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INTRODUCTION TO THE THIRD EDITION

HISTORIC BACKGROUND

There were in 1914 in Vienna two antitheses to psychoanalysis; the one was the rebellion of the suppressed group versus the individual; it was the first step beyond psychoanalysis, "group psychotherapy". I introduced this particular name to underscore that it concerned itself first of all with a "therapy" of the group and not merely with sociological or psychological analysis. The other was the rebellion of the suppressed actor against the word. This was the second step beyond psychoanalysis, the "psychodrama". In the beginning was existence, [illegible] beginning was the act.

Principle—The merely analytic and verbal method of group psychotherapy very soon led to difficulties. As long as group psychotherapy was practiced only *in situ*, that is, within the family, the factory, etc., where life is lived, in all dimensions of the present, in action, in thought and speech, as monologue, dialogue, or drama, the psychomotor element of the organism and the creative meaning of the encounter remained unconscious and uninvestigated. When, however, the moment came to move from a natural to a synthetic place — for instance, from the family to the clinic — it was necessary to restructure life in all its dimensions in order to carry out therapy in the actual meaning of the word. All relationships which occur in everyday life had, therefore, to be constructed anew; we had to have a space in which the life of the family could be lived in the same fashion as it occurred in reality as well as symbolically. The bedroom, the kitchen, the garden, the dramatis personae of the family — father, mother, child — the discussions, conflicts, and tensions between them just as they occur in everyday life, all that which is taken for granted and remains unconscious had to be reconstructed but reduced to the truly symbolic elements. What before appeared as problematic and unfortunate became an asset. Group psychotherapy was forced to enter into all dimensions of existence in a depth and breadth which were unknown to the verbally oriented psychotherapist. Group psychotherapy turned into action psychotherapy and psychodrama.

ROLE THEORY

The Role Concept

A new body of theory developed in the last thirty years which aimed to establish a bridge between psychiatry and the social sciences; it tried to transcend the limitations of psychoanalysis, behaviorism and sociology. One of the most significant concepts in this new theoretical framework is the psychiatric role concept.

It is a "myth" that the American sociologist, G. H. Mead, has had a major influence upon the psychiatric "role concept" and its psychopathology. The formulation and development of the psychiatric role concept and of role playing techniques is the exclusive domain of the psychodramatists. This includes all forms of psychodrama from the extreme non-analytic to the extreme analytic versions, in the U.S.A., France, Germany, Switzerland, Spain, Japan and India. It is the psychodramatists who have not only formulated the concept but have initiated and carried out extensive empirical and clinical research for over forty years. It is my German book *Das Stegreiftheater*, 1923 (translated *The Theatre of Spontaneity*) which set the pace for experimental psychodrama and the techniques in the "here and now".

G. H. Mead's posthumous book, *Mind, Self and Society*, appeared in December 1934, about a year later than my *Who Shall Survive?* which was released in January 1934. At no time does Mead use the term role player, role playing, or role playing techniques, or deal with the psychopathological implications of the role concept. He was an excellent theoretician but never left the plane of theory. Were it left up to him, the vast body of role experimentation and role research would not exist. What we psychodramatists did is (a) to observe the role process within the life context itself; (b) to study it under experimenal conditions; (c) to use it as a method of psychotherapy (situation and behavior therapy); and (d) to examine and train behavior in the "here and now" (role training, spontaneity and behavior training).

EMERGENCE OF THE SELF

"Role playing is prior to the emergence of the self. Roles do not emerge from the self, but the self emerges from roles." This is, of course, an hypothesis only, which appeals to the sociometrist and the behavioral scientist but may be rejected by the Aristotelians, theologians and metapsychologists. The sociometrist will point out that the playing of roles is not an exclusively human trait, but that roles are also played by animals; they can be observed in the taking of sexual roles, roles of the nest-builder and leader roles, for instance.*

* "Sociometry of Subhuman Groups", Sociometry Monograph No. 38.

In contrast, the Aristotelians will claim that there must be a latent self postulated as pre-existing all role manifestations. Were it not for such a self structure, the role phenomena would be without meaning and direction. They must be grounded in something which unites them.

It is possible to reconcile the opinions of the behavioral scientist with those of the philosophers. The infant lives before and immediately after birth in an undifferentiated universe which I have called "matrix of identity". This matrix is existential but not experienced. It may be considered as the locus from which in gradual stages the self and its branches, the roles, emerge. The roles are the embryos, forerunners of the self; the roles strive towards clustering and unification. I have distinguished physiological or psychosomatic roles, like the role of the eater, the sleeper, and the sexual role; psychological or psychodramatic roles, as ghosts, fairies and hallucinated roles; and then, social roles, as parent, policeman, doctor, etc. The first roles to emerge are the physiological or psychosomatic roles. We know that "operational links" develop between the sexual role, the role of the sleeper, the role of the dreamer, and the role of the eater, which tie them together and integrate them into a unit. At a certain point we might consider it as a sort of physiological self, a "partial" self, a clustering of the physiological roles. Similarly, in the course of development, the psychodramatic roles begin to cluster and produce a sort of psychodramatic self and finally, the social roles begin to cluster and form a sort of social self. The physiological, psychodramatic and social selves are only "part" selves; the really integrated, entire self, of later years is still far from being born. Operational and contact links must gradually develop between the social, the psychological, the physiological role clusters in order that we can identify and experience after their unification, that which we call the "me" or the "I". In this manner, the hypothesis of a latent, metapsychological self can be reconciled with the hypothesis of an emergent, operational self. Role theory is, however, useful in making a mysterious concept of the self tangible and operational. It has been observed that there are frequent imbalances in the clustering of roles within the area of psychosomatic roles or social roles and imbalances between these areas. These imbalances produce delay in the emergence of an actual, experienced self or sharpen disturbances of the self.

