elizabeths and the Moreno Institute agree to make no distinction among trainees or applicants to this program on the basis of race, color, creed, sex, age or national origin.

e. Trainee affiliates in training at SEH are obligated to adhere to all applicable provisions of the Privacy Act of 1974 as implemented at the Hospital.

f. Exchanges of trainees will occur on a one for one basis between SEH and the Moreno Institute. Any difference in number of trainees at either institution will be equally accommodated by the other within one month unless mutual agreement to accept the difference is reached.

g. An annual review of the policies and procedures established pursuant to this agreement will be made. This agreement may be terminated at any time either upon the mutual consent of both parties or upon 30 days written notice given by one party.

David F. Swink
Training Officer, Psychodrama

Dale Richard Buchanan
Chief, Psychodrama Section

Lula M. Whitlock
Chief, Non-Medical
Training Branch

William Dobbs, M.D.
Director, Overholser Division
of Training

Zerka T. Moreno
Moreno Institute
(Date)
5/21/79

Charles E. Meredith
Superintendent,
Saint Elizabeths Hospital
(Date)
6/6/79

THE AMERICAN BOARD OF EXAMINERS IN PSYCHODRAMA, SOCIOMETRY & GROUP PSYCHOTHERAPY

Practitioner Level Certification

Offered by The American Board of Examiners in Psychodrama, Sociometry & Group Psychotherapy
A not-for-profit organization incorporated in the District of Columbia

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Dale Buchanan, M.S.
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Martin R. Haskell, Ph.D.
Carl Hollander, M.A.
James M. Sacks, Ph.D.
Robert W. Siroka, Ph.D.

Grandparenting period open from April 1979 through April 1980.

Persons who fulfill the requirements below will be considered for practitioner level certification based on inspection of submitted credentials. A non-refundable initial application fee of $50 must accompany a request for application. An additional $75 fee is required when certification procedure is completed. Candidates for certification of the grandparenting provision must meet the following requirements:

1. A minimum of 780 hours of training by a Board Certified Trainer, Educator and Practitioner of Psychodrama, Sociometry and Group Psychotherapy.
2. One year of supervised experience in Psychodrama, Sociometry and Group Psychotherapy.
3. Candidates shall submit evidence of a graduate degree in a field relevant to mental health from an accredited university or an acceptable equivalent.
4. Candidates shall present endorsements of competence and personal and professional responsibility from—their primary trainer (certified TEP);—another certified TEP;—another mental health professional familiar with the candidate's work and clinical experience.
5. Candidates activities and achievements toward fulfillment of certification under grandparenting may be extended over a period not to exceed five years part time.

Request for application and non-refundable $50 fee should be addressed to:
American Board of Examiners, 39 East 20 Street, 8th Floor, New York, New York 10003, 212/260-3860 (after 1:00 pm)

FEDERATION OF TRAINERS AND TRAINING PROGRAMS IN PSYCHODRAMA

The Federation of Trainers and Training Programs in Psychodrama is a guild of trainers conceived of by Zerka T. Moreno, John Nolte, Joseph Power and Peter Rowan in 1976. Their efforts led to the first meeting of the Federation in Miami, Florida in January, 1977. Those attending this meeting defined the purposes of the organization as follows:

- To foster a climate of mutuality, insuring a free flow of information and attitudes among member programs and organizations for professional development.
- To keep appraised of the current state of and to improve psychodrama training and education.
- To work towards the development of professional psychodramatists and to encourage diversity of applications.*
- To maintain and augment the relationship between itself and other related programs concerned with training and certification.
- To teach and support and foster program evaluation and research.

To provide continual assessment of the interaction between ourselves and social systems.

Annual meetings of the Federation followed; the second and third were held in January, 1978 & 1979 in San Francisco. To date, some of the concrete products of the Federation's work have been:

Directory of Institutes and Training Programs in Psychodrama: This preliminary document, compiled in 1977, was presented at the 1978 meeting as a reference for discussion of training programs. A second, more refined edition, planned for wider distribution, should be ready for the 1980 meeting.

Tabella: An official transcript and instrument to be used by certified trainers and their students has been prepared by the Federation. The printed prototype of the Tabella has been completed and distributed to Board certified trainers; its final form will be discussed and voted upon at the next meeting.

Professional Development Meeting: This two day session was held at the Moreno Institute in April, 1979 for the purpose of collaborating about ideas regarding the training and education of psychodramatists.

The Federation has also been influential in the education of governmental agencies on the status of psychodramatists. Perhaps most impor-

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* Modified, as printed, at January, 1979 meeting.

tantly, this organization is serving its function as a guild. It is a mutual aid association of trainers which is providing an arena for the development and advancement of the training and education of psychodramatists and the professionalization of psychodrama.

About Membership

The two categories of membership are "full" and "apprentice". Trainers, educators and practitioners certified by the American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy are eligible for full membership which entitles voting rights at meetings. Apprentice membership is open; students are encouraged to join; it does not hold voting power but entitles attendance and participation at meetings.

Dues for full membership are $50 annually. If you attended the 1979 San Francisco meeting of the Federation and paid the $30 registration fee, deduct this amount and pay only an additional $20. Those applying for apprentice membership pay $20 dues. Registration for the 1980 meeting will be $10 less than for full members.

To further support the purposes of the Federation, we encourage those of you who are eligible to join as a full member and to encourage your students and colleagues to join the Federation as an apprentice. An application form is below.

From the Executive Committee: Sandra Garfield, Ph.D., President
Peter J. Rowan, Jr., Vice-President
Jill Winer, M.A., Secretary
Shirley Barclay, M.S.N., Treasurer

THE NEXT MEETING OF THE FEDERATION WILL BE IN LOS ANGELES FROM FEBRUARY 9–11, 1980.

APPLICATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____

(Work) _____

Applying for: Full membership ($50) _____

Apprentice membership ($20) _____

Affiliation-Primary Trainer and/or Training Institute:

_____

Please enclose check for dues and send to:

Shirley Anderson Barclay, Treasurer
F.T.T.P.P.
125 West 72nd Street
New York, New York 10023
212 874–6379

For further information about the Federation, write to:

F.T.T.P.P.
9911 West Pico Blvd.
Suite 1540
Los Angeles, Calif. 90035

SAINT ELIZABETHS HOSPITAL
PSYCHODRAMA SECTION
WASHINGTON, D. C. 20032

Announcement

Stipended internships and residencies in Psychodrama are being offered by the Department of Health, Education, and Welfare, National Institute of Mental Health, Saint Elizabeths Hospital, Psychodrama Section, Washington, D.C.

Philosophy

To train psychodramatists to function as psychodrama professionals within the mental health community. Saint Elizabeths Hospital believes that this is best accomplished through an intensive 12-month internship or residency within a mental hospital setting. The trainee is prepared to develop a full range of professional roles including psychodrama clinician, mental health team member, trainer, educator, consultant, researcher and program evaluator.

Training

Training includes an interdisciplinary core program in the areas of clinical psychiatry, research, human growth and development, community mental health, mental health delivery systems and group dynamics. Specialized training is given in Quadratic Psychodrama, a concept created and developed by the Psychodrama Section at Saint Elizabeths Hospital. Quadratic psychodrama incorporates group dynamics, sociometry, social systems theory, and role theory within the framework of psychodramatic group psychotherapy and training.

Each trainee is responsible for a number of psychodrama clinical groups with a wide variety of clinical experiences including inpatients and outpatients. Specialized clinical experiences are available in the areas of deaf, forensic, geriatrics, alcoholism, drug, hospice, hispanic and school programs.

