PSYCHODRAMA WITH ALCOHOLICS:

A SOCIAL WORK PERSPECTIVE

by

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A C K N O W L E D G E M E N T S

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If you . . . would again produce your dramas of the past here, on this stage, they would exert upon you, the original and permanent hero, and everyone in the audience a comical, liberating and purging effect. In playing yourself you see yourself in your own mirror on the stage, exposed as you are to the entire audience. It is this mirror of you which provokes the deepest laughter in others and in yourself, because you see your own world of past sufferings dissolved into imaginary events. To be is suddenly not painful and sharp, but comical and amusing. All your sorrows of the past, outbursts of anger, your desires, your joys, your ecstasies, your victories, your triumphs, have become <u>emptied</u> of sorrow, anger, desire, joy, ecstasy, victory, triumph, that is, emptied of all <u>raison d'être</u>.

J L MORENO,

"The Godhead as Comedian". Translated by Moreno from his German original, "Die Gottheit als Komoediant", Vienna, 1911.

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Description of Study

This thesis consists of a review of psychodrama literature, and an empirical application of the method in a psychotherapeutic context. The literature review describes the classical psychodrama method, its history, techniques, associated and derivative methods. The descriptive part of the study also reviews applications of psychodrama, sociodrama, and role playing relevant to social work training and practice, with special reference to the field of alcoholism treatment. The empirical study compares the use of psychodrama and role playing with inpatients receiving treatment in an alcoholism programme.

Rationale for Study

The overall study, and especially the review of psychodrama presented with a social work audience in mind, is based upon a conviction that the psychodrama method holds within it the potential for strengthening the armamentarium of skills and expanding the range and foci of social work practitioners.

It was felt that extending the theoretical account of psychodrama by conducting an empirical study would make a threefold contribution; firstly, to the field of psychodrama; secondly, to the field of alcoholism treatment; and thirdly, to social work practice.

(i) Psychodrama practitioners have reported positive results attributed to the use of the psychodrama method in alcoholism treatment. However, no formal, controlled experimental studies of such usages or claims were found in a search of the literature. (See Chapter V, pp. 213-226). This present study is therefore, to my knowledge, the first empirical assessment of the use of psychodrama in the field of alcoholism treatment. It is also one of the few empirical studies of outcome evaluation of psychodrama in any of the wider practice fields reviewed. Most of the literature reviewed reports on clinical impressions and case studies. (See, for example, Chapter IV, pp. 154-169).

(ii) Persons with alcohol problems are regarded as "hard-to-reach" and to motivate into productive therapy. The treatment process is made difficult because of considerations such as the complexity of aetiological factors, psycho-social manifestations and effects of the problem, the frequency of relapse from periods of abstinence, and the commonly encountered psychodynamic defense mechanisms of denial and rationalisation. A study of any method which could aid the diagnostic and treatment process of the alcoholic, and cut through the tangle of factors enmeshed in his or her problems should, I feel, be a contribution to the field.

(iii) Following on from this latter premise, since alcoholism is a problem which pervades many areas of social work practice, any empirical study of methods which attempt to alleviate this problem may also make a contribution to social work. So many social work clients themselves have drink-related problems, or are affected by the problem drinking of a spouse or family member.

Furthermore, regarding the contribution made by the study to social work, it does provide an illustration of the use of psychodrama by a social worker trained in the method. Although references to the uses in social work training and practice of role playing, role training, sensitivity training, dramatic activities, and non-verbal action methods were identified in the social work literature, no such examples of the uses of classical psychodrama were found.

The major reason for comparing psychodrama with a related action method, role playing, was that the hospital in which the empirical study was conducted already used role playing as part of its in-patient treatment programme

and the Consultant Psychiatrist wanted to see whether psychodrama would offer any advantages over and above those derived from the variant of role playing used.

In addition, not having been exposed to psychodrama before, there was confusion amongst the staff of the hospital as to the differences between psychodrama and the role playing already being used. Considerable attention is in fact paid in the descriptive portion of this thesis to clarifying the differences between psychodrama and role playing in view of the frequent misunderstandings I have encountered regarding the distinctions and similarities between the two modalities.

The psychological variables examined for changes during the study were subject self-esteem, aggression, anxiety, authoritarian-conformity, and extroversion. The occurrence of low self-esteem, high aggression or hostility (usually expressed in an indirect, dependent or passive fashion in the unintoxicated state), high anxiety, and dependence upon and conformity to authority was repeatedly found in the literature in descriptions of the personality make-up of the alcoholic. (See, for example, Chapter V, pp. 198-201.)

Although some controversy exists as to whether these traits predispose the alcoholic to drink, or whether they are a result of alcohol dependence, research indicates that these traits predominate, and may be changed with therapy.

The individual with a poor evaluation of self-worth will usually be unable to withstand the pressures of

interpersonal and environmental situations without experiencing anxiety. Low self-esteem coupled with anxiety is likely to produce an individual who uses alcohol to diminish anxiety and to bolster self-esteem. In addition such persons, and especially those with a conforming, passive-aggressive mode of behaving, are also likely to use alcohol to express feelings of anger or social assertiveness. The deterioration in social and family relationships which usually follows alcohol abuse further lowers self-esteem and raises anxiety, and often a vicious circle hard to break sets in.