As the matrix of identity is at the moment of birth the entire universe of the infant, there is no differentiation between internal and external, between objects and persons, psyche and environment, it is one total existence. It may be useful to think of the psychosomatic roles in the course of their transactions helping the infant to experience what we call the "body"; the psychodramatic roles and their transactions to help the infant to experience what we call the "psyche"; and the social roles to produce what we call "society". Body, psyche

and society are then the intermediary parts of the entire self.

If we would start with the opposite postulate, that the self is prior to the roles and the roles emerged from it, we would have to assume that the roles are already embedded in the self and that they emerge by necessity. Pre-established as they are, they would have to assume forms which are predetermined in advance. Such a theory would be difficult to accept in a dynamic, changing, self-creative world. We would be in the same position as the theologians of the past who assumed that we are born with a "soul", and that from that original, given soul everything a man does or sees or feels emerges or comes forth. Also for the modern theologian it should be of advantage to think of the soul as an entity which evolves and creates itself from millions of small beginnings. The soul is then not in the beginning, but in the end of evolution.

THE TERM ROLE

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 16th or 17th 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.

Role is thus 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. It has a long history and tradition in the European theater from which I gradually developed the therapeutic and social direction of our time. I brought it to the U.S.A. in the middle twenties. From the roles and counter-roles, the role situations and role conserves developed naturally their modern extensions: role player, role playing, role expectation, acting out, and finally, psychodrama and sociodrama. Many American sociologists have monopolized the theory of action and of role, especially T. Parsons, as if they were sociological property. But most terms and meanings which Parsons and associates present in their writings can be found in my prior publications.

DEFINITION AND CONSTRUCTS OF THE ROLE

Role is the functioning form the individual assumes in the specific moment he reacts to a specific situation in which other persons or objects are involved.

The role concept cuts across the sciences of man, physiology, psychology, sociology, anthropology and binds them together on a new plane. The theory of roles is not limited to a single dimension, the social. The psychodramatic role theory, operating with a psychiatric orientation, is more inclusive. It carries the concept of role through all dimensions of life; it begins at birth and continues throughout the lifetime of the individual and the socius. It has constructed models in which the role begins to transact from birth on. We cannot start with the role process at the moment of language development but in order to be consistent we must carry it through the non-verbal phases of living. Therefore, role theory cannot be limited to social roles, it must include the three dimensions — social roles, expressing the social dimension; psychosomatic roles, expressing the physiological dimension; and psychodramatic roles, expressing the psychological dimension of the self.

Illustrations of psychosomatic roles are the role of the eater and the sexual role. Characteristic patterns of interaction between mother and infant in the process of eating produce role constellations of the eater which can be followed up throughout the different life periods. The bodily attachment of infant to mother is a forerunner of the later behavior in the sexual role. Psychodramatic forms of role playing as role reversal, role identification, double and mirror playing, contribute to the mental growth of the individual. The social roles develop at a later stage and lean upon psychosomatic and psychodramatic roles as earlier forms of experience.

Function of the Role

"The function of the role is to enter the unconscious from the social world and bring shape and order into it." The relationship of roles to the situations in which the individual operates (status) and the relation of role as significantly related to ego has been emphasized by myself.

Everybody is expected to live up to his official role in life, a teacher is to act as a teacher, a pupil as a pupil, and so forth. But the individual craves to embody far more roles than those he is allowed to act out in life, and even within the same role one or more varieties of it. Every individual is filled with different roles in whch he wants to become active and that are present in him in different stages of development. It is from the active pressure which these multiple individual units exert upon the manifest official role that a feeling of anxiety is often produced.

Every individual — just as he has at all times a set of friends and a set of enemies — has a range of roles in which he sees himself and faces a range of counter-roles 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 he operates, with the pattern of role-relations around an individual as their focus. We consider roles and relationships between roles as the most significant development within any specific culture.

Role is the unit of culture; ego and role are in continuous interaction.

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.

ROLE PATHOLOGY

Regressive behavior is not a true physiological regression but a form of unconscious role playing, a "psychodramatic" regression. The adult catatonic is still an adult, physiologically and psychologically. By acting like a helpless infant, he resorts to the lowest possible denominator of behavior.

"Histrionic neurosis" of actors is due to the intervention of role fragments "alien" to the personality of the actor.

MEASUREMENT OF ROLES

As a general rule, a role can be: 1. rudimentarily developed, normally developed or over-developed; 2. almost or totally absent in a person (indifference); 3. perverted into a hostile function. A role in any of the above categories can also be classified from the point of view of its development in time: 1. it was never present; 2. it is present towards one person but not present towards another; 3. it was once present towards a person but is now extinguished.