Each trainee is also responsible for directing one psychodrama community group. Practicums are arranged with public and private school systems, Drug Abuse Centers, Probation Offices and related community agencies.

Daily training sessions are directed by staff psychodramatists in specific areas of quadratic psychodrama. Included in these are didactic and experiential sessions involving the use of audiovisual feedback, reading seminars, group concerns, and structured psychodrama content sessions.

Assessment

Individual, group, on site and report modes of supervision are regularly scheduled. Video feedback is an integral part of supervision. Quarterly evaluations are provided by the staff to the individual trainees, and by the trainees concerning the effectiveness of the program.

Program evaluation of the training and clinical program are periodically scheduled by outside consultants. Trainee responses and suggestions to the program are incorporated within regular program evaluation procedures.

Copies of the 1976–77 program evaluation of the training program are available for inspection by prospective applicants to the program.

Accreditation

The psychodrama program, one of the first established and most advanced in the nation, is accredited by the American Society of Group Psychotherapy and Psychodrama and by the Moreno Institute. The program has also been granted a two-year interim accreditation by the recently formed American Board of Examiners in Psychodrama, Sociometry, and Group Psychotherapy.

Minimum Eligibility Requirements

For all levels of training applicants must hold a bachelor's or higher degree from an accredited college or university. Courses completed must include 24 semester hours (or academic equivalent) in one or a combination of major fields which have given the applicant a basic knowledge of fundamental concepts of normal and abnormal psychology, sociopathology, and personality development.

All applications will be evaluated in terms of education and experience based on college transcript(s) and the Personal Qualifications Statement (Standard Form 171).

The best qualified applicants will be scheduled for an aptitude evaluation which includes active participation in role playing sessions at Saint Elizabeths Hospital. Any travel or related expenses must be borne by the applicant. Evaluations are usually scheduled in March and April.

Veteran's Preference:

Applicants with creditable military service are given preference under the Veteran's Preference Act of 1944. Non-citizens may only be considered if there is an insufficient number of qualified citizens.

Dates:

The 12-month program begins July 1 and ends on June 30, of the following year.

Stipends:

Annual stipends range from $7,766 to $12,949 per annum depending upon education and experience. Trainees are not eligible for Federal benefits except for annual and sick leave.

Staff:

The current staff consists of Dale Richard Buchanan,* M.S., Chief, William J. Picon,* Ph.D., Intern and Resident Training Coordinator, and staff psychodramatists Barry N. Spodak, M.S.W., David F. Swink, M. A., Monica L. Meerbaum, M. A., and Kerry Paul Altman, Ph.D.

In addition to the permanent staff, numerous SEH and NIMH personnel serve as adjunctive faculty. The following prominent psychodramatists have provided training and consultative services to the program: Don Clarkson,* M.S.W., Jacklyn Balsham Dubbs,* M.S.W., James M. Enneis,* M.S., Don Hearn,* Zerka T. Moreno,* James M. Stacks,* Ph.D., Robert W. Siroka,* Ph.D., and Hannah Weiner,* M.A.

Applications:

For applications and further information regarding the program contact the Psychodrama Section, Saint Elizabeths Hospital, Washington, D. C. 20032. (202) 574–7219.

Submit completed Standard Form 171, "Personal Qualifications Statement," an official transcript(s) from each college or university attended and two letters of reference, using the Psychodrama Reference Form, not later than April 1, 1979 to:

Employment Office—Psychodrama
Attention: Mrs. Betty Dunkins
Saint Elizabeths Hospital
Washington, D.C. 20032

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A BASIC COURSE IN PSYCHODRAMA

Neville Murray, Clinical Associate Professor of Psychiatry, University of Texas Health Science Center, San Antonio—Course Director
James M. Enneis, Chief, Psychodrama Section, St. Elizabeth's Hospital, Washington, D.C.
Zerka Moreno, President and Director, Moreno Institute, Beacon, New York
Lewis Yablonsky, Professor of Sociology, California State University, Northridge: Santa Monica

	Subjects and Speakers
CASSETTE ONE:	Warm-up Techniques (Mr. Enneis)
Side 1:	Introduction, goals, and definitions (Dr. Murray) . . . Cluster warm-up . . . Director-directed warm-up . . . Protagonist-directed warm-up . . . Questions and answers . . .
Side 2:	Warm-up of the individual . . . Questions and answers . . . Warm-up in the staff or school setting . . . Warm-up to space.
CASSETTE TWO:	Functions of the Auxiliary Ego (Mrs. Moreno)
Side 1:	Historical perspectives . . . Spectrum of functions. . . . Auxiliary representing an absentee . . . Auxiliary representing the protagonist (the double). . . .
Side 2:	Selecting auxiliaries . . . Auxiliary egos 'at a distance' . . . Case histories of 'mirror psychodrama' to attain engagement . . . Questions and answers.
CASSETTE THREE:	Functions of the Director (Dr. Yablonsky)
Side 1:	Importance of the director . . . Warming yourself up . . . Guiding direction of action . . . Dyadic uses . . . Avoiding direct role in action . . . Handling role reversals . . . Selection of auxiliary ego . . . Managing body posture . . . Controlling emotional focus . . . Value of charisma. . . .

Side 2: Protecting vulnerability of 'hypnotic' protagonist . . . Handling humor . . . Dealing with release of hostility . . . Psychodramatic aspects of terrorist/hostage situation . . . Questions and answers . . . Psychodrama in clinical practice.

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THE AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

The pioneering membership organization in group psychotherapy, the American Society of Group Psychotherapy and Psychodrama, founded by J. L. Moreno, M.D., in April 1942, has been the source and inspiration of the later developments in this field. It sponsored and made possible the organization of the International Committee on Group Psychotherapy in Paris, France, in 1951, whence has since developed the International Council of Group Psychotherapy. It also made possible a number of International congresses of group psychotherapy. Membership includes subscription to the journal *Group Psychotherapy and Psychodrama,* founded in 1947, by J. L. Moreno, the first journal devoted to group psychotherapy in all its forms.

The Society is dedicated to the development of the fields of group psychotherapy, psychodrama, sociodrama and sociometry, their spread and fruitful application.

Aims: to establish standards for specialists in group psychotherapy, psychodrama and allied methods, to increase knowledge about them and to aid and support the exploration of new areas of endeavor in research, practice, teaching and training.

The following membership categories are now available: Student (for undergraduate students only), Member and Fellow.

Membership in any of these categories enables the member to attend the annual meetings at the registration fee limited to members.

Student membership is open to students whose interests are devoted primarily to specializing in the field of group psychotherapy and psychodrama, but who have not as yet attained the training and profes-

sional experience required for membership. Student membership is a non-voting membership, includes the journal, *Group Psychotherapy and Psychodrama,* and costs, $8.00 annually. It is limited to two years when the student should apply for a change in status to full member.

Membership is often to psychiatrists, psychologists, sociologists, social workers, educators, group workers, mental health workers, and other professional persons who have contributed or show promise of contributing to the advancement of group psychotherapy and psychodrama. Membership costs $15.00 annually and includes the journal, *Group Psychotherapy and Psychodrama.* Members can serve as elected officers of the society.

Fellowship is open to all members of not less than two years' standing who have specialized in the practice of or research in group psychotherapy and psychodrama for not less than five years and who are practicing or doing research in group psychotherapy and psychodrama, either in private practice or institutional work; and whose accomplishments—position, publications and activities—on behalf of the society are approved by the Council. Fellowship costs $30.00 annually and includes the journal, *Group Psychotherapy and Psychodrama.* Fellows can serve as elected officers in the society.

