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## 18 Psychodrama

Zerka T. Moreno

### Historic Background

THE ROOTS OF PSYCHODRAMA go back to the Greek theater. It is generally conceded that Aristotle was the first to observe and describe the notion of "catharsis" in *De Poetica*. While dissecting the structure of tragedy, he stated it to be "imitation of an action, in a dramatic, not in a narrative form; with incidents arousing pity and fear, wherewith to accomplish its 'catharsis' of such emotions."

At the time Moreno arrived upon the scene, drama constituted a problem for him. His concern was with what would happen to the actor if the script were taken away—if, so to speak, the actor became poet-playwright, actor, and observer in one. He began to work with children in the gardens of Vienna, at first telling them the fairytales so beloved of the young. Gradually it occurred to him that the children, for whom play is a natural habitat, should be allowed to enact the tales rather than be passive receptacles of this cultural heritage, however valuable. Moreno began to let them choose their own roles, or to assign them as he sensed the needs of the child. When they enacted these fairytales for the first time they were wonderfully creative, inventive, and spontaneous. The more often they repeated the same roles, however, the less free became their expression; they became more rigid and frozen; rehearsals also reduced their spontaneity and creativity. The next step was, therefore, to discard the script, to permit them to develop their own roles, their own fairytales. In the course of organizing large numbers of impromptu play groups it became evident that the children not only enjoyed the drama, but that they learned and grew. Some unpleasant personality characteristics appeared to be modified, while various desirable ways of interacting with others were given a chance to emerge.

From these naïve beginnings, Moreno developed the theoretical foundations involving such concepts as the encounter, spontaneity-creativity versus cultural conserves, the spontaneity factor, the pathology of spontaneity, spontaneity training, the act in the here and now, performance neurosis, the warming-up process, the role and its pathology, the pathology of interaction, tele, and sociosis, and many others.

In 1921 he made his first attempt to establish a Theater of Spontaneity for adults (1). This took more the form of what he later came to designate as "sociodrama," that is, the enactment of a problem relating to and involving an entire group, rather than that of a specific individual. The problem was that of Europe in disorder. It was a time of ferment, a few years after World War I; the great Hapsburg Empire had collapsed, Russia was still in the throes of the aftermath of revolution, restlessness was everywhere. There was no powerful leader to guide the people of Europe. It came to Moreno that this was a time to test the potential for new ideological leadership. He secured a theater for one night and invited representatives from foreign countries in Vienna to this open house. The night of the performance, April 1, only an empty stage was visible, with an empty throne and a crown resting upon it. But there was neither cast nor play. There was only the stage director—himself. He addressed the audience and invited one after another of the illustrious participants to step upon the stage and address the audience, conveying their own ideas of how the problems of the world could be solved. Many tried but none were elected. The world remained as leaderless as ever.

The incident was less vital in itself than some of the questions that led to it and also from it, namely: First, how well will an individual perform in a role which, though proscribed by society, needs original inventiveness? Second, man is a role player in a drama which he is forming in an ongoing fashion with other human actors. He may have been spontaneous once but the more often he repeats the role, the less is his spontaneity. Is there, then, a method by means of which this spontaneity can be uncovered and reinfused? Third, can spontaneity be an art form in itself, apart from its therapeutic potential? Fourth, will making the actor more spontaneous also produce a deeper kind of catharsis in the spectator? Fifth, what is the nature of creativity? Are there several forms of creativity? In what ways does the creativity of a highly developed type, such as that found in a Da Vinci or a Beethoven differ from the type required to live life creatively, day by day? Sixth, what are the forces impinging upon spontaneity and creativity which render it pathological?

In opposition to the psychoanalytic view of man, the underlying assumption was that the human psyche is not a closed system, that it is the human being *plus* his interrelations with others that ought to be the concern of the psychiatrist. Individual treatment does not necessarily create change of behavior or improve human interaction. Insight alone may not

produce cure. The main emphasis is on the primordial nature of the act. Moreno considered verbal communication both ontogenetically and phylogenetically, a rather late development in man. Below language is the action matrix. It is man as an actor and interactor who is the focus of concern. His insights developed from man in interaction with one or more significant others and not from the treatment of the individual in isolation.

Before attempting adult sociodrama in 1921, Moreno had tried out a number of other innovative approaches to groups. Among these was verbal group psychotherapy of prostitutes; another was the application of psychodrama to entire families, between 1910 and 1914. He was concerned about the differences between a natural group and an intentional one; the impact of emotional infection between group members; the pushes and pulls of emotional entanglement in a group; the effect upon man's creativity of the products of that same creativity such as machines, books, tools, and finished products of all types, and whether these children of man's mind might not constitute a danger to the children of his loins. He observed that because the male of the species cannot bring forth children from his body, he loves better and becomes more attached to the children of his invention, and that the latter might become enemies of the former, turning against their creators like a Frankenstein.

During World War I his assignment was as medical superintendent of a resettlement camp of Tyrolean wine-growing peasants who had been moved from their mountain homes. As they were largely "irrendenta" with sympathetic leanings toward Italy, they constituted a threat to the Hapsburg Empire. In the uprooting consequent to this resettling, their multiple interactional problems emerged starkly. Out of this setting, as well as out of his earlier family practice, Moreno developed the systematic study of group organization, a science of human relations which he called "sociometry," that is measurement of human society.

In the course of undertaking the treatment of entire families, he gradually forged the interactional, not solely verbal, form of therapy. The partners in a conflict were made to enact it, rather than to talk about it. This led to the idea of "redoing" the conflict scenes in many different ways, with an opportunity to experiment with more suitable alternatives. The idea of role reversal between the original partners emerged, each taking the role of the other, and, still later, the idea of the *auxiliary ego*. The latter became eventually the crucial instrument in the treatment of mental patients. The auxiliary ego was a therapeutic actor, enabling the relevant absentees to be portrayed so that the patient could present his inner and interactional drama completely. With the psychotic, especially, the auxiliary ego was fundamental in the patient's coming to grips with delusions, hallucinations, fears, dreams, body parts, and threatening objects, all of which could now be dealt with in concrete fashion.

Between 1922 and 1925 Moreno organized the Theater of Spontaneity in Vienna, the laboratory in which many of his ideas could be tested and further developed. Although it was originally conceived as an art form, it gradually became a therapeutic theater, and subsequently the psychodrama was established as a full-fledged approach to major mental disease. Its clinical application was begun in 1936 at Moreno's mental hospital in Beacon, although he spent several years in New York City with groups of actors in impromptu theater production at Carnegie Hall and at the Civic Repertory Theater between 1927 and 1932, as well as working with children at Mount Sinai Hospital and the Plymouth Church play school.