Another significant method of measurement is the analysis of role diagrams and sociograms of individuals and groups from the point of role interaction, role clustering, and prediction of future behavior.

CO-UNCONSCIOUS STATES AND THE "INTER-PSYCHE"

By means of "role reversing" one actor tries to identify with another, but reversal of roles can not take place in a vacuum. Individuals who are intimately acquainted reverse roles more easily than individuals who are separated by a wide psychological or ethnic distance. The cause for these great variations are the developments of co-conscious and co-unconscious states. Neither the concept

of the individual unconscious (Freud) nor that of the collective unconscious (Jung) can be easily applied to these problems without stretching the meaning of the terms. The free associations of A may be a path to the unconscious states of A; the free associations of B may be a path to the unconscious states of B; but can the unconscious material of A link naturally and directly with the unconscious material of B unless they share in unconscious states? The concept of individual unconscious states becomes unsatisfactory for explaining both movements, from the present situation of A, and in reverse to the present situation of B. We must look for a concept which is so constructed that the objective indication for the existence of this two-way process does not come from a single psyche but a still deeper reality in which the unconscious states of two or several individuals are interlocked with a system of co-unconscious states. They play a great role in the life of people who live in intimate ensembles like father and son, husband and wife, mother and daughter, siblings and twins, but also in other intimate ensembles as in work teams, combat teams in war and revolution, in concentration camps or charysmatic religious groups. Marriage and family therapy for instance, has to be so conducted that the "interpsyche" of the entire group is re-enacted so that all their tele-relations, their co-conscious and co-unconscious states are brought to life. Co-conscious and co-unconscious states are by definition, such states which the partners have experienced and produced jointly and which can, therefore be only jointly reproduced or re-enacted. A co-conscious or a co-unconscious state can not be the property of one individual only. It is always a *common* property and cannot be reproduced but by a combined effort. If a re-enactment of such co-conscious or co-unconscious state is desired or necessary, that re-enactment has to take place with the help of all partners involved in the episode. The logical method of such re-enactment a deux is psychodrama. However great a genius of perception one partner of the ensemble might have, he can not produce that episode alone because they have in common their co-conscious and co-unconscious states which are the matrix from which they drew their inspiration and knowledge.

FUNDAMENTAL RULES

Psychodrama was introduced in the United States in 1925, and since then a number of clinical methods have developed — the therapeutic psychodrama, the sociodrama, the axiodrama, role playing, the analytic psychodrama and various modifications of them.

The chief participants in a therapeutic psychodrama are the protagonist, or subject; the director, or chief therapist; the auxiliary egos; and the group. The protagonist presents either a private or a group problem; the auxiliary

egos help him to bring his personal and collective drama to life and to correct it. Meaningful psychological experiences of the protagonist are given shape more thoroughly and more completely than life would permit under normal circumstances. A psychodrama can be produced anywhere, wherever patients find themselves, in a private home, a hospital, a schoolroom, or a military barracks. It sets up its "laboratory" everywhere. Most advantageous is a specially adapted therapeutic space containing a stage. Psychodrama is either protagonist-centered (the private problem of the protagonist) or group-centered (the problem of the group). In general, it is important that the theme, whether it is private or collective, be a truly experienced problem of the participants (real or symbolic). The participants should represent their experiences spontaneously, although the repetition of a theme can frequently be of therapeutic advantage. Next to the protagonist, the auxiliary egos and the chief therapist play an important part. It is their responsibility to bring the therapeutic productivity of the group to as high a level as possible.

The Protagonist—The protagonist, in order to get into the production, must be motivated consciously or unconsciously. The motive may be, among other things, self-realization, relief from mental anguish, ability to function in a social group. He is frustrated, let us say, in the role of the father or any other role in life itself, and he enjoys the feeling of mastery and realization by means of psychodrama which gives him symbolic satisfaction.

RESISTANCE

The term resistance is used here in an operational sense. It means merely that the protagonist does not want to participate in the production. How to overcome his initial resistance is a challenge for the therapist's skill. He may send an auxiliary ego to play the "double" of the protagonist. The double usually places himself back of the patient and begins to soliloquize. He gets the protagonist to participate in the soliloquy and perhaps to admit the hidden reasons he has for refusal. This technique is a "soliloquy-double technique".

The chief therapist himself may use another technique — the "soliloquy technique of the therapist". He may sit on the side of the stage and begin to soliloquize about as follows: "I know that Jack (the patient) doesn't like me. I don't see what other reason he would have for not cooperating." The patient might fall in with this and say, "It isn't *you* I don't like. It is this woman in the front row. She reminds me of my aunt."

Another method is to let the patient (A) step back into the group and start with another patient (B) and then call patient A back to be an auxiliary ego in any episode to B, for instance acting as his father, a policeman or a doctor. This is the "patient's auxiliary ego technique". A, who did not want to present

his own problems, may be willing to help another member of the group present his.

A further method of breaking resistance is the "symbolic technique", starting on a symbolic production so that fear of private involvement is eliminated as a cause of resistance. The director addresses the group thus: "There is a conflict between husband and wife because of certain irregularities in the behavior of the husband. He may be a gambler, a drunk, or whatever. They have an only child, a son, who is uncertain on whose side he should be." At this point the director turns towards the group and asks, "Who wants to take the part of the husband, of the wife, or of the son?" These roles being non-committal for the private lives of the members of the group, the director may more easily provoke some of them to participate.

