PSYCHODRAMATIC WAYS OF COPING WITH POTENTIALLY DANGEROUS SITUATIONS IN PSYCHOTIC AND NON-PSYCHOTIC POPULATIONS*

DONELL MILLER

Johnston College, University of Redlands

How would you feel if one of your colleagues, as protagonist on a psychodrama stage, were to reveal a recent psychotic episode, complete with hallucinations, distortions and delusions? This is what happened at a Beacon seminar some years ago, while I was still a director-in-training. Such "irregular" behavior occurs regularly enough, I have since discovered, that my mentioning the incident today would hardly constitute a breach of confidence or even be a source of embarrassment to the person involved, were he (or she) here now. Indeed, far from feeling dismay for a friend's indiscretion in telling "too much," I was proud of his trusting us and gratified to know one more psychotherapist capable of appreciating the length, breadth and depth of his patients' troubles. The very next session featured a nurse's re-living on stage a recurrent nightmare. The similarity of both form and content to a psychotic experience struck me forcibly, ample evidence for a "psychopathology of everyday life." And that was not all; as I looked within myself I found another parallel in a favorite daydream. Try as I might, I could not dismiss the impression, so there I was on stage the next day, playing out my whole science fiction scenario. With a boyhood background in religious revivals, I was no stranger to public confessions and I had, after all, been protagonist on that same stage many times before blurting out quite a few hitherto undisclosed, unflattering secrets, but oddly enough, my chronic daydream fantasy proved the most difficult to own, as if I were another nude Adam caught with apple core in hand! Fortunately, there is no audience anywhere so gentle, sympathetic and understanding as a veteran psychodrama group. Their acceptance of the erstwhile unacceptable me made me acceptable to myself once again. Gladly I rejoined the human race, as thousands of protagonists have before me.

SHARED COMMON GROUND

What is more, the whole incident confirmed a growing conviction, now a cornerstone for this paper, that the psychotic patient shares considerable common ground with everyone else. A patronizing attitude is a luxury the psychodramatist of psychotics can ill afford, for the patient's differentness stems from his existential position, not from any essential variation in his human nature. The psychotic's hallucinations, for example, differ from normal perceptions only in the negative sense that we can find no stimulus calling them forth, a deficiency

overlooked by the patient, seized as he is by the immediacy of the experience. If and when he finds out that others have not heard the voices, such information counts for relatively little in his estimation, so little of himself is invested in the "outside" human world anyway his own experience is the more compelling reality. If the patient can be led to shift more and more of his investment to the social relationships present, his existential position varies accordingly. In any case, psychodrama method, most of the time supports and challenges patient and normal protagonist in precisely the same way. Thus the skilled psychodramatist, confronted for the first time with patients diagnosed psychotic, is likely to find himself on familiar territory. When the unexpected comes he will find himself expending energy in his effort to understand the individual protagonist, rather than cast around for some specialized technique, tailor-made for a patient population.

Of course there is "psychodramatic shock therapy"[1] which may, at first glance, seem to be just such a specialized technique, but even so heroic a treatment as this is hardly without parallel in everyday psychodramatic practice. The patient's reluctance to return deliberately on stage to the psychotic abyss from which he has just now emerged has its counterpart in the neurotic's hesitation in confronting the phobic object as psychodramatically reconstructed. And the treatment rationale is quite similar, for neither can successfully master his fears through simple avoidance. Both are in the position of the small child who gains control of himself and his feelings as he returns again and again to the staircase he has fallen down. Doing consciously and deliberately what was formerly thrust upon him quite apart from his wishes or expectations regains for him his lost control of the situation, evaporates his fears and expands his universe. Another comparable situation is the frequently heard psychodramatic assignment to the protagonist that he deal with the "worst that can happen." The therapeutic value of the experience depends upon the director's skill in concretizing the subject's imagination, that the almost unbearable pain may be fully felt, but now rendered bearable through sufficient support from director, doubles and the cohesive group as a whole.