Foreign members must add $1.50 to the above membership fee to cover additional postage for mailing of the journal.

Certificates for Students and Members are issued upon entering membership in one of these categories. Fellowship certificates are issued upon entering the Fellowship category and costs $5.00 per copy.

Applications for membership and requests for further information should be sent to Stephen F. Wilson, Secretariat, A.S.G.P.P., 39 East 20th St., New York, N.Y. 10003. Tel: 212–260–3860.

ANNOUNCEMENT

A.S.G.P.P. 38th ANNUAL MEETING

The 38th Annual Meeting of the American Society of Group Psychotherapy and Psychodrama will be held April 17–20, 1980 at the Barbizon Plaza Hotel. For program information write to A.S.G.P.P., 39 E. 20th St., New York, N.Y. 10003.

EXCERPT FROM 37th ANNUAL MEETING AND TRAINING INSTITUTE APRIL 26, 27, 28, 29, 1979 The American Society of Group Psychotherapy and Psychodrama

Thursday April 26 10:00 am–12:30 pm Demonstration Sessions 113–125

113 A Psychodrama Demonstration
Leon J. Fine, Ph.D., Clinical Psychologist, Clinical Professor of Psychiatry, University of Oregon Health Services Centers; President, Seminars in Group Processes, Portland, Ore.; **Johnee Mosher, M.A. & John Devling, M.A.;** Blue Sky Consultants, Seattle, Wa.

114 Once Upon A Time: A Psychodramatic Use of Fairy Tales in the Group Setting
Paul D. Reid, Director, Psychiatric Day Treatment Program, University of Connecticut Health Center, Farmington; Associate Director of Psychodrama Training. New Haven Center for Human Relations.

115 Advanced Workshop for Warm-Up Techniques in Group Therapy
Jane A. Taylor, Ph.D., Program Administrator, Special Projects Branch, National Institute on Alcohol Abuse and Alcoholism, Rockville, Md.; **E. J. Harper,** Director, Program Development and Training, Earle E. Morris Jr. Alcohol and Drug Addiction Treatment Center, Columbia, S.C.

116 Improvisational Technique in Training Auxiliary Egos
Barry N. Spodak, M.S.W., St. Elizabeths Hospital, Washington, D.C.

117 The Infant Remembers: Personality Reintegration Through the Primal Process
Arthur Totman, DiMele Center for Psychotherapy; Vice President, International Primal Association, N.Y.C.

118 Archaic Postures in Art and Their Functions
Seymour Howard, Professor of Art History, University of California, Davis, Ca.

119 Group Skills in Early Treatment of the Alcoholic: Techniques and Theory
Carol Joyce, M.A., R.N., Clinical Specialist and Coordinator, Group Program in Alcohol & **James Boyle, A.A.S., B.S.,** Alcoholism Counselor and Group and Family Therapist; St. Vincent's Hospital Medical Center, N.Y.C.

120 Introduction to Voice Therapy: Singing as a Therapeutic Process
Maria Jutasi-Coleman, M.A., Singing Teacher and Voice Therapist, N.Y.C.; Workshop Leader, Connecticut Society for Bioenergetic Analysis, Hamden, Ct.; Bioenergetic Society, Berkeley, Ca.

121 Psychodrama with Single Parents
Jessica Osband, Intern, New England Institute of Psychodrama, Boston; Counselor Peabody Council on Youth Needs, Peabody, Ma.

122 Psychodramatists as Medical Consultants
Jessica Scott Myers, M.A., Psychodramatist, Provident Hospital, Baltimore, Md.

123 Existential Analysis—The Therapist's Use of Self in Psychotherapy: Experiential and Didactic
Carl Goldberg, Ph.D., Associate Clinical Professor of Psychiatry, George Washington University Medical School; Consultant in Marital and Family Psychotherapy, Saint Elizabeths Hosp.; Washington, D.C.

124 Parental Role Rehearsal in Family Therapy
Daniel F. Hobbs, Jr., Ph.D., Department of Child and Family Development, University of Georgia, Athens, Ga.

125 Psychodrama Dealing with Severe Emotional Crises
Michael Gass, M.S.W., Ph.D. & Rochelle J. Haskell, M.A.; California Institute of Socioanalysis, Long Beach, Ca.

Thursday April 26 2:00 pm–4:30 pm Demonstration Sessions 126–136

126 Safety First: Generating a Trustworthy Atmosphere: Experiential
James M. Sacks, Ph.D., Director, New York Center for Psychodrama Training, N.Y.C.

127 Applied Psychodrama Within a Social Systems Framework
Dale Richard Buchanan, M.S., Chief, Psychodrama Section; Assisted by Staff of Saint Elizabeths Hospital: **William J. Picon, Ph.D., Barry N. Spodak, M.S.W., David F. Swink, M.A., Monica L. Meerbaum, M.A., Kerry P. Altman, Ph.D.**

128 Non-Verbal Communication and Psychodrama Without Words
Georges Balassa, Ph.D., (Bio.), Ph.D., (Psych.); Maître de Recherche, C.N.R.S.; President, Centre de Recherches pour la Psychotherapie de Groupe, Montpellier; **Gerard Nauret, M.A.** (Psych.), France.

129 Creative Anger Groups: A Time-Limited, Skills-Training Approach to Emotional Re-education
Kay Boals, Ph.D., M.S.W., Counselor and Group Dynamics Specialist, Family Service Agency of Princeton.

130 Roleplaying: Empathy (tacit), Doubling (explicative), Acting (Interpretive) vs. Improvisation (creative).
Israel Eli Sturm, Ph.D., Director, Community Services, Franklin County Community Services, Malone, N.Y.

131 The Role of Group Therapy in the Treatment of Chronic Back Patients
Diana D. Dunten, Ph.D., Counselor, Atlanta Back Clinic, Ga.

132 Psychodrama With A Family
G. Douglas Warner, Ph.D., Psychologist, Psychodramatist, Psychological Services of Hagerstown; **denton bliss,** The U.S. Public Service Hospital, Department of Psychiatry, Baltimore, Md.

133 The Initial Interview in Conjoint Family Art Psychotherapy
Selma H. Garai, A.C.S.W., Instructor, The New School, N.Y.C.; **Josef E. Garai, Ph.D.,** A.T.R., Chairperson, Graduate Art and Dance Therapy Department, Pratt Institute, Brooklyn, N.Y.

134 The Group as an Adjustment Modality for Aphasic Patients
Sharon Cerny, M.S.W., Social Work Coordinator; **James Blair, M.S.W.,** Staff Social Worker; **Mike Walsh, M. Ed.,** Speech Therapist; all from Boston VA Medical Center, Boston, Ma.

135 Use of Humor in Dealing with Separation and Divorce: Experiential
Joseph August, Organization Consultant, N.Y.C. Human Resources Administration, N.Y.; **Diane Borchelt, Ph.D.,** Licensed Clinical Psychologist, Assistant Professor of Psychology, Jersey City State College, N.J.

136 Facilitating Interpersonal Communication: Assertiveness Training
Iris G. Fodor, Ph.D., Associate Professor, Department of Educational Psychology, N.Y.U.

Friday April 27 10:00 am–12:30 pm Demonstration Sessions 215–225

215 Integrating Theory and Practice in Psychodramatic Therapy
Robert W. Siroka, Ph.D., Executive Director, Institute for Sociotherapy, N.Y.C.; Past President, American Society of Group Psychotherapy and Psychodrama.