Moreno ascribed his faith in the psychodrama to the fact that he had been his own first patient, using the method on himself. He wanted to prove that a person could be what might be designated as insane, pushing himself to the brim of sanity, yet remaining creative and productive. One of his basic postulates was that unless man can make peace with his God-likeness, with what he termed "the I-God" within him, he could not endure and remain balanced in what appears to be an unfriendly universe. Therefore, he believed and put into practice the principle of God-playing as a systematic approach to emotional imbalance. This God-playing is evident in children and is the source of creativity and spontaneity. In our society, rather than supporting this God-likeness, it is suppressed, distorted, denied, negated, scorned, and pushed underground, and it is responsible for numerous forms of emotional illness. Obviously, this is almost the exact antithesis of the psychoanalytic view of man. One of Moreno's main theses is that if spontaneity and its twin principle, creativity, are denied healthy expression, they will find unhealthy forms in which to emerge. According to this view man is a multiple role player, an improvising actor on the stage of life. Denying him the ability to complete his numerous dramas will lead to unhealthy manifestations of his emotional needs. Rather than attempting to reach objectivity through analysis and rational interaction, Moreno advocated the completely subjective route to gain genuine objectivity. It is this delicate balance between objectivity and subjectivity which is one of the main axes of intervention for the psychodramatic therapist, and one of the main reasons why this approach is both so threatening and so difficult to learn. Moreno taught that incomplete living through of fantasy may cause eruptions into reality, which then become difficult to deal with and to control in life itself. He referred to psychodrama as a "kindergarten for adults" and as "a cosmetic for the psyche." We have come to look upon it also as "a small dose of insanity under conditions of control." Control can be taught only after expression in action has been completed. Psychodrama is often described falsely as "a method for acting out." It is obvious from the previous statement that it is just as much "a method for acting in." But whereas control is expected to be applied externally in other

methods, in psychodrama it is taught to emerge from within the person. The psychodramatic position is that it is the autonomy of the actor which needs to be mobilized and guided into integrative rather than disintegrative channels.

Psychodrama is both an intrapersonal and an interpersonal method, a form of behavior training as well as body therapy, a form of psychotherapy as well as of sociotherapy. It has numerous areas of application: diagnosis, therapeutics, research, and education and training for a profession or vocation.

There are two main types of psychodrama: the confessional or direct form, and the nonconfessional or indirect form. In the first, the patient or the group makes a more or less open declaration of the difficulties which bring about the need for treatment. In the second, the mirroring of typical situations similar to those of the group members stimulates the spectators' own attempts at autonomous objectification and healing. This can be applied in minor maladjustments, incipient neuroses, and simple interpersonal conflicts. In more serious cases, however, this approach is but a prelude to the direct, confessional form of treatment, culminating in the personal presentation of problems on the stage.

## Basic Concepts

### MENTAL CATHARSIS

Two avenues led to the psychodramatic view of mental catharsis, the one as described above from the Greek drama; the other led from the religions of the East and the Near East. These religions held that a saint, in order to become a savior, had to make an effort; he had, first, to actualize and save himself. In other words, in the Greek situation the process of mental catharsis was conceived as being localized in the spectator—a *passive catharsis*. In the religious situation the process of catharsis was localized in the actor, his life becoming the stage. This was an *active catharsis*. In the Greek concept the process of realization of a role took place in an object, in a symbolic person on the stage. In the religious concept the process of realization took place in the subject—the living person who was seeking the catharsis. One might say that passive catharsis is here face to face with active catharsis, and aesthetic catharsis with ethical catharsis. These two developments, which heretofore have moved along independent paths, have been synthesized by the psychodramatic concept of catharsis. From the ancient Greeks we have retained the drama and the stage, and from the Hebrews we have accepted the catharsis of the actor. The spectator himself has become an actor.

## DEFINITION AND OPERATIONAL DIFFERENCES OF SPONTANEITY

*Spontaneity* is defined as a new response to an old situation or as an adequate response to a new situation. The protagonist is challenged to respond with some degree of adequacy to a new situation or with some degree of novelty to an old situation. When the stage actor finds himself without a role conserve or the religious actor without a ritual conserve, they have to "ad lib," to turn to experiences which are not performed and ready-made, but which are still buried within them in an unformed stage. In order to mobilize and shape them, they need a transformer and catalyst, a kind of intelligence which operates here and now, *hic et nunc*—"spontaneity." Mental healing processes require spontaneity in order to be effective. The technique of free association, for instance, involves spontaneous acting of the individual, although it is restricted to expressing in words whatever goes through his mind. What is working here is not only the association of words but the spontaneity which propels him to associate. The larger the volume of word associations, the more significant and spontaneous is its production. Other conditions being equal, this is true of all methods of psychotherapy. In psychodrama, particularly, spontaneity operates not only in the dimension of words but in all other dimensions of expression, such as in acting, interacting, speaking, dancing, singing, and drawing. The significant event was the linking of spontaneity to creativity, in our view the highest form of intelligence, and to recognize them as the primary forces in human behavior. The dynamic role which spontaneity plays in psychodrama, as well as in every form of psychotherapy, should not imply, however, that the development and presence of spontaneity in itself is the "cure." There are forms of pathological spontaneity which distort perceptions, dissociate the enactment of roles, and interfere with their integration on the various levels of living.

## ROLE THEORY

The *role* is defined as a unit of functional behavior. Role playing is prior to the emergence of the self; roles do not emerge from the self, but the self may emerge from roles.

"Role," originally an old French word which penetrated into medieval French and English, is derived from the Latin *rotula*. In Greece and also in ancient Rome, the parts in the theater were written on "rolls" and read by the prompters to the actors who tried to memorize their part by heart; this fixation of the word role appears to have been lost in the more illiterate periods of the early and middle centuries of the Dark Ages. It was not until the sixteenth or seventeenth centuries, with the emergence of the modern stage, that the parts of the theatrical characters were read from "roles" or paper fascicles. In this manner, each scenic "part" becomes a role.

Thus, role is not by origin a sociological or psychiatric concept; it came into the scientific vocabulary via the drama. It is often overlooked that modern role theory had its logical origin and its perspectives in the drama.

The function of the role is to enter the unconscious from the social world, bringing shape and order into it. Every individual has a range of roles in which he sees himself and faces a range of counterroles in which he sees others around him. They are in various stages of development. The tangible aspects of what is known as ego are the roles in which the individual operates, with the pattern of role relations around an individual as their focus. We consider roles and relationships between roles as the most significant developments within any specific culture.