Another "resistance remover" is the use of significant relations existing between members of the group. The director, for instance, knows that there is a rivalry between two individuals, A and B. He may invite them to fight it out on the stage: "Let the group evaluate who is fair and who is unfair."

Another method is to utilize "leader tensions" or "ethnic hostilities", for instance, of refugees versus Americans, Puerto Ricans versus the Negroes in the group.

An effective technique to break resistance is to use comical themes or caricatures in order to arouse the sense of humor of the members.

Last but not least, particular attention should be given to resistance which is directed against the "private" personalities of the chief therapist or of the auxiliary egos. In such cases, the therapist or auxiliary egos may have to be replaced, and it may even be necessary to restructure the group itself so as to meet the needs of the patient.

It is up to the resourcefulness of the director to find clues to get the production started and, once it is started, to see that it grows further along constructive lines. The causes for patient's resistance may thus be summarized as being *private, social, or symbolic.*

THERAPEUTIC, CONTROLLED ACTING OUT

The psychodramatist argues as follows: "Why not let him act out these hidden thoughts and strivings as an alernate to an 'analysis' of his resistance?" The patient on the couch, for instance, may be a woman who suddenly has an urge to get up and dance, or talk to her husband whom she suspects of being disloyal to her, or, ridden by a feeling of guilt, she may want to kneel down and say a prayer. If these activities are forbidden to the patient, certain elements which are upsetting him do not come to the fore and cannot be explained and treated. But if the patient knows that the acting of his hidden thoughts

and strivings is tolerated by the therapist, he will display them. The therapist, in turn, will be able to utilize the forthcoming material to the advantage of the patient. If, for instance, the patient plans a suicidal attempt the next day, and if he is permitted to portray this attempt within the framework of a therapeutic session, the therapist may prevent the acting out in life itself. But if he makes nonacting out a rule, the patient may kill himself the next day, and so he may not return to the next psychoanalytic hour, except in the form of an obituary note from the relatives. If acting out does take place during the session and if the episode is not properly carried out by the therapist, this, of course, also can be harmful to the patient. So the crux of the matter is that acting out be tolerated and allowed to take place within a setting which is safe for execution and under the guidance of therapists who are able to utilize the experience.

The whole problem of noninvolvement goes back to the original attitude of many of the early psychoanalysts — fear of direct love or direct hostility, their fear of acting out of the patients toward them and their own acting out toward the patients. The confusion here is particularly increased by the different meanings of the term "acting out". When I introduced this term (1928), it meant acting *that* out which is within the patient, in contrast to acting a role which is assigned to a patient by an outsider. It did not mean that they *should not* be acted out because they camouflage a form of resistance of the patient (psychoanalytic view). I meant just the opposite — that they should be acted out because they may represent important inner experiences of the patient which otherwise remain camouflaged and difficult if not impossible to interpret. In psychodramatic thinking, acting from within, or acting out, is a necessary phase in the progress of therapy; it gives the therapist an opportunity to evaluate the behavior of the patient and gives the patient a chance to evaluate it for himself (action insight). But if natural behavior is persistently prohibited, the psychodramatic effort is in danger of deteriorating to a game of words, a parlor game without feeling and with reduced therapeutic value. In order to overcome the semantic confusion I suggested that we differentiate two types of acting out, *irrational, incalculable acting out* in life itself, harmful to the patient or others, and *therapeutic, controlled acting out* taking place within the treatment setting. An illustration of therapeutic, controlled acting out is the following *Magic Shop Technique*. The director sets up on the stage a "Magic Shop". Either he himself, or a member of the group selected by him, takes the part of the Shopkeeper. The shop is filled with imaginary items, values of a non-physical nature. These are not for sale, but they can be obtained in barter, in exchange for other values to be surrendered by the members of the group, either individually or as a group. One after another, the members of the group volunteer to come upon 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 highly or without which their life seems worthless. An illustration follows: A depressive patient, who was admitted in the course of 1948 after a suicidal attempt, came to the Magic Shop requesting "Peace of Mind". The shopkeeper, Illustrus Randolph, 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 who come to this shop long", 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 a sensitive spot. Maria, the protagonist, was engaged but she refused to get married because of deep-seated fear of sex and childbirth. Her fantasy preoccupations involved images of violent suffering, torture, death, etc., in the act of childbirth.

THE CONCEPT OF THE ENCOUNTER; TELE AND TRANSFERENCE TOWARD THE THERAPIST AND AUXILIARY EGOS

Transference is the development of fantasies (unconscious) which the patient projects upon the therapist, surrounding him with a certain glamour. But there is another process which takes place in the patient, in that part of his ego which is not carried away by autosuggestion. It sizes up the therapist and estimates intuitively what kind of a man he is. These feelings into the intermediate behavior of the therapist — physical, mental, or otherwise — are tele relations. *Tele* (from the Greek: far, influence into distance) is feeling of individuals into one another, the cement which holds groups together. It is *Zueifuhlung*, in contrast to *Einfuhlung*. Like a telephone, it has two ends and facilitates two-way communication. Tele is a primary, transference a secondary structure. After transference vanishes, certain tele conditions continue to operate. Tele stimulates stable partnerships and permanent relations. It is assumed that in the genetic development of the infant tele emerges *prior* to transference.