PERTINENCE OF GROUP PROCESSES

This brings me to another major conviction, the context of any event is of decisive importance to an adequate coping with that event. This is one of the great strengths of psychodrama. In the examples above, psychosis, phobia, and the "worst that can happen" are placed within the context of a warm, firm social support with success taken for granted, rather than in a cold, isolated, distant nowhere, with failure a foregone conclusion. Moreover, what other therapy can incorporate within a single form of reference the living and the dead, the real and the unreal, the natural, social and fantasy worlds of past, present and future, rendering any or all here and now, making vital contact with the whole protagonist, his behavior and feelings, not simply words and ideas alone and unconnected?

On another level, it is crucial that the psychodramatist see psychodrama as *group* psychotherapy—with a capital "G." And group psychotherapy must not be confused in practice with individual therapy done in a group setting. For a director to "go it alone" with the protagonist would be like Bruno Walter conducting *Die Walkure* without benefit of tenor, orchestra and chorus. Furthermore, the director who forgets his group is like a barber of the old tonsorial parlor days assaulting the inner recesses of his patient's throat without the benefit of anesthetic. More often than not, when the disillusioned amateur claims that psychodrama won't work for him, the defect turns out to be his failure in appreciating the potential power of the group as *the* therapeutic instrument in group therapy.

Nor does it end there. If we have learned anything at all from group dynamics, we must recognize that even a psychodrama suffers enormously from an unfriendly, passive or perfunctory hospital setting. The psychodramatist's analysis of processes *outside* the group may prove as fundamental to the success of his work as his grasp of group processes *within* the group. We cannot afford to ignore the illusions of professionals schooled in psychoanalytic thinking, bent on seeing all action as acting out, and all acting out as resistance, necessarily inimical to treatment, and productive of disruptive, uncontrolled behavior. Here the critic has overgeneralized, for even if his assumption may apply to the analytic situation, it does not follow that it applies equally well to another treatment modality where the rules are quite different. The truth of the matter is that psychodrama teaches restraint and control quite as well and as often as release. Spontaneity and impulsivity are poles apart; the psychodramatist is no more an advocate of the latter than his critic. Likewise we overlook at our peril the Puritan, anti-play conscience of lower-level nursing personnel, with their ready recourse to domineering parental roles in the name of "confrontation" and "reality therapy." Psychotic patients, consciously living in the shadow of the unconscious, prove to be remarkably aware—certainly more than most staff, which programs really count with those most able to determine their immediate fate.

Other hospital personnel often suspect and, it must be admitted, not entirely without justification, that they are represented rather unfavorably in the patients' scripts. In handling this problem one may emphasize the importance of the "group oath"[2] and confidentiality, so that half truths do not leak out to feed the insecure imagination. But this only works in cohesive groups, and groups so "open" a patient may be pulled out to run an errand, mop the floor or visit the dentist—to say nothing of being suddenly sent on leave, or shifted to another part of the hospital, cannot be considered cohesive. In such an event the more effective route is to include as group members a few ward personnel, who in turn are required to commit themselves to regular attendance and participation. Predictably their loyalties quickly become tied to the group, and thus they prove of invaluable aid in creating within the hospital that sort of atmosphere which allows psychodramatic therapy to flourish.

Even when a particular setting forbids ideal conditions, it would be a mistake for the psychodramatist to identify with or be especially protective of authority figures within the hospital. There is abundant therapeutic value in the patient's coming to feel that finally he is being heard. He is no longer "low man on the totem pole" but now has a powerful figure or two in his own corner. Here he may safely reveal himself; here he can be understood without being destroyed. Now he can let go of some of the "smoke screen" he has been hiding behind. It is not necessary to agree with the patient's perceptions or opinions, only to acknowledge that they matter, for he has presented them with sincerity and conviction. Indeed, such is the appropriate stance with regard to his hallucinations and delusions as well. The fact that the psychodramatist refrains from "holding up other people's reality" to the patient, and actually shows sincere interest in the patient's own reality encourages the patient's trust, resulting in his sharing more and more of his private world with the group. What a boon for him to discover that he is not as alone as he had thought, that others experience terrors something like his, and seek to protect themselves in similar ways, while his frantic efforts to keep from "drowning" are appreciated even by those reputed to be sane!