The individual with low self-esteem is also likely to be more dependent upon the evaluation and acceptance of others for his or her behaviour than is the person with a high self-esteem. A pattern of conforming to authority yet with accompanying hostility and feelings of frustration is often noted. Along with anger, self-punitiveness, impulsivity and a poor tolerance for frustration, researchers note an interior rigidity and lack of spontaneity and creativity in interpersonal relationships, withdrawal and an absence of a sense of social connectedness which is often compensated for by recourse to alcohol to produce an artificial sense of extroversion or of social expansiveness.

There is speculation as to the inter-relatedness of the five factors examined in this study and the accountability of the other four to a lack of self-esteem as a central feature. However, the psychological literature regards these all as separable and identifiable traits which may be measured and assessed.

The General Survey was chosen to test aggression, anxiety, authoritarian-conformity, and extroversion since it has scales designed to tap all four of these personality dimensions in one test. It is also a shorter test than other personality tests which tap similar dimensions such as the MMPI, which takes about one hour to complete. The General Survey takes approximately 15 minutes to administer. Two tests of self-esteem were used, the one a non-verbal measure (Ziller SSE), and the other a measure based on verbal self-reports (Jackson SE).

Personal Note

My own personal interest in psychodrama grew out of my experience in using dramatic activities with orthopaedically disabled children. As a caseworker, I appreciated the exchanges which took place between the "drama group" and individual casework sessions, and saw how the children's ease of emotional expression, articulation of needs, self-confidence, improved body image and awareness of body parts and distortions, and their personal creativity were strengthened by their participation in creative drama.

I sought further training, studying creative drama and movement in Johannesburg, and then at the Remedial Drama Centre, London. At the Sixth International Congress on Psychodrama and Group Psychotherapy in Amsterdam, Holland (1971), I saw psychodrama in action for the first time, and realised that this was the modality which brought together what I most valued in therapeutic social work and

in drama. I went on to begin my training as a psychodramatist at the Moreno Institute, Beacon, New York, in 1974, and completed the course requirements towards certification as a psychodrama director in 1977.

I myself conducted the psychodrama sessions used in the empirical study, whilst the occupational therapist employed in the hospital conducted the role playing sessions.

Contents of Chapters

Chapter I of this thesis gives a description of classical psychodrama and the basic psychodramatic concepts and methods as developed by Dr J L Moreno.

In Chapter II the various derivative forms of psychodrama are described, such as sociodrama, role playing, and role training. Role playing and psychodrama are contrasted, and descriptions of psychodrama techniques including role reversal, soliloquy, the double, and auxiliary chair are given.

Chapter III presents details of the history of psychodrama, beginning with Moreno's early experience in Vienna, moving to the later influence of psychodrama on experiential laboratory training methods and on the modern "human potential" movement in psychology. The training requirements for psychodrama are summarised.

A review of psychodrama applications which have relevance for social work practice and training appears in Chapter

IV. In addition, the more frequently occurring criticisms of the method are presented, and some contra-indications and possible sources of abuse are noted.

In Chapter V psychodrama applications in the field of alcoholism treatment are outlined, with special reference to the causes and effects of alcoholism.

Chapter VI consists of a comparison between role playing and psychodrama, and pays special attention to possible sources of misunderstanding between the two.

Chapters VII, VIII and IX are concerned with the actual experimental study conducted at the William Slater Hospital, in which the relative effects of role playing and psychodrama are compared.

The hospital and its therapeutic programme are described in Chapter VII. The hypotheses of the research study are also stated, and the various aspects of the methodology used are noted. These latter include the sampling and experimental design, and the psychological tests and interview schedules used.

Chapter VIII provides a quantitative analysis of the results of the study. These include background variables, and measures of improvement after treatment such as psychological test scores, abstinence at follow-up, and participation rate in the total hospital programme.

In Chapter IX the responses of patients and staff concerning their evaluation of role playing, psychodrama, and other aspects of the hospital programme are presented.

Chapter X is a summary of the entire thesis, including the field study done at the William Slater Hospital. The final section in this chapter consists of a re-statement of the major hypotheses tested in the study together with an indication of the extent to which these are confirmed. In closing, directions for further study are suggested.

There are thirteen Appendices giving examples of personality tests, interview schedules, and role playing sessions. A complete transcript of one psychodrama session is included, as are illustrative examples of patient and staff comments on role playing and psychodrama.

Finally, the Bibliography contains the works cited in the thesis.

P A R T O N E

PSYCHODRAMA: THEORY AND METHOD

A meeting of two: eye to eye, face to face. And when you are near I will tear your eyes out and place them instead of mine, and you will tear my eyes out and will place them instead of yours, then I will look at you with your eyes and you will look at me with mine.

J L MORENO,

"Invitation to an Encounter". Translated by Moreno from his German original, "Einladung zu einer Begegnung", Vienna, 1914.

CHAPTER I

THE PSYCHODRAMA METHOD

A. PSYCHODRAMA

Psychodrama is a systematised method of role playing which enables an individual to explore the psycho-social dimensions of his or her conflicts, problems, interpersonal relationships, and life situations through enactment rather than solely verbal means.