The telic relationships between protagonist, therapist, auxiliary egos, and the significant dramatis personae of the world which they portray are crucial for the therapeutic progress.

ABREACTION AND SPONTANEITY

The difference between abreaction and the psychodramatic process is one of quality and not of quantity. Various abreactions come forth from the

patient and the auxiliary egos as well as from the audience, and these are integrated into the psychodramatic production. Psychodramatic production consists of structured scenes, each scene of structured roles, and each role of structured interactions. The various abreactions are obviously interwoven into a symphony of gestures, emotions, strivings, and interactions. Several individuals — the protagonist, the auxiliary egos, the director, and the group — take part in their development. A great deal of emotion, thinking, scientific and artistic skill goes into their making. Although created without rehearsal and without aesthetic pretensions, as human documents they can be well compared with plays such as *Hamlet* or *King Lear*. It would be utter nonsense to call Shakespeare's *Hamlet* just a high form of abreaction. It would be a misuse of words.

OPERATIONAL DEFINITION OF SPONTANEITY

My operational definition of spontaneity is often quoted as follows: 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, the religious actor without a ritual conserve, they have to "ad lib", to turn to experiences which are not performed and readymade, but 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 speaking out whatever goes through his mind. What is working here is not only the association of words but the spontaneity which propels them to associate. The larger the volume of word association is, the more significant and more spontaneous is its production. Other conditions being equal, this is true of all other methods designed to assist in mental cures. In psychodrama particularly, spontaneity operates not only in the dimension of words but in all other dimensions of expression, such as acting, interacting, speaking, dancing, singing, and drawing. *It was an important advance to link spontaneity to creativity, the highest form of intelligence we know of, 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.

FREE ASSOCIATION, SPEAKING AND ACTING A ROLE

It is not quite accurate to say that psychoanalysis is a dialogue between two. It could be said with more justification that it is a monologue, held in the presence of an interpreter. There are so many varieties called psychoanalytic technique today that it is hard to draw the line. A dialogue, not only in its dramatic but in its common sense, is an encounter of two, each with equal opportunity for combat and repartee. This is definitely *not* the case in psychoanalysis. It is equally inaccurate to call psychodrama a dialogue taking place between several individuals. Just as psychoanalysis is less than a dialogue, psychodrama is more than a dialogue, in the sense that living is more than a dialogue. The contrast between words and actions is difficult to define, speaking being a form of behavior. But the emphasis of psychoanalysis has been the concentration upon word symbols and their interpretation. When a patient free associates, his actions are artificially limited and restrained. He is not permitted to act and interact freely. Because of the natural interweaving of actions and words and their frequent linkage in adult behavior, we should not weaken the profound distinction between action and words which is most pronounced in early childhood and in certain definite mental states. When we say words, we mean words spoken in a specific language, for instance English or German. But English or German, or any other syntaxed language, is not born with us. During a very important part of our life, the earliest part of it, our infancy, we have no such means of "normalized" social communication, but the impress of this period of our life upon our future development is ever present. In this period, acts are acts and not words, and the action matrices which we develop in infancy are prior to the word matrices which we integrate with them later.

CATHARSIS

Catharsis, as a concept, was introduced by Aristotle. He used this term to express the peculiar effect of the Greek drama upon its spectators. In his *Poetics* he maintains that drama tends to purify the *spectators* by artistically arousing certain emotions which act as a kind of relief from their own selfish emotions.

This concept of catharsis has undergone a revolutionary change since systematic psychodramatic work began in Vienna in 1919. This change has been exemplified by the movement away from the written (conserved) drama toward the spontaneous (psycho) drama, with the emphasis shifted from the spectators to the actors.

In my treatise, *The Spontaneity Theatre* (*Das Stegreiftheater*), published

in 1923, the new definition of catharsis was: "It (the psychodrama) produces a healing effect — not in the spectator (secondary catharsis) but in the producer-actors who produce the drama and, at the same time liberate themselves from it."

There have been two avenues which led to the psychodramatic view of mental catharsis. The one avenue led from the Greek drama to the conventional drama of today and with it went the universal acceptance of the Aristotelian concept of catharsis. The other avenue 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 actual 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; aesthetic catharsis with ethical catharsis. These two developments which heretofore have moved along independent paths have been brought to a synthesis by the psychodramatic concept of catharsis. From the ancient Greeks we have retained the drama and the stage, from the Hebrews we have accepted the catharsis of the actor. The spectator has become an actor himself.

Mental catharsis cannot be always attained on the reality level, to meet all the situations and relationships in which there may exist some causes for disequilibrium. But it has to be applied concretely and specifically in order to be effective. The problem has been, therefore, to find a medium which can take care of the disequilibrating phenomena in the most realistic fashion, but still *outside* of reality; a medium which includes a realization as well as a catharsis for the body; a medium which makes catharsis possible on the level of speech; a medium which prepares the way for catharsis not only within an individual but also between two, three, or as many individuals as are interlocked in a life-situation; a medium which opens up for catharsis the world of phantasies and unreal roles and relationships. To all these and many other problems an answer has been found in one of the oldest inventions of man's creative mind — the drama.