Broad As Life

But context spreads out even farther than these, for psychodrama is as broad as life itself. Surely you've heard a psychodramatist say of someone not in his psychodrama group, "Let him have his psychodrama." Here the therapist has come to see each person everywhere in pursuit of his own catharsis. The psychotic is no exception, for the painstaking construction of his lonely personal world may be seen as an abortive attempt at creativity. Recogniton of this fact led to the invention of the "Auxilliary World Technique,"[3] whereby several auxilliary egos agree to help the patient in structuring his off-stage world according to the requirements of his heretofore private world. One can see why psychodramatists are such a pain to bureaucrats and other conformists.

Lest you think such a procedure strange and unnatural, permit me to emphasize that you and I are similarly engaged in living out our own psychodramas at this very moment, enlisting in our service any "auxilliary egos" we think we need. As practiced and expert role players ourselves, we manage our interpersonal relations in such a way that, while I call on you to be auxilliary in my psychodrama, I offer you myself as auxilliary ego in your psychodrama. Inasmuch as patients lack this high degree of interpersonal skill, we offer them our assistance in completing psychodrama in life, when we have been unsuccessful in getting it on stage. The patient's psychodrama may be too limited for our taste, but unless we help in realize his psychodrama in some form, he will never feel sufficiently free to dare aspire to a more comprehensive, fulfilling and realistic psychodrama.

On the other hand, the world has had more than a taste of those frightening figures, whose grandiose plans find ready acceptance from an inferiority-laden,

frustrated public. Thus young Adolf Hitler, smarting from the deafness of the city fathers to his proposals for Vienna's reconstruction, abandoned a possible career as city-planner, for the sake of a determined scheme to re-make, not merely Vienna, but the whole map of Europe—and from there, the world! How different our history would have been, if the city fathers had employed a psychodrama consultant, capable of restructuring Hitler's early dream in accord with the auxilliary world technique. The inconvenience would have been a small price to pay, that the world should be spared so much grief! Psychodramatists have been lacking such opportunities to date, but there have been instances, in the microcosm of the mental hospital, where patients who disdained the psychodrama stage were encouraged to find fulfillment in an environment structured according to their "delusions." A classic case is described in Volume II of *Psychodrama* under the heading, "The Psychodrama of Adolf Hitler." What a stark contrast this provides to the "reality therapies" so widely pursued today!

Psychodramatic Babies and Psychoses

A rather common feminine form of the quest for a psychodrama is the "psychodramatic baby,"[4] the fantasy baby a woman may carry deep inside her. Even the virginal spinster is not immune from the possible impact of such unfinished business, as she externalizes her longing in the lavish care of pets, in much the same way that her little nieces mother their dolls. Likewise many a man carries a psychodramatic baby, which he can partially express in an original paper at a scientific meeting. The more usual experience, however, may be found in the mother of several children, who nonetheless fall far short of her high hopes. How she suffers! Again and again she carps, "Why aren't you?" or "Why don't you?" Thus the real baby is sacrificed for the sake of the dream, in much the same way that romantic adolescents of every age eventually distance the lover at hand for the lover in the head. The psychodramatic answer, of course, is to play the midwife, "let her have her psychodramatic baby." Thus the psychodramatist helps the protagonist picture her child at significant life stages, such as walking at nine months (this is a precocious baby, of course!), talking at fourteen months, entering kindergarten . . . etc. Reverse roles frequently; let her be the child. Freedom from the fantasy comes through affirmation by the group, never through denial. When delivery has been accomplished, the director listens for the cue, or if necessary himself supplies it, that the mother return to the image of her real children on stage, now perhaps for the first time able to accept them as they are ** Subsequent psychodramas may look into the motivational basis for the mother's exorbitant need which is likely to be found in her own sense of having failed in life. Thus she turns to her own offspring for compensation. When they seem to be headed toward failure themselves (as she has narrowly defined it), her frustration pressed her to redouble her efforts. She may have even resorted to violence, if such were part of her own socialization process. Careful role training in parenting can reduce the possibility of another

battered child and in the next generation, another battering parent. Thanks to the psychodrama, mother may live to see in her children a happier immortality for herself.