#### *Role Playing, Role Perception, and Role Enactment*

Role perception is cognitive and anticipates forthcoming responses. Role enactment is a skill of performance. A high degree of role perception can be accompanied by a low skill for role enactment and vice versa. Role playing is a function of both role perception and role enactment. Role training, in contrast to role playing, is an effort through the rehearsal of roles to perform adequately in future situations.

#### *Methods of Role Analysis*

We consider: (a) how the expectancy of acting in a role in the future affects a subject and each member of the audience; (b) role deficiency of a subject; (c) adequacy and superiority in a role on the stage and in actuality; and (d) whether a role is dominant or secondary to the subject and each member of the audience, on the stage and in actuality. Expectancy of acting in a certain role may produce a fear of entering situations in which that role comes to expression. In another case, the expectancy of a role may produce the opposite effect; getting a chance at expressing this role may increase courage, self-confidence, and satisfaction in the role.

#### TELE AND TRANSFERENCE

*Tele* is defined as a unit of feeling transmitted from one individual toward another and is always considered in terms of mutuality. *Tele* differs from transference in that it pertains to the actual feelings between persons based on the reality factor within the personalities involved and the real feelings generated between them. A relationship is a stick with two ends; *tele* is responsible for facilitating two-way communication within a relationship. *Tele* includes both transference and empathy. Transference and empathy are, furthermore, one-way relationships and not two-way relationships. *Tele* is the tree trunk of which one branch is transference; the other is empathy. It is clear that these three categories of perceiving the other are not always mutually exclusive. But no relationship can be built on

transference or empathy. Tele is the factor responsible for cohesion between two or more individuals in a group, whereas transference is the dissociative factor. Transference is built on fantasy; even the concept of countertransference is actually a misnomer. In *transference* the movement of feeling is from one person toward another; it is the projection from one person upon another and contains within it the fantasy construction of the projector. Since countertransference is also a one-way process, there are actually two parallel processes operating. Two lines in a parallelogram do not meet. There are, therefore, at best two parallel processes going on in transference-countertransference. In this context transference is considered the pathological aspect of the relationship. Empathy, on the other hand, first emerged in a situation of aesthetic behavior, that is, from a person upon an object as, a tall sculpture in a museum. A person standing in front of the sculpture might be seen to stretch himself to his fullest height to feel himself, so to speak, into the sculpture in all its dimensions. Obviously the sculpture was not reciprocating in kind. *Empathy* is a one-way projection of feeling from a person upon an object and does not require mutuality. Tele is the all-inclusive concept encompassing all three forms of perception and feeling.

#### THE SOCIAL ATOM

Man as an interactor creates a network of interrelations between himself and his relevant others. The individuals so related form together what is known as a "social atom," which consists, therefore, not merely of the single individual, but of the individual *plus* his significant others *plus* the relationships between them. In this context the relationship is as much the focus of attention as the persons concerned. When treating a dyad, husband-wife, mother-child, employer-employee, we are aware that we deal with three entities, not two, the two partners *and* their specific relationship. Thus, we are as much relationship therapists as we are psychotherapists.

The social atom can be employed in the exploration of the world of the psychotic as well as that of the neurotic or normal. It charts the delusional system in terms of the relationships and the personae which the patient has constructed for himself and which have replaced the objective or real social atom, that is, the real persons and their relationships to him and to one another. Once conceived and charted, the auxiliary egos can, under the direction of the chief therapist or director, represent these delusional roles, assisting the patient in clarifying and completing his needs for and with them. These same auxiliary egos, having been accepted by the patient on these terms, are now potential agents for therapeutic redirection and guidance into the real other world. In every sense of the word, they are auxiliary to the psychodrama, director or chief therapist who does not be-

come involved in the action. More important, they are auxiliary to the patient so as to help complete his inner psychotic drama which he is helpless to do on his own, and auxiliary to the world of the real persons to whom the patient must eventually return on some level of interaction. Thus, all the psychotic constructions of the patient can be embodied, concretized, and reintegrated. We consider the psychotic as a creative person who has been unable to complete his creation; the psychodrama provides helpers, midwives, in the creative process. We humans are unable to let go of those precious ideas, situations, relationships which have been left incomplete and unfulfilled. Once they have been brought to completion, it is easier to relinquish them. Psychodrama also offers what life itself usually does not, namely, the exploration of other possibilities and a thorough experiencing of the consequences of one's actions so as to evaluate the best route to take before trying it out in life itself. We have found the catharsis of action to be a more complete one than either interpretation, insight, or disillusionment can provide. Indeed, the psychotic profoundly resists these latter approaches, but psychodrama is his natural milieu; he is more comfortable with it and even enjoys it.

Once the patient has given up the delusional social atom and is coming out of the psychotic world, the objective social atom can be examined and the relevant others within it can be brought into the treatment situation. Indeed, the patient is not considered completely ready to resume going into the outside world until the outside world has been brought to him and made part of the treatment process itself. A comparison between the psychotic social atom and the objective one may point to the emotional needs not being met by the real one; there may have to be substitutions made or such corrections as will remedy the deficiencies experienced by the patient which supports his withdrawal from the real world and will precipitate him back into the psychotic world.

#### TREATMENT OF THE FAMILY

What is now known as "sculpting" in family therapy comes from the construction of the family into an action sociogram. Instead of depicting the relationships on paper, the family members are asked to place themselves spatially and mimically in relationship to all other family members, in such postures as they see themselves and each other. The family tableau is constructed subjectively by each family member, and each in turn can co-experience every other member's perception and experience of what the family interaction means to him. The elucidation of family conflict is then worked through in psychodrama and various other modes of interaction are tried out within the therapeutic setting. Thus, all participants in the conflict are simultaneously involved in diagnosis and treatment. This is a great step forward diagnostically; however, frequently it leaves something

to be desired from the point of view of therapeutics. With all the family members being co-protagonists, the ability to be spontaneous in behalf of total self-expression or availability for the others' needs is notably inhibited. The usual pressures and interpersonal conflicts operate in the therapeutic sessions as they do in life. Under these conditions total family interaction may be or may become inadequate or even negative. Repeating the "normal" course of events within the therapeutic setting often reinforces interpersonal pathology rather than resolving it. It may also happen that one or another member is unavailable at a crucial moment, for instance, in the case of resistance to treatment, or illness, or other circumstances which prevent attendance. A frequent finding has been the special importance of deceased family members who continue to dominate family interaction; their presence needs to be brought actively into the treatment process. Here the introduction of the auxiliary ego is so felicitous. It may be a trained professional or a family member whose objectivity, sensitivity, and talent for interpersonal contact make him or her a useful assistant in the therapeutic intervention.