The enactments could deal with current concerns, the anticipated future, or the unresolved past. The subject-matter of psychodrama is the existential reality of the individual's total personal experience. This includes not only objective fact or external reality, but also the subjective aspects of internal experiences such as fantasy, feeling, symbol, and desire.

The originator of the method, Jacob Levy Moreno (b. 19.5.1892, d. 14.5.1974), defined psychodrama as that which " . . . explores the 'truth' by dramatic methods."[1] He derived the term "psychodrama" from a transliteration of the Greek for "a thing done to and with the psyche", or "the psyche in action". "Drama" is derived from the Greek word meaning "action" or "a thing done".[2] With its emphasis on this exploration of reality, psychodramatic group therapy has been referred to as the theatre of truth or the

theatre of reality.

Classical psychodrama as developed by Dr Moreno is a form of group therapy and as such shares the goals of other psychotherapeutic modalities.[3] Amongst these might be listed:-

- the diminution of stress, anxiety, and tension
- the minimisation of distorted perceptions
- the manifestation of unconscious motivation
- the strengthening of self-esteem
- increasing socialisation and social adaptability
- the enhancement of empathic awareness and sensitivity to others
- enhancing self-understanding, and the acquisition of new insights about the self
- the breaking of cyclical, repetitive, maladaptive responses to situations
- learning the use of adaptive patterns of behaviour
- facilitating positive interpersonal relationships and personality change, growth, and development
- the release of optimal personal creativity and spontaneity in the service of the above

Psychodrama specifically emphasises the constructive catharsis or release of emotion and the evocation of spontaneous, creative reactions to changing life situations. Because of its experiential nature, much of its power lies in the simultaneous involvement of the three major human modes, viz., thinking (cognition), action (behaviour), and affect (emotion). It provides direct immediate and objective feedback to participants and is a flexible and adaptable tool.

NB 3 human modes.

Psychodrama may be used as an independent treatment modality on its own; as an adjunctive approach in a total integrated programme; or within the context of ongoing

verbal, individual, conjoint, family, or group therapy. Psychodramatic derivatives and major related forms may also be employed within these therapeutic contexts, or adapted for use within educational and community settings.[4]

B. BASIC ELEMENTS OF PSYCHODRAMA

Five basic elements may be distinguished in the classical system of Moreno psychodrama.[5] These are:

1 The "Protagonist" or person portraying his life situation

2 The "Director" or leader of the psychodrama session

3 The "Auxiliary Egos" or persons portraying the roles of absent others in the protagonist's drama

4 The "Audience" or group members who are present during the psychodrama

5 The "Stage" or "Action Area" of the psychodrama (i.e. the locus of the action portion of the session)

1 Protagonist

The term used to refer to the subject of a psychodrama is borrowed from the title of the chief actor in ancient Greek theatre.[6]

The protagonist usually emerges from the group as a result of the "warming-up" process or initial period of a psychodrama. He or she might be the person who is strongly "warmed-up" or most ready and motivated to work on or explore a specific problem or concern. He or she might be the person who experiences the theme of the group dynamics most intensely or who relates to it most strongly; or whose theme of concern is identified with by the other group

members, who in turn choose him or her to be the protagonist. Hollander refers to this type of protagonist as the "theme-carrier" for the session.[7] On the other hand, a protagonist could have been preselected by the group or director, referred by a therapist or outside agency, or have volunteered to work in the session.

Once the group has agreed upon the choice of protagonist, he moves with the director onto the stage and into the action phase of the psychodrama session.

2 Director

The director is the person who conducts the psychodrama. He or she might be a trained and qualified psychodramatist, or a social worker, psychotherapist, or professional person with some knowledge of and skill in the psychodrama method.[8]

Moreno describes three directorial functions: that of producer; of therapist; and of analyst.[9]

As producer, the psychodrama director co-ordinates and provides continuity, suggests scenes and introduces action techniques, and is responsible for a production which will meet the personal and collective needs of players and group alike. The group is always considered even although the focus is upon one individual during the enactment.

> . . . [the producer] has to be on the alert to turn every clue which the subject offers into dramatic action, to make the line of production one with the life line of the subject, and never let the production lose rapport with the audience.[10]

As therapist, the psychodramatist intervenes actively when necessary: remains passive when she judges that the session should be directed by the subject for maximum involvement and release of spontaneity. She might use an interviewing mode, confrontation, or humorous verbalisation if appropriate. In the role of therapist, the final responsibility for the therapeutic value of the total session is vested in the psychodramatist. It is assumed that she conducts herself according to the ethics and values of the therapeutic task.

As analyst, the director might function in the role of social investigator; testing out hypotheses, using the auxiliary egos or supporting players to elicit information, or converting interpretive insights into an "actable idea". At times, in the role of analyst, it might be appropriate for her to summarise her insights and hypotheses during the concluding phase of the session.

