offering comments would be quite a factor in her ability to take it. I don't believe she would have accepted criticism so well from adults." "Were the girls sitting in on training only taught by indirect, spectator methods, or did they also get a chance to appear as subjects?"

Discussion of audience participation

In audiences of similar construction to whom these films were shown, the participation quotient of Audience type I, ranging from 73% to 89%, was considerably greater than that of type II, which ranged from 31% to 42%. The amount of catharsis received and observable in the first type was thus significantly greater than in the second. The latter showed irritation, rejection, conflicts and endless questioning. It would seem that the amount of catharsis obtained from therapeutic motion films by the audience depends upon: (a) the problem portrayed; (b) the type of actor; (c) the solution to the problem; (d) the type of audience; and (e) the interaction between the members of the audience. Each of these factors contributes to the amount of participation and role identification possible on the part of the spectators.

Conclusion

This sort of inquiry leads us to believe that the limitation of the therapeutic film is that, especially as it is able to stir up audiences, many spectators may leave the theatre with a number of conflicts sensitized and dormant problems reawakened without being able to satisfy and resolve what it has activated. The follow-up, indeed, the completion by an actual psychodramatic session under skilled guidance, appears to be the only alternative to an otherwise risky therapeutic undertaking.

Article 5

Clinical Psychodrama: Auxiliary Ego, Double, and Mirror Techniques

Toeman, Z. (1946) *Sociometry: A Journal of Inter-Personal Relations* IX, 2–3: 178–183

Zerka's comments

During this time at Beacon the air seemed palpable with Moreno's ideas. He was the creator, he expected others to work out the details. It was a role that came naturally to me, because I believed so strongly in his vision. He picked me as double most of the time.

For Moreno doubling was an established form of practice, but new for me. I wrote this article in order to articulate some of the discoveries I was making in action as an auxiliary. It was the first time it had all been so clearly set down. At times I thought "I'll never know enough." However, there really wasn't time to do anything but move forward.

At this point I was not thinking of myself as a psychodrama director. We were dealing with such severe cases that only Moreno directed. It took me a long time to feel myself as a "psychodrama professional." I just wanted to be the best damn auxiliary I could be. This time period was a stimulating adventure. I never knew from day to day what worlds I would be asked to enter.

One instructive doubling experience was with Sylvia, a mute psychotic patient (not her real name). I was told to be the voice she didn't let out. I just did what I felt and a scream arose in me. The patient listened intently. Another patient, who was not at the session and therefore did not see the patient, later reported that he had said to himself upon hearing it, "Oh, Sylvia's screaming" even though he knew she didn't speak.

It should be noted that the use of doubling described in this article was with psychotic patients. These days as director I do not often use a double who stays with the protagonist throughout the drama, because I encourage the "normotic" (that is, "normal neurotic") protagonist to be empowered and responsible to provide their own words and feelings to the greatest extent possible.

Among the factors of consequence in the function of the auxiliary ego are: (a) the relationship to the subject or patient; (b) the relationship to the

problem which the patient represents; (c) the relationship to the role which the auxiliary ego is to portray; (d) the warming up process which takes place between the subject and auxiliary ego immediately prior to the action on the stage; and (e) the relationship of the auxiliary ego to the director.

The auxiliary ego, in portraying a role, may go about it as follows: (1) by drawing from his or her own private resources; the ability to do this makes at times a fully untrained person an excellent auxiliary ego within certain limits, for instance, in the role of a father, husband, brother, lover, sister, mother, wife, girl friend, etc., the very fact that he or she is untrained may make the auxiliary ego more spontaneous and less conscious of involvement; (2) a further development of auxiliary ego training results in the learning to adapt his own resources to the subject's expectancies of her brother, husband, child, or whomever the auxiliary ego represents; (3) at a still later stage of training the auxiliary ego may draw into the presentation information obtained about the actual person to be portrayed; this information may have been received either from the subject, or from another person, or directly from the person to be enacted.