This was, in fact, how the idea of the auxiliary ego originally emerged. There are numerous advantages in the employment of the auxiliary ego: it is freer, more spontaneous, both subjective *and* objective at the same moment. He or she can assume any number of roles as available in his or her role repertoire; he or she can enact the special role of a pet, delusions and hallucinations, ideas, values, needs, body parts of the protagonist or relevant others, and so on. This makes possible intrapersonal as well as interpersonal guidance and retraining until such time that the relevant other(s) are ready and can be brought actively into the treatment process.

As each participant can work first with a suitable auxiliary, the onus of one family member is spotlighted as *the* patient is removed and the focus of attention is placed on the entire family, where it rightly belongs.

### GROUP OATH

Group psychotherapists and psychodramatists frequently feel the need to convey to group members, at the beginning or in the course of a session, the nature of their responsibility during the process of treatment. The suggested group oath is not to be taken as a ritual, word for word, or as a dogma, but it tries to convey the spirit of such an oath which may be expressed or silent, or tacitly accepted by all.

This is the group oath to therapeutic science and its disciples.

Just as we trust the physician in individual treatment, we should trust each other. Whatever happens in the course of a session of group therapy and psychodrama, we should not keep anything secret. We should divulge freely whatever we think, perceive or feel for each other; we should act out the fears and hopes we have in common and purge ourselves of them.

But like the physician who is bound by the Hippocratic oath, we are bound as participants in this group, not to reveal to outsiders the confidences of other patients.

Like the physician, each of us is entrusted to protect the welfare of every other patient in the group.

## Code of Ethics for Group Psychotherapists

The advent of group and action methods in psychotherapy—the procedures most popularly known are group psychotherapy and psychodrama—has brought about a radical change in the relationship of the therapist to his patients and to the general public. Urgently needed is an “open discussion” of new principles to guide practitioners in this field. Here is a list of applicable rules. The fact that they are put in numerical order from one to ten should not imply that there is any finality about the formulation of these principles or that ten is a holy number or that this is a rank order as to importance or that they cover all aspects of the potential problems.

These principles are addressed to all group psychotherapists. They are not laws, but standards for maintaining a high level of ethical conduct.

1. The principal objective of group psychotherapy is to render service to every member of therapeutic groups and to the groups as a whole.

2. A group psychotherapist should practice methods of healing founded on a scientific basis, approved by official professional boards.

3. The designation “group psychotherapist” or “psychodramatist” should be used only by psychotherapists who have obtained training in recognized institutes of learning. As the field is new and expanding, the therapists should continuously improve their knowledge and skill; they should make available to other therapists and their patients the benefits of their attainments.

4. A principal objective of the group psychotherapist is to protect the patient against abuse and to render service to groups of patients with full respect for the dignity of every patient.

5. Therapeutic groups should be so organized that they represent a model of democratic behavior. Regardless of the economic, racial, and religious differences of the patients, they should be given “equality of status” inside the therapeutic group.

6. Should patients of the same therapeutic group pay the *same* fee or not? Could charging different fees to members of the *same* therapeutic group produce feelings of inequality and thwart the therapeutic aim?

7. The patients should be free to choose the therapeutic groups in which they participate as members. The therapist, in turn, is free to accept or refuse to serve in behalf of a therapeutic group. Indications or contraindications for “coercive” placement in the groups should be carefully

weighed in exceptional cases, as in the treatment of deteriorated mental patients.

8. The Hippocratic oath binds the physician to keep all matters of his professional practice secret. *In group psychotherapy the Hippocratic oath is extended to all patients and binds each with equal strength not to reveal to outsiders the confidences of other patients entrusted to them.* Like the therapist, every patient is entrusted to protect the welfare of the co-patients.

Should group psychotherapy and psychodrama be televised, it would produce "leaks" of the confidence pledge difficult to control. Closed circuit television broadcasting for subscribers only is a tolerable but unsafe way out of the dilemma. But the "open" circuits may become the major route for mass psychotherapy. How can we utilize them without taking risks?

9. Every patient is expected to divulge freely whatever he thinks, perceives, or feels, to every other in the course of the treatment sessions. He should know that he is protected by the "pledge" and that no disadvantage will occur to him because of his honest revelations of crimes committed, of psychological deviations from sexual or social norms, of secret plans and activities. The confidence so entrusted may never be violated unless it is imperative to do so by law in order to protect the welfare of the individual or of the community. In extreme cases of improper conduct, therapists and patients may be disqualified from practice or treatment. How can this be brought into harmony with our therapeutic philosophy of taking care of every individual patient?

10. The timing of the "pledge" has to be carefully considered by the therapist responsible for the group. In order that it may not frighten the participants or produce the effect of an unnecessary restraint upon their freedom, it should not be discussed prematurely; the therapist should wait until the group is ripe and well formed and until the meaning of the pledge is clear to all members. The critical moment, for instance, may arise when a patient in the course of the treatment sessions is put on the spot and hesitates to reveal a highly personal event in his life. His hesitancy may be internal, as in feelings of guilt, or external, such as fear of gossip, public discomfort, or persecution. In such an intense situation the therapist can step forward and reassure the patient that all members of the group are bound by a pledge, just as the physician is bound. Thus, an atmosphere of confidence in the proceedings and a feeling of collective security can be established.

## The Instruments

The psychodramatic method uses mainly five instruments—the stage, the subject or patient, the director, the staff of therapeutic aides or auxiliary

egos, and the audience. The first instrument is the *stage*. Why a stage? It provides the patient with a living space which is multidimensional and flexible to the maximum. The living space of reality is often narrow and restraining; he may easily lose his equilibrium. On the stage he may find it again due to its methodology of freedom—freedom from unbearable stress and freedom for experience and expression. The stage space is an extension of life beyond the reality tests of life itself. Reality and fantasy are not in conflict, but both are functions within a wider sphere—the psychodramatic world of objects, persons, and events. In its logic, the ghost of Hamlet's father is just as real and permitted to exist as Hamlet himself. Delusions and hallucinations are given flesh—embodiment on the stage—and an equality of status with normal sensory perceptions. The architectural design of the stage is made in accord with therapeutic requirements. Its circular forms and levels, levels of aspiration, pointing out the vertical dimension, stimulate relief from tensions and permit mobility and flexibility of action. The locus of a psychodrama, if necessary, may be designated everywhere: wherever the patients are, the field of battle, the classroom, or the private home. But the ultimate resolution of deep mental conflicts requires an objective setting, the therapeutic theater. As in religion, although the devout may pray to his God in his own chamber, it is in the church that the community of believers attain the most complete confirmation of their faith.