216 Using Action Sociograms
Peter J. Rowan, Executive Director, New England Institute of Psychodrama; Assistant Professor, Expressive Therapies Program, Lesley College Graduate School, Cambridge, Ma.

217 Sociodrama on the Guyana Tragedy
Clare Danielsson, Ph.D., Acting Director of Training, Moreno Institute, Beacon, N.Y.

218 Psychodrama with Adolescents
Kerry Paul Altman, Ph.D., Staff Psychodramatist, Saint Elizabeths Hospital, Washington, D.C.

219 Warm-Ups: A Continuum
R. L. Coberly, Ph.D., Consulting Psychologist & **Yvonne Jagodinski, M.A.,** Psychodramatist, U.S. Navy Alcohol Rehabilitation Center, NAS Jacksonville, Consultant, Naval Regional Medical Center, Jacksonville, Fl.

220 Sociometry: A Method for Understanding Foster Care and Community Care: Paper and Discussion
Gerard R. Kelly, School of Medicine, Department of Psychiatry, University of Maryland & **Margaret E. Edwards;** VA Medical Center, Perry Point, Md.

221 Sobriety: The Natural Child Returns
Elizabeth A. Stewart, M.A., Northern Virginia Stress Management Center, Annandale, Va.; Professor, Washington School of Psychiatry, Washington, D.C.

222 The Community College Speech Class: Facilitation of the Communication of Warmth and Acceptance
Doris Newburger, Ph.D., Chairperson, Department of Speech Communication and Theatre Arts, Borough of Manhattan Community College, N.Y.C.

223 Psychotherapeutic Psychodrama with Psychotic Patients: Didactic and Experiential
William J. Picon, Ph.D., Psychodramatist & **Jon M. Sherbun, M.S.W.,** Intern in Psychodrama; St. Elizabeths Hosp., Washington, D.C.

224 Feeding Ourselves: Food, Fat, and the Female Experience
Carol Bloom, M.S.W., Psychotherapist, N.Y.C. and Staten Island, N.Y.

225 Psychodrama Directors' Workshop—Open to ASGPP Members Only
Coordinated by the Delaware Valley Society of Group Psychotherapy and Psychodrama **Thomas Treadwell, M.A.,** Psychodramatist and Associate Professor, West Chester State College, West Chester; **Chip Nesbit, B.A.,** Psychodramatist, Northwest Institute of Psychiatry, Fort Washington; **Joyce Posner, M.A.,** Hanemann's Children's In-Patient Unit; **Paul Curnow, Ph.D.,** Staff Psychologist, Friends Hospital; **Ira Orchin, M.S.,** Clinical Psychologist, Philadelphia, Pa.

Friday April 27 2:00 pm—4:30 pm Demonstration Sessions 226–236

226 Psychodrama and Your Future
Hannah B. Weiner, M.A., East Coast Center for Psychodrama, N.Y.C.; **Nicholas E. Wolff, C.S.W.,** Director, Nassau-Suffolk East Coast Center for Psychodrama; **Marilyn Middleton,** Counselor, South Oaks Foundation for Alcoholism Studies, Amityville, N.Y.

227 Just Take Me As I Am: A Workshop for Couples and Couple-Helpers
Marta Vago, A.C.S.W., Philadelphia Professional Associates, Philadelphia, Pa.

228 Weight Control Through Mind Control: Demonstration
Anath H. Garber, M.A., Psychodramatist, East Orange Hospital, East Orange, N.J.; East Coast Center for Psychodrama, Brooklyn, N.Y.

229 The Common Teachings: What is Me and Not Me
Jeffrey S. Landau, Ph.D., Psychologist, Private Practice, N.Y.C.

230 Basic Psychodrama Training for the Mental Health Professional: Experiential and Didactic
Robert Flick, A.C.S.W., Psychotherapist and Psychodramatist; Institute for Sociotherapy, N.Y.C.; Principal Psychiatric Social Worker, Raritan Bay Mental Health Center, Perth Amboy, N.J.

231 Innovative Group Treatment for Alcoholics
Valerie R. Levinson, C.S.W., Alcoholism Treatment Supervisor, Health Insurance Plan, Brooklyn; Faculty, Adelphi University, ABLE Program, N.Y.C.

232 An Experiential Gestalt Demonstration
Carol Fleischmann, Psychotherapist, Director, Center for Psychotherapy and Personal Development, New Haven, Ct.

233 Musically Induced Fantasy and Psychodrama
David F. Swink, M.A., Staff Psychodramatist, Saint Elizabeths Hospital, Washington, D.C.

234 The Spook Who Sat By the Door: A Psychodramatic Exploration of the Dynamics Affecting the Minority Group Member in the Professional World
Lillian Donnard, B.S. & Devane Nelson, B.S., Saint Elizabeths Hospital, Psychodrama Section, Washington, D.C.

235 Educating Graduate Counseling and Psychology Students in Psychodrama: Didactic and Experiential
Jack I. Novick, Ph.D., Professor and Director of School Psychology Training, Southern Connecticut State College; Clinical Professor of Psychiatry, Yale University, New Haven, Ct.

236 Psychodrama Directors' Workshop—Open to ASGPP Members Only
Continued from morning session #225. Open to afternoon participants. (Limited to 20).

Saturday April 28 10:00 am–12:30 pm Demonstration Sessions 313–327

313 How I Am A Loving Person: Experiential
Zerka T. Moreno, President, Moreno Institute, Beacon, N.Y.

314 Integrating the Body into Psychotherapy: A Workshop for Professionals
Shere Friedman, M.A., Certified Feldenkrais Teacher; Staff, Ramapo College, Mahwah, N.J.

315 Gestalt Psychodrama: Unfinished Business with Parents
R. Evan Leepson, M.S.W., Staff Trainer, Gestalt Institute of Western New York; Lecturer, College of Health Science, SUNY, Buffalo, N.Y.

316 A Psychodrama Session for Dieters: Experiential
Stephen F. Wilson, A.C.S.W., Psychotherapist, Institute for Sociotherapy; Director, Michael's Farm, Summer Community for Children, N.Y.

317 You and Your Elderly Parent
Alfred R. Wolff, Ed.D., Professor of Counselor Education & Human Resources, U. of Bridgeport, Ct.

318 Rites of Passage: Adolescents and Psychodrama
Gerald Tremblay, M.A., Psychodramatist, Horsham Clinic; Curriculum Coordinator, The Academy of Psychodrama and Sociometry of Horsham Foundation, Ambler, Pa.

319 Integrative Creative Arts Therapy with Hospitalized Psychiatric Patients
Gary J. Flatico, Ph.D., Associate Clinical Professor of Psychology, UCLA; Clinical Psychologist, Brentwood VA Medical Center, Ca; **Janet M. Helm, M.A.,** Recreation & Movement Therapist, Brentwood VA Medical Center, Ca.

320 A Model for Training Programs in Business, Public Agencies, and Education
Carol Hurewitz, Ph.D., Training Supervisor, Adelphi University, Long Island, N.Y.

321 Experiential Focusing and Listening: Theory and Practice in a Group Setting
Neil Friedman, Ph.D., Center for Experiential Therapy, Associate Professor, School of Social Welfare, State University of New York at Stony Brook, N.Y.