The group leader or director should be sensitive to the non-verbal as well as verbal clues to dynamics and problems given by the protagonist, and use these in the selection of helpful techniques and interventions. She is responsible for setting limits and for guiding the psychodrama process from heightened emotional expression and "peak experience" towards adequate integration and closure. She should be aware of and account for intra-group dynamics throughout the session; and should use group handling skills, especially in the beginning and final portions of the psychodrama, to promote a warm, accepting, permissive and non-threatening climate for group cohesion and

individual risk-taking and exploration.

The director guides the psychodrama process in enabling the protagonist to explore his inner world and social reality and by enactment or re-enactment of situations to gain insight, release of feeling, or mastery over areas of conflict or tension. Although she might be an "expert" in terms of her specialised knowledge of human behaviour and training in skills and techniques, Moreno maintains, referring to the protagonist, that "no one is as much of an authority on himself as himself."[11] The protagonist knows himself, his pain, his history and his present far better than does any other. The director constantly checks this out with him. The protagonist also knows where he must go and how far he needs to, or is able to go in the process of self-exploration and therapy. It is in this self-regulating mechanism that one of the controls of the method lies. However great the protagonist's resistance as he nears the core of his problem or conflict, the director cannot force the protagonist to "do" anything. She can only suggest or advise that a certain technique be used. In essence, the director follows where the protagonist leads; starts from where the protagonist is; and moves only into areas that the protagonist is ready to explore.

3 Auxiliary Egos

"Auxiliary Egos" or "auxiliaries" play the roles of persons who are relevant for the protagonist's drama. For example, an auxiliary might play the part of an absent

wife, a son, employer, or friend;[12] two or more auxiliaries might play the parts of significant others in the protagonist's social atom;[13] or the auxiliary might play the part of a fantasied other, such as an idealised father the protagonist did not know, the "Prince Charming" who will rescue the protagonist, God, or the Devil. In certain enactments, it might be useful for an auxiliary to play the part of an inanimate object, as for example a house, or a motorcar. Auxiliaries might also represent an abstract personification of a collective stereotype, concept, or symbol such as "society", "authority", "conscience", "justice". It is often helpful for auxiliary egos or supporting players to represent different parts of the protagonist's psyche or self-concept. An auxiliary ego might be chosen to project a part of the subject's own ego.[14] In this technique he functions as a double or alter ego in order to help the subject express and explore his inner feelings with greater clarity and ease.[15]

Moreno indicates that the auxiliary egos, or "therapeutic actors" have a twin significance in a psychodrama. They function not only as extensions of the patient, portraying "actual or imagined personae of their life drama", but also as extensions of the director, being "exploratory and therapeutic".[16]

Auxiliaries might be specially trained personnel or untrained members of the psychodrama group. The professional auxiliary is trained to assume roles quickly and easily, to grasp the production line of the director's intent, and to be sensitive to the dynamics of personality,

role relationships, and interactions. The trained, experienced auxiliary is very useful in maximising the therapeutic potential and effectiveness of classical psychodrama. Institutes or centres in America which have independent psychodrama programmes use trained auxiliaries. Hospitals or institutions with ongoing programmes of psychodrama or psychodrama units will either have trained auxiliaries or use staff members such as nurses, psychologists, social workers, or occupational therapists as therapeutic assistants. Many such institutions have in-service training programmes for developing staff knowledge and experience of psychodrama techniques.

The choice of untrained members of the group to play auxiliary roles is not only helpful for the protagonist but also for the auxiliaries. The opportunity to play auxiliary roles provides group members with a vehicle within which they can offer support to a peer, and also promotes the process of altruism, seen by Yalom[17] as one of the primary curative factors in group therapy. Empathic awareness is often sharpened by playing an auxiliary role in somebody else's psychodrama.

Indirect therapeutic gains may be obtained by and for the auxiliaries. The director might choose an auxiliary from the group to play a role designed to help with his problem at the same time as it furthers the protagonist's exploration. For example, roles requiring behaviours opposite to the auxiliary's usual style might help to facilitate his spontaneity and freedom of expression. Should it be considered therapeutically advisable for a

auxiliary, or staff member in certain settings, is likely to be assigned an auxiliary role by the director.

When choosing auxiliaries from the group, the degree of identification with the protagonist's situation, or that of the other roles in the enactment, should be considered. Discussing the issue, Blatner, in his handbook on methodology, points out that the nature and amount of identification experienced if the auxiliary has a conflict in his own life similar to that of the protagonist can either increase or decrease the value of an enactment for the protagonist.[18] The possible effect upon the auxiliary of entry into a scene should also be considered. In certain circumstances an amount of identification with similarities may be beneficial for both parties. In others, the identification might become projective and intrusive if the auxiliary plays out his own themes and concerns in the drama. This might disconcert and confuse the protagonist. Blatner cautions: "Unless the director is alert to the auxiliary ego's behavior and applies firm control, the auxiliary can impose artificial issues upon the protagonist's drama."[19]

It is interesting to note that the auxiliary ego does not need to be like the absent other when in the role, nor need he be fully spontaneous and productive in the role in order to evoke powerful and real images and feelings in the protagonist. Macdonald, for example, writes an account of her subjective experience in a psychodrama:

> . . . it is not the auxiliary ego per se who is important in warming the subject up to the absentee person. Another point which stands out

relation to itself.[21]