The portrayal of the actual person may differ greatly in many respects from the picture the subject has of that person. It can be seen easily that a number of distortions of the role can thus take place: (a) the distortion that comes from the auxiliary ego himself as it is colored by his own experiences; (b) the distortion which the subject suggests to the auxiliary ego because of her subjective experiences in reference to the person to be portrayed by the ego; and (c) the distortion which may come from the actual person. These multiple interactions of distortion or bias require continuous analysis and clarification by the director in order not to hamper the therapeutic process and to constantly "deconserve" the auxiliary ego from clichés and prejudices which otherwise may become confirmed and established during the auxiliary ego's training and performance.

In the double and mirror techniques to which this report will limit itself, the auxiliary ego is closely identified with the patient's problems and, especially in the latter, aware of the social atom of the patient. The double technique has been found extremely valuable in the clarification of the patient's conflicts, both normal and abnormal. For the double ego technique the patient and auxiliary ego are placed on the stage together. In order that the patient (often called "primary ego") accepts the presence of the auxiliary ego on the stage, she is told to consider the ego as her double, the invisible "I," the alter ego with whom she talks at times but who exists only within herself. In the psychodrama this invisible double is projected into space, embodied by an actual person and experienced as outside of the patient. The patient represents the deeper, inner levels of experience while the ego acts as double, copying physical bearing in every way and representing the outer levels. However, in actuality the patient usually begins by first revealing the superficial layers. The auxiliary's task is then, for strategic

reasons, the reverse of the director's formal instructions. It is her job to stir up the subject to reach deeper levels of expression by peeling off the outer, socially visible "I" of the subject, and to reach for those experiences and imageries which a person would reveal when talking to herself, alone, in the privacy of her own room.

The task of the auxiliary ego becomes one of producing quick, kaleidoscopic views, "other parts" of the subject's "I." Often therefore, the auxiliary ego represents the subject more fully than the patient realizes and may, at times, become aggressive if the warming up of the patient lags behind. In general, my experience as auxiliary ego in double scenes has been that too much verbal warming up previous to the portrayal disturbs spontaneity and blocks freely flowing action. A sensitive auxiliary ego should not be told everything about the patient or her problem, as this predisposes towards overheating both the subject and the auxiliary ego, while catharsis may take place verbally instead of psychodramatically. Many things are better left unsaid beforehand and brought out in the interaction that follows.

As the auxiliary ego becomes adept at drawing out essentials from the subject, information not gathered in advance and crystallized by the performance itself acts as an inspiration to the ego, a self-propelling force, and increases catharsis for the patient. Usually, before stepping upon the stage we have very little idea of what will actually transpire. It would be unwise for the auxiliary ego to make up her mind that certain aspects *must* be revealed, as this would coerce the subject and would not be therapeutic support. In the main, it is the subject who determines the course of action. The auxiliary ego supports and guides the subject into channels that appear, on the spur of the moment, desirable. Obviously, therefore, predetermined action would prevent spontaneity for the patient, reduce the tele flowing from the patient to the auxiliary, and furthermore throw the ego off the therapeutic track. This double ego technique is carried on in the first person; the two I's interacting as one. The two may disagree violently, the auxiliary ego may challenge the subject, stimulating her to respond more genuinely, or they may agree in every respect. We know from experience that this technique is a potent one in exploring deeper levels and producing catharsis which, however, is often much delayed, showing its effects days and even weeks later.