The second instrument is the *subject or patient*. He is asked to be himself on the stage, to portray his own private world. He is told to be himself, not an actor, as the actor is compelled to sacrifice his own private self to the role imposed upon him by a playwright. Once he is warmed up to the task, it is comparatively easy for the patient to give an account of his daily life in action, as no one is as much of an authority on himself as he is. He has to act freely, as things rise up in his mind; that is why he has to be given freedom of expression, spontaneity. Next in importance to spontaneity comes the process of enactment. The verbal level is transcended and included in the level of action. There are numerous forms of enactment: pretending to be in a role, reenactment or acting out a past scene, living out a problem presently pressing, creating life on the stage, and testing oneself for the future. Moreover, there is the principle of involvement. We have been brought up with the idea that, in test as well as in treatment situations, a minimum of involvement with other persons and objects is a most desirable thing for the patient. An illustration of this is the "Rorschach." The Rorschach situation is reduced to ink blots. In the Rorschach the subjects change, but the situation is always the same. It is thought to be its greatest virtue that it is pure and therefore offers an "objective" test. The psychoanalytic interview in its orthodox form also tried to be pure and objective, by reducing the involvement with the analyst to a minimum. In the psychodramatic situation, a maximum of involve-

ment with other subjects and things is not only possible but expected. Reality is not only not feared but provoked. Indeed, in the psychodramatic situation all degrees of involvement take place, from a minimum to a maximum. In addition, there is the principle of realization. The patient is enabled to meet not only parts of himself, but the other persons who are involved in his mental conflicts. These persons may be real or illusions. The reality test, which is mere verbiage in other therapies, is thus made true on the stage. The warming-up process of the subject to psychodramatic portrayal is stimulated by numerous techniques, only a few of which are mentioned here: self-presentation, soliloquy, projection, interpolation of resistance, reversal of roles, double ego, mirror techniques, auxiliary world, realization, and psychochemical techniques. The aim of these sundry techniques is not to turn the patients into actors but, rather, to stir them up to be on the stage what they are, more deeply and explicitly than they appear to be in the reality of life.

The third instrument is the *director*. He has three functions: producer, therapist, and analyst. As producer, he has to be on the alert to turn every clue which the subject offers into dramatic action, to make the line of production one with the lifeline of the subject, and never to let the production lose rapport with the audience. As therapist, attacking and shocking the subject is at times just as permissible as laughing and joking with him; at times he may become indirect and passive, and for all practical purposes the session seems to be run by the patient. As analyst, he may complement his own interpretation with responses coming from informants in the audience: husband, parents, children, friends, or neighbors.

The fourth instrument is a staff of *auxiliary egos*. These auxiliary egos or therapeutic actors have a double significance. They are extensions of the director, exploratory and therapeutic, but they are also extensions of the patient, portraying the actual or imagined personae of their life drama. The functions of the auxiliary ego are threefold: the function of the actor, portraying roles required by the patient's world; the function of the therapeutic agent, guiding the subject; and the function of the social investigator.

The fifth instrument is the *audience*. The audience itself has a double purpose. It may serve to help the patient or, being itself helped by the subject on the stage, the audience becomes the patient. In helping the patient, it is a sounding board of public opinion. Its responses and comments are as extemporaneous as those of the patient, and may vary from laughter to violent protest. The more isolated the patient is—for instance, because his drama on the stage is shaped by delusions and hallucinations—the more important becomes the presence of an audience which is willing to accept and understand him. When the audience is helped by the subject, thus becoming the patient itself, the situation is reversed. The audience sees itself—that is, one of its collective syndromes—portrayed on the stage.

The stage portion of a psychodramatic session has opened the way to action research and action therapy, role test and role training, situation tests and situational interviews whereas the audience portion has become the common ground of the better known forms of group psychotherapy, as lecture methods, dramatic methods, and film methods. Scientific foundations of group psychotherapy require as a prerequisite a basic science of human relations, widely known as sociometry. It is from "sociatry," a pathological counterpart of such a science that knowledge can be derived as to abnormal organization of groups, the diagnosis and prognosis, prophylaxis and control of deviate group behavior.

Now that we have described the five basic instruments required to run a psychodramatic session we may ask ourselves: To what effect? We will limit ourselves here to the description of a single phenomenon, mental catharsis (stemming from the Greek, it means purging, purification).

Breuer and Freud were ignorant of the psychotherapeutic implications of the drama milieu to which Aristotle referred. It remained for psychodrama to rediscover and treat the idea of catharsis in its relation to psychotherapy. We picked up the trend of thought where Aristotle had left off. We, too, began with the drama but reversed the procedure. It was not the end phase but the initial phase of the drama toward which we directed attention. Mental catharsis was to be found only in dramatic literature when we entered the scene with our investigations, in faded memories of Aristotle's old definition, and the term itself was practically out of circulation. The psychoanalysts, after a flareup in the early 1890s, had pushed it aside. As practically every human activity can be the source of some degree of catharsis the problem is to determine in what catharsis consists—in which way it differs, for instance, from happiness, contentment, ecstasy, need satisfaction, and so forth—and whether one source is superior in the production of catharsis to another source; indeed, whether there is an element common to all sources which operates in the production of catharsis. Therefore, our aim has been to define catharsis in such a way that all forms of influence which have a demonstrable cathartic effect can be shown as positive steps within a single total process of operation. We discovered the common principle producing catharsis to be spontaneity.

From studies of both phylogenetic and ontogenetic development of man, we observed that language is a rather late arrival. Yet the human infant is demonstrably an actor long before the onset of speech. I designated this need for action as "the act-hunger syndrome" and concluded that beneath the level of speech lies an older one, that of the act; that speech is not the royal route to the psyche; and that we need to concern ourselves with the deeper level of action to comprehend what the source of spontaneity might be.

Because of the universality of the act and its primordial nature, it engulfs all other forms of expression. They flow naturally out of it or can be

encouraged to emerge verbal associations, musical associations, visual associations, color associations, rhythmic and dance associations, and every other stimulus which might arouse or inhibit the emergence of one or another factor: for instance, the use of psychochemical starters like sedatives, such as barbiturates, sodium amytal, sodium pentotal; or shock methods such as insulin, metrazol, or electricity. Endocrinological medications such as thyroid are fully within the scheme of total catharsis; they may condition and prepare the organism for psychodramatic integration. The need for action can be temporarily choked, for instance, by sleep or shock therapies. But the fundamental need for the realization of certain fantastic imageries cannot be "shocked away." Unless the subject is reduced to a brain invalid by surgery or prolonged shock treatments, the temporarily scared patient is bound to relapse and reproduce the same type of mental syndrome he had before treatment began. It is into the stream of action catharsis that all the rivulets of partial catharsis flow.