In addition to supportive participation during the action, the audience members share their feelings, identifications and associations with the protagonist in the final post-action phase of the psychodrama. As they recount similar experiences and conflicts, the protagonist realises he is not alone, different, or alienated -- that he shares a common humanity and experience. Further support might be given as the group members reveal how they have dealt with similar concerns. The protagonist might learn about different, possibly more effective approaches to his own problems. The group context of psychodrama enables this supportive process of universalisation to take place, and furthers the climate of acceptance, mutuality, and cohesiveness so vital for therapeutic growth.[22]

This recognition of the self in the other, and the other in the self, is true for the audience members as well. They benefit from watching the enactment and from the accompanying identification, evocation of emotion, or new insights obtained. Implicit in the audience-centred function are the gains reaped by the group members. Moreno writes: "In a psychodramatic session, the audience is always the patient, or at least, a learner."[23] The process benefits of the group context or presence of an audience flow from audience to protagonist, protagonist to audience, and between audience members.

In relation to the subject, the audience represents

the world at large; the community from which he comes and to which he will return. He is sensitive to what the audience members think of him, and especially members of the so-called socially deviant sub-cultures might cast the audience into the role of "public opinion". Approval and confirmation of their dignity and worth as persons rather than stereotypes might be vital for the self-esteem of persons who feel different, or deviant, or who have lost social status. The presence of the audience might highlight their initial sense of isolation, for, as Moreno writes: "[The protagonist] has always lived in the world more or less anonymously but he has never lived 'in front' of it."[24]

Despite the potential power for support and acceptance in a group, there are rare instances when a protagonist is so isolated or socially deviant that the presence of an audience is not considered advisable. In other instances, the presence of an audience might be inhibiting or counter-productive for a particular individual. At times, a protagonist or co-protagonists might be working on themes which they experience with strong feelings of guilt and shame. In such situations, the director might initially work alone with the protagonist, or subjects; then move on to add a few auxiliaries; and, possibly, eventually allow them to enter the group when ready to do so.

5 Stage or Action Area

The stage is the fifth component of the psychodramatic

method. It need not be a raised platform, but could be any area delineated for the action portion of the psychodrama. This might be in the centre of a group, or an area in the corner or at the side of a room. The action might take place in situ, i.e. within the actual locus of a conflict or problem situation. In situ psychodramas might take place in a family home, a ward or committee room; in a classroom or factory; or out on the street, in a recreational area, or within a community setting.

Moreno conceived of a circular stage with three levels, each one representing a different degree of commitment and involvement in the exploration of the protagonist's problems. In his psychodrama institutes, as well as other centres and hospitals in America, a three-tiered circular stage, together with a fourth level or balcony, comprise part of the formal structure of the therapeutic theatre. (See Figure 1)

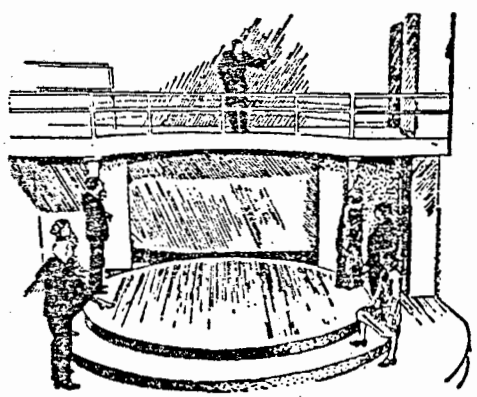

Fig. 1. Stage at the Moreno Institute Therapeutic Theatre. SOURCE: Adapted from cover page of Journal of Group Psychotherapy and Psychodrama, XV, No 2, 1962.

The group might commence seated on the stage. When a protagonist is selected, the group members move over into the audience area. On the other hand, the group warm-up might take place in the audience area. The protagonist, once chosen, would then move over into the action area or stage.

In essence, the stage represents "an extension of the life space of the protagonist."[25] Here he explores his relationships, his problems, his world. The clear demarcation of action/audience helps his movement from the role of audience member to protagonist. It also aids the process of "de-roling" and his return to the group. When an audience member becomes an auxiliary, he steps into the phenomenological world of the protagonist. The proscenium arch of conventional theatre serves much the same purpose. The "as-if" reality of the drama takes place on a raised platform separated from the audience.

On the first level of the Morenean psychodrama stage, the protagonist is interviewed by the director and presents his perception of his problem and his idea of where he would like to start his exploration. As he "warms-up" to the reality of his problem-situation, he moves up further. Finally, when fully involved and "into" his world, having usually quite forgotten the presence of the audience, he is moving on the third level of the stage. The second level is often used by the director to "warm" the subject up and help him to alleviate anxiety and establish a bond of trust and feeling of confidence. The director might walk round the stage on the second level

with the protagonist, or near him while he soliloquises aloud about his problem or his feelings. The soliloquy might accompany the subject's entry into a scene, or it might serve the purpose of exploring more of the ramifications of his problem and providing more dynamic information for the director. As soon as the director has selected what might be termed an actable idea for a starting scene, the subject or protagonist moves onto the central level for the enactment.