> At the verified complaint of the father, twenty-five year old Sarah had been imprisoned for beating her children unmercifully. In psychodrama it became clear she was a perfectionist with unrealistic high standards for herself. Thus she considered herself a failure in many "minor" areas, but was determined that she would not fail as a mother. "Someday her children would thank her." Only gradually did she come to see her rage at herself for not "measuring up" and her own mother's disappointment in her for not realizing mother's aspirations also.

In more pathological settings, however, the psychodramatic baby may be far from an ideal. A pregnant woman, wary of what life has given her already, actually may anticipate disaster. She may abort the baby, even make an attempt on her own life, rather than deliver another monster like herself, or the introjected mother-figure within her. If a real baby is born, she may unconsciously undertake its murder, a little bit at a time. This is delicate and difficult psychodramatic work, but the stakes are high. The chief task is helping her to carve out a new and healthier identity for herself. No more must the overwhelming burden of "normal" expectations be held over her head. More modest, realizable, and finely graduated responsibilites may be provided through several role-training sessions, while the group offers her love and approval at her successes, solace for her failures. At a time when she appears stronger, there may be a psychodrama session in which the psychodramatic monster within the mother miscarries, or is magically exorcised, or meets with an "unfortunate accident." One must beware, however, of provoking more guilt, or fostering any role training suggesting active violence toward the helpless infant, lest we inadvertently promote the very thing we are trying to prevent.

The Schizoid Posture

To understand the direct analogy between the psychodramatic baby and the psychotic experience itself, it may be useful to review some of J. L. Moreno's concepts.[6] Every human being is his own social and cultural atom. The social atom consists in the tele range of an individual, that is, the smallest constellation of psychological relations . . . "of one individual to those other individuals to whom he is attracted or repelled, and their relation to him." The cultural atom is the various roles by which these relationships are articulated. As a person comes to develop a picture of himself, he may consider this much more significant than any picture others may have of him. With the former self he pushes the latter farther and farther out; the peculiar "feeling relationship" that develops between the ego and its extrojection may be called "auto-tele."

The schizophrenic patient's social atom shows much more confusion in its telic relationships than a normal person's. The significant figures' way of relating to

him contained so many mixed, double-binding messages, he found it hard to identify with them, so he did the only thing he could do, back off from them. The identity fragments he retained were themselves of such vague and mixed character they provided a poor basis for role taking. While the normal person is extending the range and precision of his role taking ability, the preschizophrenic falls farther and farther behind and becomes progressively less able to cope with real people. Psychiatrists, on back to Bleuler, have been impressed with the schizophrenic patient's inappropriateness or blunting of emotional response as a key problem, possibly referrable to a hereditary defect. In my view, however, the schizophrenic patient, like a master poker-player, has overlearned the apparent security value of keeping his feelings to himself. The task becomes easier as he learns to care less. He gradually relinquishes his claim on real people in favor of the more readily controllable, wish-fulfilling world within. Thus the patient seeks to develop the fragments within him into some definite and personally meaningful form, constructing a less threatening social and cultural atom for himself. With so little of himself invested in social relationships, the patient's already defective role reversing ability suffers further damage. He blunders into provoking others into fulfilling his fearful expectations, and thus he is impelled to put more and more distance between himself and them, even to the point of withdrawing his ego from its extrojected form in his own body, thereby enabling him to deny his own outer, bodily actions as actually his. Now, just because of the split from body actions and its concommittant live-in feelings, the patient's attempted psychodrama remains in embryo. As Laing has pointed out,[7] without a body acknowledgeable as his, the patient becomes a no-body (nobody), an identity yet unborn. Indeed, Anton Boisen,[8] upon recovery from his own catatonic experience, defined the goal of his psychotic episode in terms of religious conversion, a being "born again." Therefore the psychodramatist of schizophrenics again assumes the midwife role, and facilitates the delivery of the inner psychotic world on the psychodrama stage. A word of caution: the patient's growing love of his therapist may become a threat to the patient's existence as he knows it and lead to a homicidal attempt to remove the threat of engulfment, or a suicidal attempt to prevent the homicidal impulse. The therapist's ability to accept this, should it emerge on the psychodrama stage, will go a long way toward forestalling any real danger, for his strength will seem less dangerous to the patient now and provide a positive platform upon which the patient may begin to build a new identity. The psychodramatist may have occasion to recapitulate three important stages in the development of the infant[9] consisting in "identity, recognition of the self, and recognition of the other." The techniques especially suited for each stage are the double, the mirror, and the reverse roles, respectively.