THE DIRECTOR

Relation to Production — From the point of view of production, the significant relation between psychodrama and the dream has been often empha-

sized. Lewis Mumford said on one occasion, "Psychodrama is the essence of the dream". It is correct that in both cases we deal often with fantastic productions in which the protagonist is profoundly involved. Just as in a dream, so a psychodrama appears to be an exposition of unconscious dynamics. But it may be appropriate to point out some fundamental differences. The characters in a dream are hallucinated phantoms. They exist only in the dreamer's mind, and they vanish as soon as the dream is over. But the characters in a psychodrama are real people. The dreamer can go on dreaming the most fantastic things without any resistance from his dream characters, his dream characters and the whole plot being his own production. In a psychodrama, however, the auxiliary egos playing roles frequently resist the reveries of the protagonist, they talk back and fight back and modify the course of the plot, if necessary. There is counter-resistance, one may say, propelled toward the protagonist from all sides. They may for exploratory and therapeutic reasons "interpolate" resistance of all sorts, contrary to the protagonist's design. The protagonist in a psychodrama is never as alone as the nocturnal dreamer. Without the counterforces which the auxiliary egos and the members of the group inject, the opportunities for the protagonist to learn would be very much reduced.

Relation to Patient — The general rule of directing is to depend chiefly upon the protagonists to provide the *clues* as to how to carry on the production. The first clue of a hallucinating patient may be: "I hear my father screaming."

Th: "Where does the voice come from?"

P: "It comes from behind the wall."

Th: "Is your father alone?"

P: "No, he is with my mother, they are fighting."

A clue may or may not be found, but if it is, then the episode is acted out. The director instructs two auxiliary egos to experiment with the portrayal of father and mother and the conflict between them.

The father sits down.

"No", the protagonist protests, "He is not sitting, he is walking up and down."

P: "No, he doesn't hold his head up. He coughs and spits like this." He tries to show the auxiliary ego how.

The protagonist may ask over and over for new modifications; if he protests too much he may be asked to take the part of the father himself. Now he gives "his own interpretation" of the hallucinated father as he perceives him. Here we notice that "straight" role playing can be insufficient, and we see why psychodramatic techniques need to be introduced. It is (1) to get

the protagonist into deeper action by involving him more in his own experience, and (2) to make his hallucinations become more tangible either through his own enactment of them or by an auxiliary ego's enactment. *Our hypothesis is that if such experiments are made at the time when hallucinations are active, controls are interpolated in the patient's mind, conditioning barriers, which become particularly important as a reservoir of preventive measure in case of later relapses.* If he should have a relapse, the previous episodes of similar hallucinations will return to him associated to "controls", not as much in his memory as in his behavior, and these preventives will return with them and reduce the violence of the new attack.

The patient may, of course, use even psychodrama itself as a means of resistance. But the psychodrama director has the opportunity to intervene with various techniques so as to hinder the protagonist from "not playing the game" and using the psychodramatic situation itself as a screen for noncooperation.

Relation to Auxiliary Ego — The directing therapist has a significant relation to the patient; the patient must be aware that the therapist has overall responsibility for the treatment. But the therapist is not left alone in his task. He has a number of therapeutic aides, the auxiliary egos, to help him. An auxiliary ego, may, at times, refuse to play the roles the protagonist wants him to play. The reason for not participating may be that the patient always wants to act in sadistic roles, roles of omnipotence, and, in such episodes to humiliate the partner. For instance, he may always want to sit in the car and let the auxiliary ego be the taxi driver, or he may want to be a big shot in a night club and have the auxiliary ego as a waiter, or to be a big general who orders people around according to his whims. It may very well be that the auxiliary ego comes to the realization that one or two such episodes may have a cathartic value for the patient, but that the repetition may become harmful. He might then step in and suggest that the situation be reversed — that the auxiliary ego be Napoleon and the patient be the little man. If the patient does not accept, the auxiliary ego may further explain that he has had enough suffering and refuses to act. This kind of resistance may be classified as "resistance for therapeutic reasons". Then there may be a kind of resistance which is private in nature. The auxiliary ego may feel that, by playing the role of an intimate friend in that particular episode, he is getting personally involved and hurt. For instance, I treated a young woman on the stage who was arguing against her husband because of his imagined disloyalties toward her. At this moment the auxiliary ego was ordered to take the part of a woman friend of the patient and was instructed to protect the husband and emphasize his innocence. But when she stepped upon the stage, she did the exact opposite of what she was expected to do. Instead, she supported the wife in her delusions

and said that she should throw her man out of the house; that he was not worthy of her love. When the auxiliary ego was stopped afterward and reminded of her complete reversal of behavior on the stage, she broke out in tears and said, "I couldn't help it because I am in the same position as the patient in my own private life". We distinguished, therefore, two kinds of resistance; the one for therapeutic reasons and the other for personal reasons.