The treatment of audiences has become an important alternative to individual treatment. The relationship of the audience to itself in a psychodramatic session, being treated by its own spokesman on the stage, gives us a clue as to the reasons for the cathartic effect of psychodrama. According to historians of the Greek drama the audience was there first, the chorus, musing about a common syndrome. There were "keynoters" among them, but they remained within the chorus. Aeschylus is credited with having put the first actor upon a social space outside of the chorus, the stage, not speaking to them, but portraying the woes of their own hero. Euripides is credited with having put the second actor on the stage, thus making possible the dialogue and interaction of roles. We may be credited with having put the psyche itself on the stage. The psyche which originally came from the group, after a process of reconversion on the stage, personified by an actor, returns to the group—in the form of the psychodrama. What was most startling, new, and spectacular to see and to feel on the stage appears to the participants after thorough exposure as a process which is familiar to them and intimately known—as their own selves. The psychodrama confirms their own identity as does a mirror.

## Psychodramatic Techniques

Psychodrama has been applied to a large variety of settings, clinical as well as educational. It is not our intention to cover all possible uses. The following is but a bare listing and description of techniques.

1. *Soliloquy*. A monologue of the protagonist in situ: for example, the patient is preparing to go to bed and, combing her hair, speaks to herself: "Why don't I cut my hair short again? It is such a nuisance, this long hair.

On the other hand, it really suits me better this way and I don't look like everybody else."

2. *Therapeutic soliloquy.* The portrayal by side dialogues and side actions, of hidden thoughts and feelings, parallel with overt thoughts and actions.

The patient is confronting her superior, who has called her on the carpet for participating in civil rights demonstrations. The auxiliary ego, as the superior, asks her to account for her whereabouts the previous evening. The patient tells her she went to visit a sick friend. The auxiliary ego states she has evidence that this is not the truth. The director stops the overt action, asks the patient to express how she feels, explains that "her superior" won't hear her and will not react, since she could not have known what was going on inside of her in the real situation. Patient states: "I really *did* go to that demonstration; she can't really do anything to me because I have tenure, but she can make it unpleasant for me." Director: "What do you want to do?" Patient: "Give her a raspberry, but of course I can't." Director: "Here you can." Patient belches lustily. Director asks her now to continue the scene as it was and end it on the reality level.

3. *Self-presentation.* The protagonist presents himself, his own mother, his own father, his brother, his favorite professor, and so on. He acts all these roles himself, in complete subjectiveness, as he experiences and perceives them.

4. *Self-realization.* The protagonist enacts, with the aid of a few auxiliary egos, the plan of his life, no matter how remote this may be from his present situation. For instance, he is actually an accountant, but for a long time he has been taking singing lessons, hoping to try out for a part in summer stock (musical comedy), planning eventually to make this his life's work. Alternatives may be explored: success of this venture, possible failure, the return to his old livelihood, preparing for still another one, and so on.

5. *Hallucinatory psychodrama.* The patient enacts the hallucinations and delusions that he is at present experiencing (though they may not be so designated by the director). The patient portrays the voices he hears, the sounds emanating from the chair he sits on, the visions he has when the trees outside his window turn into monsters which pursue him. Auxiliary egos are called to enact the various phenomena expressed by the patient, to involve him in interaction with them, so as to put them to a reality test.

6. *Double.* The patient portrays himself, and an auxiliary ego is asked also to represent the patient, to "establish identity with the patient," to move, act, behave like the patient. The patient is preparing to get up in the morning; he is in bed. The auxiliary ego lies down on the stage alongside of him, taking the same bodily posture. The double may start speaking: "What is the use of waking up? I have nothing to live for." Patient: "Yes,

that is true, I have no reason for living." Auxiliary ego: "But I am a very talented artist, there have been times when life has been very satisfying." Patient: "Yes, but it seems a long time ago." Auxiliary ego: "Maybe I can get up and start to paint again." Patient: "Well, let's try and get up first, anyway, and see what will happen." Both patient and auxiliary ego get up, go through the motions of washing, shaving, brushing teeth, all along moving together as if they were one. The auxiliary ego becomes the link through which the patient may try to reach out into the real world.

7. *Multiple double*. The protagonist is on the stage with several doubles of himself, each portraying another part of himself, one as he is now, another as he was five years ago, a third as he was when at three years of age he first heard that his mother had died, another how he may be twenty years hence. The multiple representations of the patient are simultaneously present and act in sequence, one continuing where the other leaves off.

8. *Mirror*. When the patient is unable to represent himself in word or in action, an auxiliary ego is placed on the action portion of the psychodramatic space. The patient or patients remain seated in the group portion. The auxiliary ego reenacts the patient, copying his behavior and trying to express his feelings in word and movement, showing the patient or patients "as if in a mirror" in terms of how other people experience him.

The mirror may be exaggerated, employing techniques of deliberate distortion in order to arouse the patient to come forth and change from a passive spectator into an active participant, an actor, to correct what he feels is not the right enactment and interpretation of himself.

9. *Role-reversal*. The patient, in an interpersonal situation with his mother, "steps into his mother's shoes" while the mother steps into those of her son. The mother may be the real mother, as in psychodrama in situ, or she may be represented by an auxiliary ego. In role reversal, the son is now enacting his mother, the mother enacting her son. Distortions of interpersonal perception can be brought to the surface, explored, and corrected in action. The son, who is still himself, must now warm up to how his mother may be feeling and perceiving "himself"; the mother, now the son, goes through the same process.

A mother of an eight-year-old girl, after showing how they argue for ten minutes every morning during the winter as to what clothing the child should wear to school, is asked, after their own roles have become clear, to take the role of Kay; Kay is asked to take the role of her mother. They are instructed to change place in space, assuming the role, the posture, and the position of the other.

Kay stretches a foot in height in the role of her mother, shows authority and certainty, whereas in her own role her anxiety was very evident. The mother now has to subdue her ebullience and restrain herself to be her somewhat withdrawn daughter. Both open their eyes wide at the

image that each holds before the other. The mother remarks when this scene is ended: "Am I really as aggressive as Kay portrayed me? My poor Kay!"

10. *Future projection.* The patient portrays in action how he thinks his future will shape itself. He picks the point in time—or is assisted by the director to do so—the place and the people, if any, whom he expects to be involved with at that time.

The patient is an English major and has his bachelor's degree; he has been working toward his master's for almost eight years, but still has not attained it. The future projection shows him three years hence, teaching his first course in English at the university. The entire audience is his class; he is asked to face them and inspire them with the beauty of the English language. "My name is Mr. Johnson; it is a very ordinary and yet beautiful name. I should like to welcome you here today by asking you all to introduce yourselves to one another. But remember, that name stands for you. Try to present it in such a way that it sings, that it reaches out to the other as if to say, 'Here I am, who are you?'"