When Henri first came to psychodrama, it was apparent that his struggle related to his identity, for he introduced himself to us as Christ. When someone in the group suggested that Henri "walk on water" or do some other

miracle, I sprang to the patient's defense, reminding them how Satan had tempted Jesus long ago in the wilderness with similar challenges. I said that I normally accept a person to be who he says he is and take as my task discovering *just what it means to be the person one is.* "As you get to know me better, you discover what it means to be 'Don Miller'; likewise with Henri, let us get to know him better, that we may understand what he means when he says he is Christ." Accordingly, we traced the significant persons, places and experiences in Henri's life. We learned that he had felt persecuted, "crucified" like Christ, though his intent, his conscious motives, were pure as Christ's. When someone proceeded to make the obvious interpretation out-loud, I cut them off in mid-sentence with "Thus you see why it is that we must respect Henri. He is a good person, who has suffered much. Are there others here who also have suffered much? Let us share." And after having shared, I encouraged the persons present to show, nonverbally, how they felt toward Henri now. Some shook hands, others hugged him, tears streamed down his face. The next week at psychodrama it was apparent that Henri's thinking had developed more in the direction of our consensual reality. He explained that there were many Christs, of which he was one, although there was just one Jesus in history. And lated I found an opportunity to commend him for having such high ideals and mentioned how the apostle Paul also took Jesus as his model. "When one has no father, or has lost his father, what better model could one pattern himself after?" Thus we witnessed the gradual transformation of a "pathological identity" into a healthy identity through the acceptance of health in the midst of pathology.

The Depressed Patient

Typically the depressed patient's social atom is in a shrunken state insofar as living people are concerned. Each new loss has become progressively more traumatic for he seems to have lost the capacity to make replacements and it is as if the dead were calling him to join them. Indeed, his social atom may contain more death than life. The genuine relationships which remain must be capitalized upon to the fullest extent. If the patient has a good relationship with the therapist or someone in the group, so much the better. Any guilt-provokers there may be in the group will need to be controlled by frank interpretation if more subtle efforts fail. But this is not the time to interpret or otherwise undermine the patient's shaky defenses. On the contrary, now is the time for the group to be as supportive as the group can be. A comforting arm, spontaneously offered, can be an enormous help. The longed-for comfort from inaccessible persons outside the group can be brought into the group through auxilliary egos the patient may choose to play the roles. The director must remember that depression is often the outer expression of anger called forth by the persons upon whom he has been overdependent which the patient turns in on himself. It is wise to assist the patient in directing the anger toward its appropriate object while