Where a formal stage is not being used, a similar progression of participation and involvement is indicated by horizontal rather than vertical movement. The interview and initial warm-up might take place on the perimeter of the action locale. As the protagonist moves closer into the irreality of his experience, he moves closer into the centre.[26]

Although not always possible during in situ psychodramas, a clearly differentiated action/audience area is also advisable when no stage is available. This helps both the protagonist and the audience. The subject is not too close to the audience and unlikely to be inhibited by interference with his warming-up, and the audience is not too close to feel embarrassed or obtrusive.

Auxiliaries are not likely to become confused with audience members, especially if enough space is allowed for the protagonist's free movement on the stage and to accommodate those auxiliaries who are required in the action.

Simple "props" and furniture may be used on the stage

or action area. Lighting may also be imaginatively and appropriately used. In the Morenean therapeutic theatre a variety of colour combinations are used to reflect or evoke certain moods, to represent different types of scenes, to add realism, and to aid the involvement of the protagonist.

The balcony or fourth level of the Morenean stage is used for a variety of purposes. It is often helpful for a protagonist to view a scene from above. This helps him to achieve a sense of distance or perspective both in concrete terms as well as emotionally. A substitute auxiliary may stand-in for him if necessary. The balcony might be used to indicate or induce a feeling of power or authority. Auxiliaries representing God, or ancestral, or deceased persons, are often most effectively placed on the balcony. Objects or auxiliary egos representing abstract qualities are also effectively positioned on the balcony. Where no balcony is available, similar effects may be obtained by using a chair or table for height and distance.

C. PROCESS PHASES OF A TYPICAL PSYCHODRAMA

In this section the typical progression of a classical psychodrama session will be reviewed. Wherever appropriate, theoretical principles underlying methodology will be given. Three major phases may be distinguished.

1 The Warm-up Phase in which the group prepares for action (members "warm-up" to each other, the director, and the "task" of the session, and a protagonist emerges or is chosen)

2 The Enactment or Action Phase in which the

protagonist explores a problem situation and reaches a catharsis of tension or an action insight and point of new learning

3 The Post-enactment or Sharing Phase which marks the return of the protagonist to the group and the opportunity for group members to obtain relief or "spectator catharsis" and to give to the protagonist and peers in the discussion and sharing of feelings, ideas and experiences

1 The Warm-up Phase

The initial phase in the life cycle of an ongoing group, or the beginning portion of individual sessions is essentially the "warm-up" to the growth and development and eventual closure and termination of the group. Group members have a strong sense of their own separateness as individuals. They size one another up and wonder whether they will be accepted or rejected. They wonder what they will gain from the anticipated experience and how much they will have to "give up".[27] There is often a feeling of ambivalence since "most people come to a new experience both wanting it and fearing it."[28] The task or purpose of the group is defined in this phase and there is usually a sorting out of roles in terms of the emergent task and the expectations which members have carried with them into the group. All these latent or manifest dynamics need to be dealt with before the group can move into its more cohesive goal-oriented phase of "work".

In psychodrama, not only is the initial warm-up recognised as a phase in group development, but it is also acknowledged as the beginning of each session. "The importance of the warm-up in developing the goals and interests of a group and in maintaining a high degree of involvement

cannot be over-estimated."[29]

Specific "warm-up techniques" are available to serve the needs of the group. The director may employ a variety of methods to deal with initial group concerns, to allay anxiety, and to stimulate inter-group interaction and individual spontaneity. Some of these starters comprise sociometric tests, interaction or awareness games or non-verbal exercises, role playing or sociodrama. The warm-up might simply take a verbal interaction discussion form. In this case, it could be directed or focused by the director onto a specific theme or topic, or it might be totally non-directed as when the group gathers and after free associative discussion a common theme emerges and a theme-carrier is identified and volunteers to become the protagonist. The majority of the group members should experience some measure of emotional investment in the theme to be explored in the drama. The theme-carrier, or protagonist, who emerges from the warm-up is the member in whom the major themes or dynamics of the discussion crystallise, or who experiences the thematic subject very strongly. He or she might feel the fear, anxiety, anger, or even joy being expressed by the group most intensely; or might be strongly "warmed-up" to the nature of the problem-situation being discussed. When a "starter" or some form of guided interaction exercise is used, the protagonist or "theme-carrier" might emerge as the individual who experiences the strongest emotional reaction to the exercise or who identifies a personal "warm-up" to a problem or theme evoked by the exercise.

Not only the group's members, but also the director is warming up to the group and its task during the initial phase of the session. She might have to control her own personal reactions to events which took place outside of the session and put herself and her needs "in brackets", as it were, in considering the needs and personal material of the group members. She should become aware of any factors which might affect group process and any of her own possible resistances to the group, or session. She might need to clarify basic structural and contractual dimensions of the group, such as goals, purposes, method, duration and division of responsibilities. This is the preparatory phase of her own warm-up -- and the important task of encouraging group cohesion and of fostering an atmosphere within which mutual trust and acceptance may grow. In view of the initial concerns of individual members in the beginning stages of a group, at least one entire session and more might be devoted to the overall warm-up of an ongoing group. It is important to recognise that the first stage in the development of a group, although similar to it, is not equivalent to the first phase of a psychodrama session. In an ongoing group, the first stage might encompass four or five sessions, each of which has had its own individual warm-up phase to the enactment of that particular session.