I recall two specific cases. The first subject was a young woman very much troubled by the fact that, at 28, she was still unmarried. She was attractive, intelligent, and had a number of admirers who were anxious to marry her but towards none of whom she felt an equally strong emotion. After a number of diagnostic scenes were portrayed the director decided that the time had come for reaching beneath the calm surface. I, as the double ego, was instructed to be aggressive in one way or another. The scene was set for late at night in the bedroom of the subject, where she was

reviewing the happenings of the day just ended. The patient persisted in evasive talk, which I suddenly interrupted by an outburst of weeping and a cry of "Why do I go on lying to myself! I can lie to others but I can't fool myself." This produced tears in the subject who retorted, "What's the use of crying myself to sleep *again*. I've done that too often." When stepping down she was warmed up to a far greater level of self-presentation than before, and a feeling of relaxation came over her. She stated that I had formulated her situation far more clearly than she had ever done; it seemed almost as if I knew her better than she did. During the performance I was not certain that the patient would actually cry, as this was the first time I had met her. Nevertheless, the feeling came to me that this was the moment to weep or else to give up the action altogether. This particular scene was the real beginning of the therapeutic approach to the patient's problems, which ended in her successful marriage a few months later.

The second scene, which stands out in my mind, is that of a 22-year-old girl who was about to divorce her husband but had not stopped loving him. She came to the Institute for clarification of her conflicts and in the course of portraying her difficulties with her husband displayed much emotion, especially in the scene where she decided to leave him because of his inability to accept her as the only woman in his life. The director then moved into the double technique, and I (as the other part of herself) began to question the purpose of continuing to live, wondering about the possibility of suicide. This may, at face value, seem a dangerous thing to do, but that was what I felt about the subject at that moment, again without having obtained such information from her. It brought the subject to a sudden halt (we had been walking aimlessly around her room) and she broke in "Yes, that's just how I feel, but I know I'd never really do it even though life does not seem worth the trouble right now." This scene was a flashback of an actual one which had taken place a few months before, and upon descending from the stage the subject felt greatly relieved, declaring that this was exactly what had gone through her mind although she had never admitted it before, even to herself.

I want to emphasize that in the double technique the auxiliary ego loses the sense of objectivity and becomes completely enveloped by the subject's problems, feeling her way as if no single direction can be satisfactory, trying this way and that, torturing herself to find a way out. The question has been raised whether this process going both ways from the subject to the ego and from the ego to the subject is not, because of its subjective character, unreliable and invalid. In order to clarify this we have systematically interviewed every subject whose thoughts, feelings or actions I seemed to anticipate in the double situation. Among a group of thirty subjects we found confirmation of the accuracy of these revelations. Often the subjects were amazed to have them come forth without having informed me and admitted that the double came closer to expressing, in a crystallized form, many of

their deeper experiences. The question still remained whether the auxiliary ego projects into the subject some of her "own" experiences, experiences sufficiently similar to form a link between them. In order to verify this I began to check myself in the act and found myself frequently choosing and rejecting between my own experiences and experiences that I intuitively felt were those of the subject. It is as if I would have said to myself, "This is not me, that is she." Gradually I learned to choose correctly; that is, my tele experience (interaction feelings) became more accurate the more skill I developed.

In the mirror technique the patient remains in the audience as spectator while the auxiliary ego takes the patient's part, reproducing gestures typical of the patient and creating a series of scenes and situations which the patient will recognize as her own experiences, enabling the patient to "see herself as others see her." This technique is perhaps more difficult, as the patient does not lend support or point the way for the auxiliary ego. It is used (a) with patients who are completely non-cooperative and need to be stirred into action, (b) for the purpose of restoring amnestic experiences to patients, and (c) for patients who have never registered the events taking place around them, that is, not to restore memory but to acquaint them with certain facts and events. The ego then turns into the patient by herself and has to be well acquainted with the patient's social and mental syndromes. In the case of psychotics this becomes a more delicate job, especially with patients who are unable to communicate their experiences. The patient may not know at first that this is she herself being displayed before her eyes. But soon, as she warms up, she becomes interested and may, finally, be stimulated to a self-presentation although having refused to do this for some time.

In the mirror technique as in that of the double the director may indicate the general way in which action should go before the auxiliary ego begins, in order to produce the most potent form of psychodramatic shock in the patient. At times the director has in mind a specific event or image that he wishes to have reproduced and then the auxiliary ego has her task laid out. But often no instruction comes from the director and a more general enactment of the patient's various levels of experience and behavior is required.