protecting him from the accumulation of any guilt feelings for such expression. This is one time the vigilant director will guard against ordering the patient to reverse roles. It may encourage the patient to look to suicide as a way of destroying the ambivalently loved and hated person within him. Indeed, the director will bend his effort toward subtly undermining the identification. A useful tactic is "focusing on the differences." Here the director asks the protagonist to choose two auxilliaries, one to represent himself and the other to represent the "negative identity."[10] Place the two back-to-back center stage. Require the protagonist mention as many essential differences as he can and with each difference named the auxilliaries are to take one step away from each other. (Of course, if the protagonist "slips up" and lists a similarity rather than a difference, that is "penalized" by the auxilliaries' retracing a step.) Whether the protagonist produces many differences or few his reaction normally includes a discovery, which can readily be capitalized on by the director. When the protagonist has seen *many* differences, the director comments "You're not very much alike, after all!" When the protagonist cannot produce differences, the director comments on the protagonist's strong need to see sameness and the very high price he's paying to maintain that perception. What makes him willing to "buy" such a "bad bargain?" The alert director does not permit a verbal rationalization, however, but challenges the protagonist to show us what *sameness* allows him to say and do . . . etc.

This is a variation of a simple technique I devised for the purpose of calling a person's attention to transference phenomena. In its original form I have the protagonist select two auxilliary egos, one to represent the significant figure from the patient's past, and the other, that present figure who is the object of much stronger feeling than his behavior would seem to call for. With an auxilliary at one end of the room and the other auxilliary at the opposite extreme, the patient stands in the middle with the assignment of listing as many similarities and differences as he can between the two such important persons in his life. With each similarity, the auxilliaries step forward; with each difference, they step back. Of course, the exercise serves to establish the emotional identity between the two and forcibly brings it to the patient's awareness. But this is exactly what we do *not* want to achieve with the depressed patient. Therefore the "distancing technique" is substituted for the above "identification technique."

Finally, if the suicidal threat is brought out into the open, deal with the actions which lead toward the deed on stage, but "leap frog" over the doing of the actual deed itself, lest you role-train the patient in behavior you don't want. Then move into an elaborate future projection of the anticipated consequences of the deed for the significant people in the patient's life. Here one can get a very clear picture which of these is most troublesome to the patient. The future projection should be extended into the remote future, so that the finality and futility of the act be prominently displayed. One more comment: remember that the depressed patient has an exaggerated sense of responsibility, which must be

reduced to manageable proportions, and also that he lacks a sense of mastery over his own actions, for which expansion of his role-taking ability may be actively promoted on the psychodrama stage.

A 38 year old man was admitted to a state hospital after a suicidal attempt following his wife's infidelity and desertion. The preliminary psychodramatic work involved re-creating the episode on stage up to the point where the patient decided to take his own life. Then the director cut the scene, and set up instead that fantasy creation the patient expected would follow from the discovery of his death. As the sad news spread, it was easy to distinguish which relationships carried the heavier load of ambivalence. Those whose caring showed a potential positive resource were persons who regretted not knowing how desperate the patient had been and wished he had unloaded to them. On the other hand, the ambivalent focus could be clearly seen in those significant figures who under-reacted or over-reacted to the news. The latter instance included the faithless wife, who was so stricken with guilt that she took a whole bottle of sleeping pills and joined her husband in death. Just as soon as it became clear what the wife supposedly intended to do, the director cut the scene to minimize identification with the ambivalent object and to avoid the suicidal role-training itself.

Then the director returned to the present to explore the wife's actual reaction to the patient's suicidal attempt, but the patient had no direct knowledge of the impact of his behavior on her. The patient speculated that she was probably relieved he hadn't succeeded in killing himself but was also thankful the patient was conveniently out of the way. The director asked whether the patient had ever known anyone else like that. He said that his mother had done the very same thing to his father when the patient was only six years old. And, indeed, father had committed suicide under similar circumstances. Thus the father-figure was also an ambivalent object; for, after all, he deserted his son through death at his own hand!

Accordingly, through psychodramatic "surplus reality" we brought father temporarily back to life. The auxilliary taking the role berated the patient for trying to kill himself. The patient raged back at him, "Then why did you do it?" A double encouraged the patient to continue expressing his resentment, but the patient hesitated, guilt feelings flooding him now.