322 Group Methods for a Feminist Pedagogy
Peggy Brick, M.A., Teacher, Dwight Morrow High School, Englewood; Co-Founder, Affirmative Associates, In-Service Teacher Education, N.J.

323 Warm-Ups: Theory and Methods (Demonstration and Experiential)
Sandy Melnick, M.D., Resident in Psychiatry & **Elaine Selan Burke, R.N.,** Young Adult Program; Institute of Pennsylvania Hosp., Philadelphia, Pa.

324 Psychotherapy with Artists
Betty J. Kronsky, M.S., C.S.W., Gestalt Therapist, Faculty, The New School for Social Research, N.Y.C.

325 Psychodrama in the Schools III: An All Day Symposium

326 Music—Creativity—Psychodrama: Experiential
Robert L. Fuhlrodt, C.S.W., A.A.M.T., M.M., Clinical Social Worker, Certified Music Therapist, Raritan Bay Mental Health Center, Perth Amboy, N.J.; Psychotherapist, Institute for Sociotherapy; Lecturer, Marymount Manhattan College, N.Y.C.

327 Expanding Your Role Repertoire
Meg Givnish Baumm, Certified Psychodramatist, Horsham Clinic Inc., Ambler, Pa.

Saturday April 28 2:00 pm–4:30 pm Demonstration Sessions 328–342

328 Use of Psychodrama in Dealing with Physical Illness
Tobi Klein, B.Sc., M.S.W., Co-Director of *CHANGE;* Director of Canadian Institute for Psychodrama and Psychotherapy, Montreal, Canada.

329 Current Research in Psychodrama and Sociometry: A Panel Discussion Including Psychodrama Interns and Residents at St. Elizabeths Hosp. and Invited Presentors
Chairperson: **Monica L. Meerbaum, M.A.,** Staff Psychodramatist, St. Elizabeths Hosp.
Panel Members:
Susan Allen, B.A. & Lillian Donnard, B.S., Residents I: Changes in Locus of Control, Self Concept, and Perceptions of Psychodrama Competency in Psychodrama Trainees.
Lillian Donnard, B.S.: The Effects of Participation in a Psychodrama Group on Locus of Control.
Dennis Blair, B.A., Intern I, **Michael W. Smith, B.S.,** Intern I and M.
Katherine Gardner, M.Ed., Intern III: The Use of Psychodramatic Role Training to Increase Social Interactions of Ex-Psychiatric Patients.
Neil Passariello, B.A., Intern II: The Effectiveness of Psychodrama with Hispanic Patients: An Exploratory Study.
Bill Picon, Ph.D., Staff Psychodramatist, **Claire Altschuler, M.Ed.,** Inter III, **Wilhelmina Wooton, B.S.N.,** Intern II, & **Jon Sherbun, M.S.W.,** Intern III: Changes in Institutionalized Behaviors and Attitudes of Psychiatric Inpatients Participating in a Psychodrama Re-Entry Group.

Jeffrey Dickert, M.S.W., Intern III & **Mary Minner, M.Ed.,** Intern III: Psychodramatic Family Therapy With the Deal.

330 Stop Worrying!
David Freundlich, M.D., Board Certified Psychiatrist, Director, Center for the Whole Person in Manhattan and Putnam Valley, N.Y.

331 Use of Psychodrama in Private Practice
Sylvia Ackerman, M.A., Executive Director, Central Queens Psychotherapy Center, N.Y.

332 The 'Me' Inside My Job
Howard Seeman, M.A., Lecturer, Lehman College, CUNY; Educational Affiliate, Institute for Sociotherapy, N.Y.C.

333 Psychodrama with the Suicidal Person
James D. Deleppo, Ed.D., Staff Psychologist; Assistant Chief, Day Hospital, Boston VA Medical Center; Clinical Instructor in Psychiatry, Tufts Medical School, Boston, Ma.

334 A New Approach to Understanding Therapy: Integrative Eclectic Therapy
Paul Hurewitz, Ph.D., Professor, Herbert H. Lehman College, CUNY, N.Y.

335 The Relationship of Painting to Psychotherapy
Steve Ross, President, Association of Artist-Therapists, Inc., N.Y.C.

336 Interactional Group Psychotherapy for Beginners in Group Psychotherapy
Ray Naar, Ph.D., Private Practice, Pittsburgh, Pa.

337 Alternate Life Roles Through Psychodrama
Dennis W. Keene, Psychodramatist, Executive Director, Concepts; St. Luke's Hospital, Alcohol Treatment Unit, Phoenix, Az.

338 Chronic Psychotic Patients: Adolescents through Adults
Dr. J. G. Rojas-Bermudez, Medico-Siquiatra, National Hospital José T. Borda, Buenos Aires, Argentina.

339 Gestalt in Depth: Lecture, Demonstration
Kenneth Meyer, Ph.D., Program Director, Gestalt Center of Long Island; Clinical Supervisor, National Institute for the Psychotherapies.

340 Psychodrama in the Schools III: All Day Symposium
Continued from morning session #325. Open to afternoon participants.

341 Triadic Existential Psychodrama: A Workshop
Anne Ancelin Schützenberger, Ph.D., Director of Psychodrama, French Group of Sociometry, Group Dynamics and Psychodrama, Paris; Professor, Social Psychology, Nice University, France; United Nations Expert for Psychodrama.

342 Psychodrama, Action Sociometry and Human Sexuality
Joe W. Hart, Ed.D., Graduate School of Social Work, University of Arkansas at Little Rock; **Pamela D. Hedrick,** McLean Hospital, Boston, Ma.

Sunday April 29 10:00 am–12:30 pm Demonstration Sessions 406–420

406 From Stranger to Acquaintance: Using the Group Process to Facilitate Friendship
Judith Balos, Trainer, Human Relations Consultant, Human Resources Admin.; **Howard W. Polsky, Ph.D.** Professor, Columbia U. School of Social Work, N.Y.C.

407 Gestalt Therapy: Body/Mind
Murray Needleman, Ed.M., Psychotherapist, Gestalt Trainer, Radio Talk Show Host WWDB-FM, Philadelphia, Pa.

408 The Magic Time Machine
Barbara Little Horse, B.A., Supervisor, Department of Social Service; T.A. Therapist, N.Y.

409 Art Therapy: Group Techniques
Carol Beighley Paraskevas, M.A., A.T.R., Consultant, Carrier Clinic, Belle Mead; Instructor, Trenton State College, N.J.; Columbia University, N.Y.C.

410 The Mirror Technique in Psychodrama: A Tool for Cognitive Integration and Action Closure
William R. Woodruff, M.S.W., Human Services Program, University of Tennessee, Knoxville, Tn.

411 Psychodrama and Expressive Therapies with Psychotic Patients
Yaacov Naor, Ed.M., Clinical Expressive Therapist and Psychodramatist, Director of the Expressive Therapies Department, Danvers State Hospital, Hathorne, Ma.

412 Homemade Roles and Jams: Psychodrama and Transactional Analysis Script Theory
Paul F. Curnow, Ph.D., Clinical Psychologist, Friends Hospital, Philadelphia, Pa.

413 Art Therapy: Outer Expression of Inner Experience
William E. Foulke, M.A., A.T.R., Executive Director, Arizona Institute of Art Therapy, Phoenix.

414 The Family Therapist As A System Interventionist
Uri Rueveni, Ph.D., Acting Director, Division of Community and Social Intervention, Eastern Pennsylvania Psychiatric Institute, Philadelphia, Pa.; **Mira Rueveni,** M.S., St. John of God School System, Westville, N.J.