AUXILIARY EGOS

As Actors — The auxiliary egos are actors who represent absentee persons as they appear in the private world of the patient. The best auxiliary egos are former patients, who have made at least a temporary recovery and professional therapeutic egos who come from a sociocultural environment similar to the patient's. If there is a choice, "native" auxiliary egos are preferable to professional egos, however well trained the latter may be. Many investigators who tried to apply psychodrama to different cultural settings, have found that the proper choice of auxiliary egos is of primary importance. A middle-aged Puerto Rican woman suffering from weird hallucinations, who did not respond to any form of psychotherapy, responded to psychodrama as soon as native auxiliary egos were used. Many of her religion-tainted hallucinations appeared quasi-normal to her own people.

As the task of the auxiliary egos is to represent the patient's perceptions of the internal roles or figures dominating his world, the more adequately they are able to present them, the greater will be the effect on the patient. 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 externally. Such encounters go beyond verbal communication and help the patient to strengthen his vague internal perceptions to which he can relate himself without external aid. These symbolic figures of his inner life are not mere phantoms but therapeutic actors with real lives of their own.

Relation to Patient — The general rule in classic psychodrama is that the patient can choose or reject the egos portraying the significant roles in his life, and vice versa, that the egos are free to choose or reject in their willingness to cooperate with the patient. However, there are exceptions where the patient is exposed to a certain ego in a special role, created without his consent, and, at times, the therapist is instructed to assume a role which he does not particularly like to portray. Indications or contraindications are the mental benefits which are expected to be derived by the patient from such traumatic procedures.

On portraying the role it is expected that the ego will identify himself temporarily with the role to the best of his ability, not only to act and pretend but to "be" it. The hypothesis here is that what certain patients need, more

than anything else, is to enter into contact with people who apparently have a profound and warm feeling for him. For instance, if it happens that he, as a child, never had a real father, in a therapeutic situation the one who takes the part of the father should create in the patient the impression that here is a man who acts as he would like to have had his father act; that here is a woman, especially if he never had a mother when he was young, who acts and is like what he wishes his mother to have been, etc. The warmer, more intimate, and genuine the contact is, the greater are the advantages which the patient can derive from the psychodramatic episode. The all-out involvement of the auxiliary ego is indicated for the patient who has been frustrated by the absence of such maternal, paternal, or other constructive and socializing figures in his lifetime. If indicated, the auxiliary ego is permitted to be as active as the patient needs. "Bodily contact" is a basic form of communication. It is not, however, always indicated. In some cases the intimacy and warmth of contact, especially bodily contact, may be contraindicated. There are, for instance, some schizophrenic patients who resent being touched, embraced, or kissed. They would prefer their auxiliary egos to portray symbolic and omnipotent roles. One often sees that they are not quite ready for the realistic approach. They have to go through many symbolic acts before a direct and immediate encounter is acceptable.

TELE AND COUNTERTRANSFERENCE

A minimum of tele structure and resulting cohesiveness of interaction among the therapists and the patients is an indispensable prerequisite 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 countertransference phenomena dominate the relationship among the auxiliary therapists and toward the patients the therapeutic progress will be greatly handicapped. The decisive factor for therapeutic progress is the *tele*.

WARMING UP TO A ROLE

Psychodramatists trained in psychonalysis often follow the rule of psychoanalysis which has been formulated by Fenichel as "not playing the game" of the patient. Their opinion is that also in psychodrama, the classic psychoanalytic attitude of noninvolvement is desirable. The auxiliary ego is instructed,

when he enters a situation in any role, only to go through the motions of the role, but to remain as cold as possible inside, refusing altogether to get warmed up to the role he is supposed to present, playing with indifference, following the principle of neutrality. This kind of resistance of the therapist for methodical reasons is the dogma for one of the French schools of psychodrama (Lebovici and Diatkine). The difficulty with such behavior of the psychodramatist is that if the patient needs a mother or a father, a wife or a child, and the auxiliary ego who is there to portray this role does not convey to the patient the genuine characteristics of it, the patient may be harmed rather than helped. He will feel like a guinea pig rather than a human being. This method might be indicated in certain cases where the patient is autistic to such an extent that he is little aware of what is going on around him, entirely self-involved.

THE AUDIENCE GROUP

Group Psychotherapy Versus Group Psychoanalysis

One can look at the formation of synthetic groups from the point of view of the psychoanalytic frame of reference. I assembled the new members of the group (1921) in a room which was fitted out with a number of couches. Every individual was placed on a couch. The fundamental rule of free association was applied to them. The experiment failed; the free association of one began to mingle with the free associations of the other. This confused them and produced a chaotic situation. The reasons for the failure seemed to be twofold. Free association works significantly only along individual tracks; free associations which have significance along the track of individual A have no significance on the track of B or of C and, vice versa. They have no common unconscious; in psychoanalytic theory each individual has his own unconscious. When free association was rigorously applied, a number of individuals were being separately psychoanalyzed. It did not develop into group psychoanalysis but into psychoanalysis of several individuals within a group setting. But my objectives were group therapy and group analysis, not individual analysis. As the psychoanalytic method of free association proved unproductive, I developed a new method which was based on the study of the formation of groups in *statu nascendi*.