The most striking recollection I have concerning this technique is one in which a patient was suffering from pseudo-amnestic breaks in experiences while hospitalized. She stated that she had been brought to the hospital against her will and for no reason since she was not ill. She demanded to be allowed to return home to her husband and children. This was the third episode suffered by the patient within six years and she was completely non-cooperative and without insight at the time the mirror technique was used. She was confused, shallow, full of bizarre ideas, delusional and altogether intractable.

I was picked to represent the patient because of my familiarity with her syndromes and because I had witnessed each of the three attacks. Furthermore, the patient had at one time displayed deep attachment to me, while I had also recently been the object of aggression from the patient. I commenced to warm up to the part of the patient with vigor, throwing and pushing furniture around me, cursing the nurses, the doctors, the hospital, my husband, calling everything and everyone vile names and then, changing abruptly into a dancing stance that I had frequently seen the patient take, peering out of the window of my room, talking about the visions I saw, mostly of deceased relatives and well known figures of remote history.

At this point the nurse who actually took care of the patient (the patient was sitting in the audience with her eyes as if glued to me) was sent upon the stage by the director in order to give me a hypodermic needle containing a sedative. I was immediately stirred into aggressive behavior towards the nurse, threatening to hit her. The nurse went through the act of giving me the injection while trying to soothe me, but when I looked at her I saw a great deal of fear and horror in her eyes. This made me feel wildly triumphant. I thought "Well, I really scared her. I'll show her now. I'll scare them all out of their wits." Thus I revealed to myself how the patient must have felt. I picked up a fairly solid piece of furniture and threw it across the stage, down several levels. It landed below with a crash. The director stopped me and turned to the patient. She was leaning forward with her elbows resting on her knees, completely wrapped up in the performance. Then, somewhat breathlessly she spoke to the director: "Is that the way I behaved? Did I really act like that?"

From this point on the session was turned over to the patient herself who became the subject in her own psychodrama; the first one in a series that hastened her recovery. But one of the most important comments came from the nurse who had participated in the scene: "You really had me scared to death for a moment. I thought you, too, had become mentally ill." How much more then, did this scene mean to the patient who was shocked into some realization of her behavior!

These techniques are interesting from the clinical point of view because of their departure from orthodox therapeutic methods. In these techniques a maximum amount of involvement of the auxiliary ego with the patient is permissible. It should be added that deep action catharsis is gained in the mirror technique, not only by the patient but also by the auxiliary ego who at one time or another has been the recipient of hostility from the patient. Insight into the patient's condition is thereby gained with unusual accuracy and depth.

Article 6

Psychodrama: Its Relation to Stage, Radio and Motion Pictures

Toeman, Z. (1947) *Sociatry, Journal of Group and Intergroup Therapy* I, 1: 119–126

Zerka's comments

Here is an example of how everything in our lives was grist for the mill, because Moreno's vision was so comprehensive. With him one worked all the time because life was constantly presenting itself to us. Everything was about relationships – ours to each other, extending out to our near and far social atoms. Even though we worked hard, Moreno was good about socializing, especially around food.

FIRST DIALOGUE
SETTING: The Theater for Psychodrama, New York City
DRAMATIS PERSONAE: J.L. Moreno and Zerka Toeman

Synopsis: The author plans to bring, at regular intervals, dialogues showing the genesis of psychodrama in contemporary and classic literature, as well as in other forms of art-production.

TOEMAN: I am making the rounds of live and motion picture theaters, broadcasting and television stations, to examine the pseudo-therapeutic devices and detours by which they influence the public mind, and to see what psychodramatic methods can do towards their improvement. Perhaps they can learn from each other. What do you think of it?

MORENO: It is a fine idea. The creative artist of all ages, as the poet, historian, novelist, especially the dramatist, could not help but trespass the esthetic boundaries of his genius and turn into a priest, educator, sociologist, and psychotherapist. He must have had intuitive flashes of situations of therapeutic potentialities which he may have, at times, used to excess, and other times with insufficient vigor.