415 Moreno as Storyteller: Roots of Psychodrama
Daniel Yashinsky, Storyteller, Psychodramatist; Staff, Toronto Center for Psychodrama, Canada.

416 Mapping Your Magic: A Guide for Inducing and Reorganizing Experience in the Change Process
Paul Lounsbury, M.A., Neuro-Linguistic Program, Impact; Private Practice, N.Y.C.

417 Psychodramatic Techniques in Creative Life Planning: A Demonstration
Robert P. Brady, Ed.D., Psychologist in Private Practice, Toledo; **Linda M. Brewster, Ph.D.,** Counselor, Counseling and Career Development Center, Bowling Green State University, Oh.

418 Art Therapy and Androgyny
Jacqueline Bachar, Art Therapist; Faculty, Bergen Community College-Community Services; Ridgewood School of Art; Yoga and Growth Center of Bergen County; N.J.

419 Sensory Awareness Groups with Psychotic Patients
Elizabeth Krajic-Kachur, Ph.D., Psychologist, Rikers Island Mental Health Center, N.Y.C.

420 In Search of Role Models: Women in the Professional World
Monica L. Meerbaum, M.A., Staff Psychodramatist, St. Elizabeths Hospital, Washington, D.C.

Sunday April 29 2:00 pm–4:30 pm Demonstration Sessions 421–436

421 Psychodrama and Intimacy
Thomas Treadwell, M.A., Psychodramatist and Associate Professor, West Chester State College, West Chester, Pa.

422 Group-Centered Leadership: A Group Becomes a Family
W. M. Lifton, Ph.D., Professor of Education, SUNY at Albany, N.Y.; **T.N. Tavantzis,** Executive Director, Parkhurst Childrens Shelter, Schenectady; **T. Mooney,** SUNY.

423 Double Trouble: My Disowned and Dominating Parts: A Gestalt Therapy Experience
Marvin Lifschitz, Ph.D., Director, New Institute for Gestalt Therapy, N.Y.C.

424 Creative Aggression: Experiential/Didactic
David C. Belgray, M.S., Psychoanalytic Psychotherapist, Consultant in Management Development and Executive Counseling; Adjunct Professor of Management, Fordham University, Graduate School of Business, N.Y.C.

425 The Intense Feeling Process in Psychotherapy
Charlotte Saunders, Staff Therapist, The DiMele Center, N.Y.C.

426 Daring Intimacy
Alfred D. Yassky, M.A., Executive Director, American Psychotherapy Seminar Center, N.Y.C.

427 The Self-Actualizing Activity: An O.T. Approach: (Experiential)
Karen Diasio, M.A., O.T.R., Associate Professor and Graduate Coordinator, Department of Occupational Therapy, San Jose State University, Ca.

428 Music Therapy as a Treatment Modality in Psychiatric Short-Term Hospitalizations
Joan R. Weinstock, M.A., R.M.T., Music Therapist, Mt. Sinai Hospital; Carrier Clinic Foundation; Michael's Farm; Adjunct Faculty, N.Y.U., N.Y.

429 A Struggle for Identity: The Emerging Ethnic Working Class Woman—Videotape Presentation and Workshop
Judith Kuppersmith, Ph.D., Assistant Professor, The College of Staten Island, CUNY.

430 Sing It—Using Voice, Drama, and Group Energy to Emerge from Blocked, Monotone Existence

Millie Grenough, M.A.T.; Associate, Center for Psychotherapy and Personal Development, New Haven, Ct.; Psychotherapist, Soho Space for Psychotherapy, N.Y.

431 An Assertiveness Model
George Greenberg, Ph.D., Behavior Therapy Unit, Paine Whitney Clinic; Psychiatry Department, Cornell Medical School, N.Y.C. & **Deborah Zeigler, M.A.,** Lecturer, Pace University, N.Y.U., Adelphi and the Womanschool; Greenberg-Zeigler Associates, N.Y.C.

432 Closure in Groups
Carol Ann Locher, M.S.Ed.; Substance Abuse Counselor, Human Resources Center of Volusia County, Inc., Daytona Beach, Fl.

433 Gestalt Approaches in Times of Transition
Eleanor G. Restifo, M.Ed., Gestalt Therapist; Academy of Psychodrama and Sociometry, Horsham Foundation, Ambler; Norristown Life Center, Pa.

434 Recontextualization
Matthew Fried, Ph.D., Steve Hymowitz, C.S.W., Arthur Phillips, M.D., & Madalyn Phillips, A.B., Co-Directors, Meta-Communication Seminars, N.Y.C.

435 Gestalt Therapy with Individuals in Schizophrenia
John H. Gagnon, M.S., Gestalt Therapist; Director, The Counseling Center of Ridgefield, Ct.

436 Playback Theater Performance
Jonathan Fox, M.A., and the Playback Theater Company, Poughkeepsie, N.Y.

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History of the Institute

The Institute was founded in 1936 by Jacob L. Moreno, M.D., psychiatrist, psychologist, sociologist, educator, philosopher, theologian, dramaturge, teacher and poet. He developed a system consisting of three branches, group psychotherapy, sociometry, and psychodrama, which have achieved world wide recognition.

The Institute is now under the direction of Zerka Toeman Moreno, his widow and chief assistant since 1941. She has made a number of contributions to the field, both as co-author with J. L. Moreno and in her own right. She has traveled widely to bring these methods to the attention of professionals, both here and abroad.

The Theater of Psychodrama, constructed in 1936, the first of its kind, has served as a model for this type of vehicle.

The publishing house associated with the Institute, Beacon House, specializes in books and journals in the field, obtainable on order.

Qualification for Admission

The program is on the graduate level. All persons in the helping professions are admitted. Although the largest number of students go on to certification, many enroll to enlarge their armamentarium of intervention and to learn more about action and group methods. Certified Directors may wish to present themselves for examination by the American Board of Examiners for recognition at the national level.

Description of the Program

Students live in close proximity, in a miniature therapeutic society, incorporating the spirit of a scientific laboratory. Participants explore the structure of their own group. Sociometric and role tests are some of the measures used.

Participants are expected to become actively involved as protagonists, auxiliary egos, group members, or directors. Evaluation of performance, informal lectures, discussion periods, practicum sessions, videotape and films, open and closed groups are all part of the learning process. Faculty members are assisted by advance students.

Training Schedule for 1980

Jan. 4–24	July 4–24
Feb. 1–21	Aug. 1–21
Feb. 29–March 20	Aug. 29–Sept. 18
March 28–April 17	Sept. 26–Oct. 16
April 21–30	Oct. 24–Nov. 13
May 9–29	Nov. 21–Dec. 11
June 6–26	Dec. 19–Jan. 1, 1981

Write Moreno Institute for information about special workshops during intersession periods.

Special groups of four or more students from affiliated Institutes, when enrolling at one time, will be given 25% scholarships if endorsed by their teacher. Arrangements for these groups must be made at least 6 weeks in advance, due to limited accommodations.

Daily Schedule

Opening Session:	3:00 p.m. of the first day
Final Session:	5:30 p.m. of the last day
Morning Session:	10:00–12:30
Afternoon Session	3:00–5:30
Evening Session	8:00–10:30

It is requested that students plan to arrive in sufficient time to be present at the 3:00 p.m. opening, so as not to disrupt the group process.

Students unable to arrange this should so inform the office, by mail or telephone in advance.

Enrollments must be made for a minimum of three days, but students may elect either a three-day, one, two or three week periods, as their schedule permits.