The entire concept of warm-up figures centrally in Moreno's theoretical system as well as in his practical therapeutic system. It is linked to his concept of spontaneity, or the "s"-factor, and his idea of the

optimally functioning creative individual. Every human activity may be regarded within the perspective of the warming-up process. In Moreno's terms, the warm-up represents the operational "manifestations of spontaneity".[30]

> The warming up process manifests itself in every expression of the living organism as it strives towards an act. /Moreno's italics/ It has a somatic expression, a psychological expression, and a social expression.[31]

Moreno maintains that the warming-up process to states of spontaneity may be stimulated by bodily starters ("a complex process in which muscular contractions play a leading role"); by mental starters ("feelings and images in the subject which are often suggested by another person"); and by psycho-chemical starters ("artificial stimulation through alcohol, coffee ...").[32]

A continuum of phases along the warm-up process to the completion of activities may be distinguished; incorporating the warming-up, the climax or act itself, and the integration or closure. One might apply this continuum to activities such as lovemaking, role-taking, role-learning and role-fulfilment, artistic activities, athletics and sporting activities. The birth process, too, begins with a warm-up of conception and a nine-month preparatory period before the neonate is born.[33] Ballet dancers warm-up at the barre to prepare their bodies physically and to develop correct emotional "sets" before they perform. Sporting activities are prefaced by the appropriate warm-up or preparatory starters.

Hollander borrowed and transformed the concept of the normal curve from human statistics in order to denote the

pyramidal "bilateral symmetry that exists among all population activities so long as the triadic and temporal processes of 'warming up', 'activity', and 'integration' are fulfilled."[34] In addition to the horizontal continuum, a vertical dimension is employed in his "Psychodrama Curve" which denotes the emotional qualities which exist in the progress from warm-up to integration or closure. This triadic conception of the process may be depicted as in Figure 2.[35]

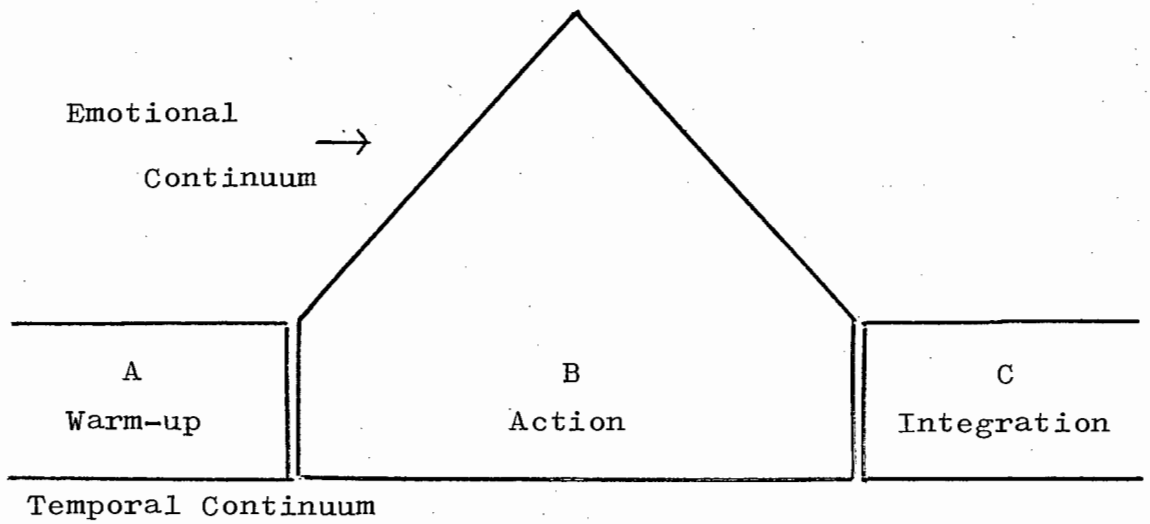

Fig. 2. Hollander's Triad of Vertical and Horizontal Dimensions. SOURCE: Carl Hollander, A Process for Psychodrama Training: The Hollander Psychodrama Curve, (Littleton, Colorado: Evergreen Institute Press, 1969), p. 3.

Hollander divides the actual warm-up phase of a psychodrama session into three micro-parts. These he calls "Encounter", "Phase", and "Sociometric Process".

> (a) The "me-me" encounter with self occurs when individual group members become aware of their state of physiological and psychological readiness for action and their internal warm-up to feeling states. They might consciously ask themselves such questions as "What's going on with me?" or "What am I warmed-up to?"
>
> The "me-you", and "you-me" encounter with others is that process involved with the inter-group relationships. ("Where am I with you?" and " . . .

you with me?"). This other-encounter has a sociometric rather than an intra-psychic base.

Should the director experience spontaneity as existing within the group at the "me-me" and "me-you" levels, the sociometry of the group can be explored in order to produce a protagonist. However, should there be anxiety or resistance impeding or blocking the flow of spontaneity, the director might introduce a "starter" or physical action technique to externalise anxieties.