11. *Dream presentation.* The patient enacts a dream instead of telling it. He takes the position he usually does in bed, when sleeping; before lying down and taking the position of the sleeper, he warms up to the setting separately. The director asks him when and where he had this dream, to describe the room, the location and size of the bed, the color of his pajamas, whether he wears top and bottom or sleeps in the nude, whether he sleeps alone, with the light on or off, window open or closed, and how long it normally takes him to fall asleep.

The patient is asked, in the lying-down position, to breathe deeply and evenly, as he does in sleep, to move in bed as he does ordinarily while asleep, and, lastly, to relax and let himself drift off. The final instructions of the director are: "Try, without telling me about it, to visualize in your mind the beginning, the middle, and the end. Do you see it? Just answer yes or no."

When the patient has fixed the various images somewhat in his mind's eye, the director asks: "Where are you in the dream? Do you see yourself? Yes? Then step out of the dream. What are you doing, walking, swimming, sitting, running, what?" Patient: "I do not see myself, I am in the dream." Director: "You are acting, doing something?" Patient: "Yes, I am flying, over the rooftops of houses." Director: "Do you see the rooftops? Get up and start to take a position resembling flying, here, stand on top of this table." Patient climbs on table, leans forward somewhat. "Yes, I see the rooftops, in fact, I'm hardly able to fly over them, sometimes it seems I'm going to crash into them." Director: "Where are these buildings and what are they?" Patient: "This is a residential section, in fact, as I realize now, this is the suburb where I live!" Director: "Do you see your house?" Patient: "No, but I seem to sense this is my section." Director:

"Are you the only one who is flying? Are you alone?" Patient: "No, I am carrying a bundle in my arms." Director: "In both arms, or in only one? Look at your arms." Patient looks down at his arms which appear to be carrying something, then drops his left arm, and says: "My right arm." Director: "What is in the bundle, do you know its contents?" Patient (*looking intently at his right arm, crooked around an object, amazed*): "It's a baby." Director: "Whose?" Patient: "My parents'; it's my baby sister, we are eighteen years apart in age." The director motions to an auxiliary ego to come upon the stage to represent the baby. The baby is asked to kneel in such a way that the top of her head is approximately at the height of his right elbow, and the director asks the protagonist to hold her as best he can. Director: "What are you doing there, flying with her?" Patient: "I am carrying her with me through life, protecting her from harm, but I'm not very sure that I am able to do this; I seem to have trouble keeping her aloft with me." Director: "Are you afraid?" Patient: "Afraid, but also very angry." Director: "Angry at whom? The baby?" Patient: "No, at fate. Why should I be saddled with this responsibility? She is my parents' child, not mine." Director: "In the actual dream, do you speak to your baby sister?" Patient: "No." Director: "Well, here you can." (This is a psychodramatic extension of the dream.) To auxiliary ego baby: "Talk to your older brother." Baby (auxiliary ego): "I am a bit scared flying this high. Do you hold me carefully?" Patient: "I am doing by best, but you are very heavy." Baby: "You won't drop me, will you?" Patient: "I can't, though frankly, I'd like to." Baby: "Why? Are you angry at me for being here with you?" Patient: "Not at you, but after all, I'm not ready for such responsibility yet, I'm just starting college, and you're just a tiny infant." Baby: "I like you, you are my big, strong brother." Director: "What happens next in the dream?" Patient: "I clutch her and the dream just fades off." Director: "You do not see any conclusive ending? Concentrate for a moment." Patient: "No, I just wake up in a cold sweat." Director dismisses auxiliary ego, returns patient to the position of the sleeper, back in bed. Director: "You wake up in a cold sweat." Patient: "Yes, I'm thoroughly soaked."

### *Retraining of the Dream*

Director: "Sounds like a very frightening dream. Obviously, you wish it had not ended this way." Patient: "I even wish it had never started!" Director: "Yes, of course. You see, in psychodrama, we can 'change the dream.' When you are there, at night, things happen to you which appear to be out of your control. But, after all, it is you who produced the dream, because of your fears and anxieties. We believe that if we can help you to change your dream pattern, to train your unconscious, so to speak, the next time when you are dreaming, your dreams will change in character, you will be in better control. Now, let's see how you wish to change your dream."

Patient: "I don't want to have this dream at all." Director: "Yes, I can see that, but what would you like to do instead?" Patient: "I would want to have a good talk with my parents." Director: "Fine, let's have a good talk with your parents. Get up, and pick a mother and father from the group, two auxiliary egos to represent them." Patient does so, and sets up the livingroom of their house. Patient now confronts his parents: "Gee, Mom, Dad, I know you have both been very ill in the past year, and, being the oldest son, I feel terribly burdened by the responsibility of the two younger kids, especially about Alice. Timmy is already older and not quite such a problem, but Alice is just a little infant." Director: "Tell them as brutally as possible what is on your mind; after all, these are not your 'real' parents, merely stand-ins. They will not be hurt by anything you say or feel or do." Patient (*blurts out*): "Why the devil did you have to go and have a menopause baby? Don't you think you have enough complications? Mother works, the housekeeper is terrible, she doesn't even speak English, is my kid sister going to learn broken English? And don't you care what she eats? That dope can't even cook, all the kid gets is cereals and mashed banana." Now mother and father respond, trying to soothe the patient, he role-reverses with them, and finally he feels more reassured that his parents still have the major responsibility for the child.

This is the unique contribution of psychodrama to dream therapy, to go into enactment over and beyond the actual dream, including actual and latent material, but, even more, to retrain the dreamer rather than to interpret. Interpretation is in the act itself.

12. *Therapeutic community*. This is a community in which disputes and conflicts between individuals and groups are settled under the rule of therapy instead of the rule of law. The entire population, patients and staff alike, are responsible for the welfare of every other person, participate in the therapeutic process, and have equal status.

13. *Symbolic realization*. Enactment of symbolic processes by the protagonist using soliloquy, double, reversal, or mirror for their clarification.

14. *Analytic psychodrama*. An analytic hypothesis, for instance, that of the Oedipus complex, is tested out on the stage in order to verify its validity. The patient takes the role of his mother in a situation with his father (coming home, fired from his job because of a heart ailment). The analyst sits in the audience and watches. Analysis of the material is made immediately after the scene.

15. *Auxiliary world technique*. The entire world of the patient is restructured around him in situ with the aid of auxiliary egos. William has been classified as a dementia praecox. He calls himself Christ and has written a proclamation to the world which he wants to save. The auxiliary egos around him live in his world and are completely guided by his needs. One auxiliary ego becomes the apostle John. Christ asks him to kneel in a corner of the room with his head bowed. He does not want him to kneel

in any other room or in any other corner. Another auxiliary ego becomes the apostle Paul with whom he prays together. A third is the apostle Peter, who is the only one he permits to bathe him, once a month. He does not permit members of his family to come to visit him. The only persons he accepts are those who people the world of his psychosis, according to his instructions.