Travel Information

Train: Penn Central to Beacon; car: Beacon, on Route 9D; plane: either LaGuardia or Kennedy Airports, then by Hudson Valley Airporter Limousine to Holiday Inn, Fishkill, N.Y., then by taxi to 259 Wolcott Avenue, Beacon. Limousine service has red phone at airports next to Baggage Claim.

Accommodations

The student residence is attached to the psychodrama theater. A number of private rooms are available.

Room and board is included in the fee. Students must make their own arrangements if they wish to sleep off campus, and carry the cost. Room assignments are on a first-come basis. In case of overflow, inexpensive rooms are available off campus. Meals can be taken at the residence as included in the fee.

Open Sessions

These take place every Saturday night. The public is admitted and students participate freely. This gives them a chance to try out their new skills with a variety of groups. Advanced students may direct some of these sessions under the guidance of a staff member. Special sessions for students from nearby colleges are also part of the resident program.

Point System

Each 6 point period is made up of 7 days. A week consists of 7 times 7½ hours, total 52½ hours. Because of the intensity of the sessions, students may wish to take a free period during the week. This will not affect the points if a minimum of 50 hours are spent in session.

Total number of points for certification is 96; the number of hours 840.

Interim Practicum Periods

Students are expected to apply their new learning between training periods. This contributes richly to the growth of skill and experience, enables the student to evaluate himself at each level and points to strengths and weaknesses which can be corrected as learning proceeds.

Consultation and guidance by staff members are offered throughout.

Certification

Although students may enroll for a minimum of three days, the actual training is divided into four levels:

1. Auxiliary Ego—Training period of six months covering four weeks of resident training and a back home practicum. 24 points.
2. Assistant Director—Training period of one year covering eight weeks of resident training and back home practicum. 48 points.
3. Associate Director—Training period of eighteen months covering twelve weeks of training and a back home practicum. 72 points.
4. Director—Training period of two years covering sixteen weeks in residence and a back home practicum. 96 points and a thesis. The thesis may be begun upon completion of the previous level.

DEPOSIT: $80.00 is required with registration blank; not refundable, but credited toward other workshops.

TUITION: Including room and meals, $60.00 per day minus deposit. Rooms are on a first-come basis.

DIPLOMATES

Graduates work in a large variety of fields: mental health center, community centers, day care centers, schools, family counseling, private practice, education, business and industry, government, theater, the ministry.

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BOOK REVIEW SECTION

Twerski, A. J. *Like Yourself and Others Will Too . . .* Prentice-Hall, 1978, 260 pp.

There is a twinkle in this book. Gone are the jargon and pomposity of traditional psychological writings. In are a down to earth yet sober language, a sadness tempered by humor, a delightful mixture of psychiatric knowledge and Hassidic wisdom.

The author keeps his theoretical pronouncements to a minimum and offers, instead, in the first part of the book, a series of examples and vignettes which show the effect upon people's lifes of a defective self-concept. The theme, of course, is a variation of the propositions advanced by theorists of the self such as Rogers, Syngg, Combs and others. The vehicle chosen, however, is one to which professional as well as lay people can relate. These exquisitely chiseled vignettes reveal not only a thorough knowledge of human nature but also an uncanny sensitivity to every aspect of people's lives, their trials and tribulations, their sorrows and joys, their hidden and public experiences. There is a curious mirror-like quality about them. It is impossible to read "Like Yourself and Others Will Too" without thinking, at one moment or another, "He must have been writing about me".

Part 2 deals with causal factors and the author transcends the traditional psychiatric habit of reducing all causality to inter-personal and intra-psychic factors. There is a fascinating and thought-provoking chapter on the possible effects of social, cultural and religious changes. Whether one agrees or disagrees with Twerski's philosophy becomes immaterial. One's thinking is stimulated. The chapter is written without dogmatism, with some wistfulness, is more descriptive than advocating. The reader experiences a deep sense of conviction, but neither a need to nor an attempt at conversion.

The last part of the book tries to answer the obvious question "What do I do now?" Although offering a couple of practical suggestions on how to enhance one's self-concept, it avoids the trap of becoming a "do it

yourself" manual and wisely steers the reader towards professional help, giving a glimpse of what professional help can be like and what it can do.

The strengths of "Like Yourself and Others Will Too" constitute, at the same time, its weaknesses. The professional reader, while captivated by the careful etching of the vignettes, may feel that Part 1, while deepening one's understanding of human behavior makes no significant addition to existing knowledge. Part 2 leaves that same reader with a sense of incompleteness. It is enough to whet but not satisfy one's appetite and one wishes that the chapter on social and cultural causal factors was greatly expanded.

Be it as it may, to read "Like Yourself and Others Will Too" was a joyous experience.

Ray Naar, Ph.D.

Glassner, Barry and Jonathan Freedman, *Clinical Sociology,* New York: Longman, Inc., 1979, 422 pp.

Envious of the technological advances made by the Physical Sciences, the Social Sciences, in the latter part of the 19th Century, attempted to emulate the hard sciences by borrowing their methodological model of Scientific Investigation.

This tendency has affected the Social Sciences in at least two ways:

—Social Scientists became largely interested in quantitative data which are amenable to measurement and testing. The goal of social science research became to develop general laws that will help us control and predict human behavior as is evident in the advent of "Behaviorism".

—The role of the Social Scientist as "philosopher King" who activates change by considering what "ought to be" was replaced by the social scientist as objective empiricist who supports the status quo by describing and organizing knowledge about "what is."

We can clearly observe these tendencies in the field of Psychotherapy. Psychotherapists faithful to behaviorism and the Freudian medical model have, by and large, sacrificed the value questions for the quantitative data, and their role as change agents for their role as "social supporters" of the status quo.

Ignoring the social ethical nature of mental illness, they chose to play the role of "social controllers" of the so-called "deviant-problem-individuals."

Clinical sociology, Freedman and Glassner suggest, attempts to deviate from traditional psychotherapy in two ways:

—It seeks to understand individuals within their sociological situational context, and hence emphasizes the social-ethical dimensions of their difficulties.
—Through the systematic application of sociological knowledge, it helps agonized individuals and group members, by diagnosing the intertwining web of their difficulties, and devising treatment that will help them change their social situation, rather than merely adjust to it.

As a form of therapy, clinical sociology is not new. J. L. Moreno, one of the first clinical sociologists, developed his sociometric methods, as early as 1917. However, clinical sociology has not yet received the recognition it deserves as a distinctive and relevant form of therapy.

In *Clinical Sociology* Freedman and Glassner take the initial step to introduce all students and professionals in the human services field to this form of therapy. Attempting to reach a wide scope of readers, Glassner and Freedman's methodology is explanatory and descriptive, seeking to initiate and introduce rather than prescribe and indoctrinate. This is not to say that the authors conceal their individual perspective. In the Introductory chapters there is a quiet, nondogmatic, plea for a contextual phenomenological approach to the treatment of individuals and groups.

The book is organized into five major sections: delineating clinical sociology, sociological theories and methodology, vital features to consider as a basis for diagnosis, and techniques of sociological therapy. Students of the human services will find *Clinical Sociology* a relevant and comprehensive textbook, and professionals in the helping fields will view it as a helpful guide for incorporating clinical sociology within their practice. It offers them valuable guidelines for sociological diagnosis and treatment. The authors give a detailed exploration of the constructive and destructive forces of certain vital sociological features (such as ethnicity, stratification, age, family, etc.,) and suggest these as a basis for diagnosis and treatment. The last chapter offers a dearth of relevant sociological questions that, if utilized by professionals in the helping field, could enable them to incorporate the sociological perspective in their therapy.