Therefore the director suggested splitting the father-figure, with the auxilliary already chosen as the father-who-deserted-him, but with another auxilliary as the father-who-loved-him. This allowed the patient to embrace the one part of the dead father and receive father's love and approbation without the complications of anger, hurt and loss the other part of father signified.

Then the two fathers joined arms and told the patient that the son must carry on and do what father cannot do, make a new life for himself. "The grandchildren need a father now, more than ever. Give to them as I would

give to you, had I the chance to do it all over again." Then following the "distancing technique" alluded to above, with the original father auxilliary turned one way and a new auxilliary, representing the patient, turned the other way. Thus the patient was finally able to let his father go.

It remained to deal with the female figures in later sessions, especially that mother-wife identity, which led to a kind of self-fulfilling prophecy provoking the wife's acting out. In any case the same sort of ambivalence needed to be rendered explicit and resolved, to clear the way for an open future.

Summary

This paper has been an attempt to arrive at some practical suggestions for the psychodramatist whose previous experience has been limited to normal, student and outpatient populations. I have taken the position that all such populations, including the psychotic, occupy a substantially overlapping continuum, whereby experience with one kind of group can be expected to have considerable carry-over to another kind of group. The importance of context and the pertinence of group processes have been stressed. The psychodramatic baby phenomenon was generalized to apply to both normal and psychotic life adjustments. A rationale for understanding the schizophrenic and depressed patients has been provided, along with specific recommendations and *caveats* for psychodramatic treatment. New techniques for maximizing or minimizing identification were described. Dangerous situations, such as child beating, homicide, and suicide received attention, each in their appropriate context.

References

1. Moreno, J. L., Psychodramatic Shock Therapy, in *Sociometry*, Vol. 2 (January 1939) No. 1, pp. 1-30.
2. Moreno, J. L., *Code of Ethics of Group Psychotherapy and Psychodrama*, Beacon House, 1962.
3. Moreno, J. L., Psychodramatic Treatment of Psychoses, in *Sociometry*, Vol. 3 (April 1940) No. 21, pp. 115-132.
4. Moreno, Z. T., Sociogenesis of Individuals and Groups, in Moreno, J. L., *The International Handbook of Group Psychotherapy*. New York: Philosophical Library, 1966, pp. 231-42.
5. Moreno, Z. T., *Ibid.*, p. 239.
6. Moreno, J. L., *The Sociometry Reader*, Glencoe, Ill.: Free Press, 1960.
7. Laing, R. D., *The Divided Self*. Penguin, 1958.
8. Boisen, A. T., *The Explorations of the Inner World*. New York: Willett, Clark and Co., 1937.
9. Moreno, J. L. and F. B. Moreno. Spontaneity Theory of Child Development, *Sociometry*, 1944, 7, pp. 89-128.
10. Erikson, Erik, *Childhood and Society*. New York: Norton, 1950
11. Moreno, J. L., A Case of Paranoia Treated Through Psychodrama, *Sociometry*, 1944, 7, pp. 312-327.
12. Moreno, J. L., Mental Catharsis and the Psychodrama, *Sociometry*, 1940, 3, 209ff.

* Prepared for the California State Psychological Association Convention, Los Angeles, California, January 28, 1972.

** As Zerka Moreno has said, "Therapy lies in helping the mother to bring the perception of the psychodramatic baby and that of the real baby closer together, first by permitting the psychodramatic baby to live in the retraining situation. Once it has been born and is outside her, finished like a real child, she can begin the separation from it; we can not let go of those precious things with which we have not yet finished. Therapy consists for all our patients, in whatever category, in learning to complete unfinished business and then settling down to the tasks at hand which require their attention, here and now. Once she has been able to deliver herself of the fantasy baby, she will be readier to become available as the mother to her live baby."[5]

Reprinted from—
Group Psychotherapy and Psychodrama
Vol XXV, No. 1-2, 1972
pp 57-68.