16. *Treatment at a distance.* The patient is treated in absentia, usually without his knowledge; he is replaced by an auxiliary ego who is in daily contact with him and acts as the intermediary between patient and therapist. He acts out in the clinic all crucial episodes in which the patient is involved. Other members of the immediate environment are drawn into action (for instance, the parents of the patient).

*Warming-up techniques* are used to induce spontaneous states:

1. *Techniques of spontaneous improvisations.* The protagonist acts out fictitious roles and tries to keep his personal character uninvolved from his fictitious characters.

2. *Mirror techniques behind your back.* Many mirror techniques are so constructed that the individual can "see" and "hear" himself through other people's perceptions of him.

In the classic mirror technique, as described above, the protagonist is physically present but psychologically absent. The auxiliary ego acts "as if" the patient were not present, so as to challenge the patient when he realizes that the person portrayed on the stage is a radically truthful exposition of himself.

## Additional Techniques

1. *Behind-your-back audience technique.* The entire audience is instructed to leave the theater, but actually they are permitted to remain seated, pretending that they are not present so as to give the protagonist full freedom of expression. The patient tells each member of the group how he feels toward him; the audience members are not permitted to respond, no matter how much he provokes them. The group members are on the spot; they see themselves in the mirror of the protagonist's world. This is frequently the starting point, the warming-up period preceding a psychodrama. It is often effective if the group members *actually* turn their back.

2. *The turn-your-back technique.* Protagonists are frequently embarrassed to present a particular episode while facing the group. They are then permitted, if unavoidable for the warmup, to turn their back to the group and act as if they are alone, in their own home, or wherever the episode takes place. The director, too, may turn his back to the audience so as to

observe the protagonist or protagonists. Once the protagonists—for instance, a married couple—have reached a high degree of involvement, they become ready to face the audience.

3. *The black-out technique.* The entire theater is blacked out, although all actions continue as if there is full daylight. This is done so that the protagonist may go through a painful experience unobserved, to retain for him the experience of solitude.

#### IMPROVISATION OF FANTASY

Since the early days of psychodrama, improvisation of fantasies has been usefully applied in order to attain therapeutic aims. A popular technique was and still is the Magic Shop Technique. The director sets up on the stage a "Dream or Magic Shop." Either he himself, or a member of the group selected by him, plays the part of the shopkeeper. The shop is filled with imaginary items, values of a nonphysical nature. They are not for sale, but they can be obtained in barter, in exchange for other values to be surrendered by the group members, either individually or as a group. One after another, the members volunteer to come up on the stage, entering the shop in quest of an idea, a dream, a hope, an ambition. They are expected to come only if they feel a strong desire to obtain a value which they cherish or without which their life seems worthless. An illustration follows: A depressive patient, who was admitted after a suicidal attempt, came to the Magic Shop requesting "peace of mind." The shopkeeper, a sensitive young therapist, asked her, "What do you want to give in return? You know we cannot give you anything without your willingness to sacrifice something else." "What do you want?" the patient asked. "There is something for which many people long who come to this shop," he replied, "fertility, the ability and willingness to bear children. Do you want to give this up?" "No, that is too high a price to pay. Then I do not want peace of mind." With this, she walked off the stage and returned to her seat. The shopkeeper had hit on a sensitive spot. Maria, the protagonist, was engaged, but refused to get married because of a deep-seated fear of sex and childbirth. Her fantasy preoccupations involved images of violent suffering, torture, death, and so on, in the act of childbirth.

This illustration indicates the diagnostic value of the *dream shop technique*. The crux of the technique is for the shopkeeper to demand of the client what he wants to give in return, what price he is willing to pay.

Another fantasy technique is the dramatization of fairytales as described in Moreno's Theater of Spontaneity. The tale remains entirely unstructured so that the protagonists are required to fill in with their own fantasies around the theme.

Still another fantasy technique is improvisation of early childhood ex-

periences. In the process of acting them out, the protagonists go far beyond what they actually remember.

There are several hundred psychodramatic techniques and many, no matter how odd and fantastic they may seem, can be traced back to the rituals and customs of ancient cultures and can be found in the classic writings of world literature. Moreno has merely rediscovered them and adapted them to psychotherapeutic objectives. Their real inventors are the mental patients of all times. The number of applications of the psychodramatic method is practically unlimited, although the core of the method remains unchanged (5, 6, 7, 8).

## Summary

The important question which remains to be answered is the scientific evaluation of psychodrama. Does psychodrama, with or without group psychotherapy, beyond the subjective reports of therapists and their patients, produce behavior change? According to John Mann (2), forty-one studies have substantiated that fundamental changes in behavior take place.

Two studies in particular, point out the kind of change that is demonstrable, one by G. S. Harrow (3), showing the effects of psychodramatic group therapy on role behavior of schizophrenic patients. According to this study

. . . the specific aspects of role-taking behavior which seemed to be most affected by psychodramatic treatment were found in: 1. Four areas of interaction: (a) social techniques; (b) ability to enter into relationships and develop them; (c) more mature choice of social relationships and (d) ability to share feelings. 2. Changes in reality orientation, that is, in the ability to perceive simultaneously more than one aspect of the same situation and to adapt behavior accordingly, together with greater conformity of thinking, action, and self-perception with the real situation and the accepted norms of a "normal" environment. 3. Increased emotional control, that is, in the development of adaptive defense mechanisms which prevent explosive expression of impulses, such as hostility and aggression. For some patients, emotional control was accompanied by more free and spontaneous emotional expression, while for other patients this control was accompanied by rigidity and repression.

The statistically significant Rorschach changes, together with qualitative observations of changes on all three tests, Rorschach, MAPS and Role tests, indicate that psychodramatic treatment may affect some fundamental personality process as well as overt role-taking behavior. These findings tend to support the assumption that role-taking is not a mechanical skill imposed upon personality, but an essential part of personality formation and adjustment.

M. R. Haskell, in his study of young, imprisoned drug users being considered and prepared for parole (4), found role training effective in that the results obtained were significant at the 1 percent level of confidence. He concluded that role training is a technique that can be administered by suitably trained persons and is a nonspecific influence that depends for success on a particular personality. Lasting effects can be demonstrated only after long-term follow-up studies of experimental and control groups.

Psychotherapy, of whatever kind, is still remiss in its inability to show objective findings as to its long-range effects and psychodrama is no exception. One can only hope that better measurement and evaluation procedures yet to be developed will be able to close this gap.

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