Individuals who never met before and who from the first meeting on have other participants in the same group represent a new problem to the therapist; he sees them when they enter spontaneously into interrelations which lead them to form a group *sub species momenti*; we can study their spontaneous reaction in the initial stage of group formation and the activities developed in the course of such organization . . . we can develp the treatment forward instead of

backward; we can begin with the initial attitude one person has for the other and follow up to what fate these interrelations lead, what kind of organizations they develop.

In support of the existence of such an initial common matrix, sociometric research has shown that "immediate response between strangers differs significantly from chance . . .". Barker, in his classic experiment took twelve university students who were complete strangers to each other and were selected from a larger class for its first meeting. Six of these students were men, six were women. Of thirty-six choices of seat mates upon the first occasion, twenty or twenty-five percent were repeated upon the second occasion. Of one-hundred-thirty-two responses to other choices upon the first occasion, eighty-one or sixty-three percent were repeated upon the second occasion. These percents are both considerably higher than would have been obtained if the subjects had chosen entirely at random.

In other words, *there is tele already operating between the members of a group from the first meeting*. This weak, "primary" cohesiveness can be utilized by the therapist toward the development and sharing of common therapeutic aims. All the interactions between men, abreactions, soliloquies, dialogues, tele, and transference relations to therapist, auxiliary egos, and each other in the course of therapy will be influenced by this original structure and will in turn modify it. This is the new operational frame of reference from which one can look at the successive stages of a synthetic group.

IMMEDIATE BEHAVIOR OF THE GROUP AND THE "BEDSIDE MANNER" OF THE THERAPIST

Sociograms — The chief concern of the psychodramatic therapist is the immediate behavior of the group. When the therapist faces his group for the first session, he perceives immediately, with his skilled sense for interpersonal relations, some of the interaction between the members, such as the distribution of love, hate, and indifference. It is not just a collection of individuals. He notices one or two sitting all by themselves, physically isolated from the rest; two or three clustered together, smiling and gossiping; one or two engaged in an argument or sitting side by side but giving each other the cold shoulder. In other words, the first contours of a sociogram begin to simmer in his mind. He does not have to give a formal test in order to obtain this knowledge. He takes notice of this "embryonic matrix". It is coming to him through his immediate observation. It becomes his empathic guide for the therapeutic process in becoming. The group has, from the first session on, whatever its size, a specific structure of interpersonal relations which, however, does not reveal itself at once on the surface, an underlying sociometric or group matrix.

It is useful to differentiate intuitive recognition of structure (intuitive sociogram; sociogram is a diagram which portrays the forces of attraction, repulsion, and indifference operating in groups), observer's recognition of structure (observer's sociogram), objective recognition of structure (objective sociogram), and perceptual recognition of structure (perceptual sociogram). The therapist may hesitate to impose upon the group a sociometric test to start with, but he will let the sociogram, in its intuitive form, grow in his mind as he looks around, in the "bedside manner" of the group psychotherapist. After one or two sessions he may make (afterward) notations as to the impression he has of the existing structure, and he may ask one of his cotherapists to do the same thing independently and then compare data. Such an observer's sociogram has a greater degree of objectivity and supplements the original intuitions. If after several sessions the group is well established and the contact with the therapist is favorable, the strategic moment may come for a formal sociometric test from which an "objective" sociogram will result. A further step in the clinical exploration of group structure is gained by letting every member of the group make his own sociogram, that is by letting him indicate who among the members of the group, he thinks, chooses or rejects him. He reveals the perceptions he has of what people around him think of him, a perceptual sociogram. He may think of himself as being liked by everyone but in the objective sociogram he may be shown to be a rejected individual. Such a discrepancy between his perceptions and the objective facts may provide important clues to his interpersonal status and a further refinement of his position in the sociogram.

CONCLUSIONS

Behavioristic schools have been limited to observing and experimenting with "external" behavior of individuals. leaving out major portions of the subjective. Many psychological methods, such as psychoanalysis, Rorschach, and TAT, went to the other extreme, focusing on the subjective but limiting the study of direct behavior to a minimum and resorting to the use of elaborate systems of symbolic interpretation. The psychodramatic method brings these two extremes to a new synthesis. It is so designed that it can explore and treat immediate behavior in all its dimensions.

Because we cannot reach into the mind and see what the individual perceives and feels, psychodrama tries, with the cooperation of the patient, to project the mind "outside" of the individual and objectify it within a tangible, controllable universe. It may go the whole way in the process of structuring the world of the patient up to the threshold of tolerance, penetrating and surrounding reality ("surplus" reality), and may insist upon the most minute details

of episodes in physical, mental, and social space to be explored. Its aim is to make total behavior directly visible, observable, and measurable. The protagonist is being prepared for an encounter with himself. After this phase of objectification is completed, the second phase begins; it is to resubjectify, reorganize, and reintegrate that which has been objectified. (In practice, however, both phases go hand in hand.)

The psychodramatic method rests upon the hypothesis that, in order to provide patients, singly or in groups, with a new opportunity for a psychodynamic and sociocultural reintegration, "therapeutic cultures in miniature" are required, in lieu or in extension of unsatisfactory natural habitats. Vehicles for carrying out this project are (1) existential psychodrama within the framework of community life itself, *in situ,* and (2) the neutral, objective, and flexible therapeutic theater. The latter represents the laboratory method in contrast to the method of nature and is structured to meet the sociocultural needs of the protagonist.