Alia Abdul-Wahab-MA, M.S.W.

Poetry in the Therapeutic Experience, Edited by Arthur Lerner Ph.D. Pergamon Press, New York, 146 pp.

Poetry in the Therapeutic Experience is a collection of 12 essays written by professional men and women who use poetry as a healing art. In his introduction, Dr. Lerner, who edited the volume, admits that "the field

known as poetry therapy is presently composed of a wide variety of experiences and interests groping for a central theory or rationale . . . the use of poetry therapy is a tool not a school," and he hopes that "the various schools of psychology can find a place for poetry . . . in their respective frames of reference." Dr. Lerner makes no attempt to suggest a "central theory or rationale." While we await the theory, we may learn from the practice.

The book may be divided into four sections which focus on: the patient as poet, the patient responding to a poem presented by the therapist, poetry therapy in a hospital environment, and discussion of the techniques of poetry therapy in a group context.

In the opening essay Dr. Edward Stainbrook speaks of patient-produced poetry as an activity which can integrate aspects of the self and "create and maintain personal meaning." Dr. Charles Ansell treats the patient's poem as a "bridge" or collaborative creation between the unconscious and the evolving ego. He echoes his colleague when he writes of our "forever creating personal meanings out of our chosen ways of perceiving experience." Poems then become, in the phrase of Dr. Ken Edgar, "epiphanies of the self," and poetry-making the dredge and salvage process by which "unwanted emotions" may be brought to consciousness and gradually integrated. Dr. Edgar's essay is particularly rich in quotations of poetry and excerpts from the therapeutic dialogue. And in Dr. Owen Heninger's account of "the healing power of poetry" we follow the personal "odyssey" of one of his patients. Again the emphasis is on poem-making as a process leading to "insight", achieved through "the venting of potentially explosive psychic forces."

Poems are also interventions which the therapist may assign in order to stimulate feelings and open new vistas for possible exploration. Here the concern shifts to different questions: what kind of patient is most likely to benefit from poetry therapy? what kinds of poetry are most effective? And if the interpretation of the poem becomes a tool for diagnosis and treatment then how does the therapist establish interpretive norms by which to measure the "pathological distortions" (Ross) of the mentally disturbed? Dr. Franklin Berry reports on studies he ran to answer the first two questions, while Dr. Robert Ross sets forth a recondite technique for "mapping" poems in order formally to "describe relations within texts that give these texts their meaning."

Allan Abrams, Louise Davis, and Julius Griffin all describe their experiences with poetry in the hospital environment. Louise Davis works as a paraprofessional at Woodview-Calabassas Hospital, where Dr. Lerner is Director of Poetry Therapy. For her poetry had "a less threatening effect than formal psychotherapy," while one of her patients described a group

poetry experience as "group therapy, only kinder." Dr. Griffin reports on his work at a Veteran's Administration Hospital where he pioneered the establishment of a "patient literary discussion group." As a social experience alone, using literature in a hospital context appears to have considerable value. Dr. Allan Abrams' overview and conclusions accord with his colleagues: "Poetry therapy seems to be a highly compatible member of the hospital's treatment team." All three indicate that it takes time for both staff and patients to accept a new approach.

Finally two essays, "Action Techniques in Psychopoetry" by Drs. Schloss and Grundy, and "Zen Telegrams" by Mary Clancy and Dr. Roger Lauer describe practical methods for using poetry in group settings, especially as a warm-up for action therapy. Roger Lauer's "Abuses of Poetry Therapy" reminds us that no method can be a panacea, no technique work in every situation. He moderates the enthusiasms of his colleagues with three fables of excess.

This book clearly indicates that pluralism flourishes in certain quarters of the psychiatric community. These essays provide an update on the state of the art as far as poetry therapy is concerned, and if Dr. Lerner's dream of a "central theory or rationale" is yet to be realized, he and his colleagues seem to be enriching their practice without it. On our way to such a unified field theory, where might we go from here? There were certain voices missed in this volume. One was the voice of the poet, someone who has taught poetry and written it and who might be able to comment on its healing and educative functions. (To say nothing of poets for whom writing has been a lifeline.) Missed also were the voices of patients who had undergone poetry therapy as a healing experience. How might they reflect upon writing and reading poems, about sharing poetry in a group? And finally a third voice, perhaps more philosophical, which might speculate on what Shakespeare saw when he wrote in *Midsummer Night's Dream* that "the poet, the lover and the lunatic are of imagination all compact."

Peter Pitzele Ph.D.

Great Cases in Psychotherapy edited by Dan Wedding and Raymond J. Corsini. Itasca, Illinois: F. E. Peacock Publishers, Inc., 1979. xiv + 314 pp.

Judging from the cases published in academic and professional journals, case method is a research approach that is alternatingly viewed by social and behavioral scientists with either contempt or annoyance. Generally

case method has more acceptance among those with a clinical orientation, who are less involved in "doing studies" and more involved in meeting clients. This is because the way in which someone has managed a case may be instructive to someone else who has a similar case.

Say an empiricist has designed a study, filled cells, tested subjects, described behavior, run data and has convincing evidence that "disclosure is significantly associated with intimacy in marriage." What becomes of the finding? The empiricist is off designing another study, unconcerned with whether the results can be utilized in some practical situation. The clinician is faced with what might be useful to real, live people on Monday morning. How that gets accomplished is the problem.

Some theories of human behavior are so well elaborated that it is easy to imagine that they exist only in the abstract, and have no direct application to individuals. Clinical case studies serve to remind us that a complex theory grew out of repeated experiences with individuals. They also serve to illustrate how someone else has tested a theoretical approach and used the theory to produce certain results.

There are a number of reasons that case studies have not been widely used in the past. These include the lack of verbatim accounts before the general availability of recording equipment, and the confidentiality issue, but most importantly, the reluctance of therapists to expose their own professional behavior to the scrutiny of their colleagues. Subsequently, students of psychotherapy have had to learn by trial and error or from novices. Except for random successes, students missed out on what the major figures did, what worked, and how it worked.

Taking to heart Samuel Johnson's statement that "example is always more efficacious than precept," the editors of this volume have put together an interesting and illustrative collection of clinical cases as they were responded to and reported by leading representatives of the various approaches to psychotherapy. It was the purpose of the editors to bridge the distance between the vague abstraction of the therapeutic process to a clinical reality, from the theoretical formulations by which systems of psychotherapy are generally known to actual interchanges between client and therapist.

The cases are well selected, representing all the major psychotherapeutic approaches including behaviorist, psychoanalytic, and more "humanistic" methods. The major figures are included such as Freud, Jung, Adler, Rogers, Ellis, Wolpe, Perls, Moreno, Berne, Greenwald, and Glasser. The cases span time from the 1800's pioneering efforts of Pierre Janet to the open encounter of William Schutz in the 1970's.

It is generally known that academic and professional journals do not publish research "failures" such as nonsignificant findings. Apparently

this kind of standard applies to the publishing of clinical cases as well. So, unfortunately, the only cases available for the editors to draw from are "successes" which demonstrate the effectiveness of the method and the expertness of the practitioner. A beginning clinician may come to believe that only he/she is baffled, uncertain, confused, or "stuck." There is no opportunity here to learn from the failures of others. Readers will be forced to take the cases as examples of what might be done and learn from their own failures.

Alton Barbour, Ph.D.

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