(b) The implementation of a physical starting technique or guided intervention by the director marks the beginning of the second subdivision or micro warm-up phase. A simple intervention technique such as re-arranging seating patterns might promote the beginning of group interaction. The termination of the phase is marked by the point at which group members begin to interact and co-act.

(c) This point in turn heralds the beginning of the sociometric process during which "the group's wishes are made known, the theme to which they need to relate is disclosed, and the sociometric star (or protagonist) emerges."[36]

2 The Action Phase

Once the protagonist emerges and is brought onto the stage or action area, the psychodrama enactment or action phase begins.[37]

As soon as she has a suitable clue to redefining the protagonist's presenting problem into enactment, the director guides the protagonist into the first scene. A trichotomy of time-place-reality is adhered to in the setting of the scene. This helps the belief of the protagonist and intensifies his warm-up and involvement. The protagonist's description and enactment of the first scene is often significant diagnostically and suggests the production line for the entire drama. The first scene also helps the audience and potential auxiliaries to warm up to

and enter the Weltanshauung and reality of the protagonist's experience.

The protagonist is encouraged to describe the initial and subsequent scenes in the present tense, and to behave as though they were occurring in the present (hic et nunc). Attention to details such as the positioning, colours, textures of physical objects, smells, and atmosphere further enhances the realism of the scene for the protagonist. Maximum physical activity and participation on his part in arranging furniture and "props" and moving about the stage also adds to his involvement and triggers his emotional memory of past episodes.

Once the first scene has been "anchored" in time, place, and reality, the director invites the protagonist to select auxiliary egos from the group to play the roles of necessary others. (In certain instances the director may choose the auxiliaries.) A variety of techniques may be used to assist in the warm-up of auxiliaries to their roles. The most frequent is for the protagonist to role reverse with the auxiliary and to present himself in interaction or be interviewed in the role of the other. In this way the auxiliary (director and audience too) learn about basic identifying, physical, and personality data relevant to the role of the other. In addition, the protagonist's perceptions of the other are revealed and valuable directorial information is gained relating to affective distortions, resistances, and blocks, as well as to positive areas of feeling.

The initial scene is enacted usually with the support

of appropriate auxiliaries. The first scene begins at the level of the protagonist's reality. As the director develops her existential diagnosis of the protagonist's problem from the information obtained during the interview-exploration and initial scene, she sets up subsequent scenes and invokes a variety of techniques to help the protagonist explore and express the emotional dimensions of his problem. The director may often condense a series of problem situations in order to distil only the emotional essence of the protagonist's experience into a single climactic scene.

> As the protagonist moves from the periphery to the center of his quest for integration, exactness of detail becomes less significant than the emotional qualities related to his experiences. Encouraging only the crisp essence of an experience, the director catalyzes the action and interaction toward an apex.[38]

Once the climax or affective peak of the psychodrama has been reached, the action is not abruptly stopped; but contained and worked through in an integrative manner. A "cooling-down" process needs to take place before the protagonist returns to the group. (The possible ways in which this cooling-down, working through, and integrative process may take place are described in subsequent pages below.)

Broadly speaking, the therapeutic goals of each session, may be subsumed under two main aims. These are:

(a) Guiding the process to the point at which the protagonist experiences actorial or action catharsis

(b) Helping the protagonist to achieve action learning or action insight

In psychodrama, the catharsis aimed for is not merely

a catharsis of abreaction, but what Moreno describes as a catharsis of integration in which the protagonist's "own self has an opportunity to find and reorganize itself, to put the elements together which may have been left apart by insidious forces, to integrate them and to attain a sense of power and relief."[39]

He points out that practitioners or therapists who use psychodramatic methods superficially are mistakenly identifying the phenomenon of abreactivity with therapeutic productivity.[40] Abreactions per se, he feels, are often harmful, reinforcing rather than dissolving certain symptoms. However, abreactions can be turned into reliable therapeutic contributions.[41]

ACTING-OUT
defense against criticism

Psychodrama does not encourage the simple acting out of impulses and feelings. It aims at a form of controlled acting out within the structure of its group content and with the aid of its methodological elements and techniques. Acting-out refers to "the psychological defense mechanism by which the individual discharges his internal impulses through symbolic or actual enactment."[42] In the psychoanalytic sense, acting-out would be occurring when a patient discharges his internal feelings of tension by lighting up and smoking a cigarette. Another patient dealing with conflictual material regarding the oedipal situation might flee from facing his internal dynamics and the feelings evoked within the analytic relationship by trying to resolve his anxiety through a newly instigated sexual relationship. In the analytic framework, acting-out in this sense is discouraged because it represents

"resistance to the recovery of unconscious memories in the transference relationship."[43] Acting-out is viewed as an "unconscious repetition of the past in the present" instead of remembering repressed events.[44]

The reason for acting-out is largely unconscious -- with little or no conscious understanding, awareness, or control of the impulses and circumstances surrounding the impulses, towards action. Blatner feels that the structured psychodramatic environment helps to make the protagonist's impulses, associated fantasies, memories, and projections consciously explicit, bringing them into conscious awareness, and serving the expression of feelings whilst at the same time developing self-awareness. The significant therapeutic function is to channel the individual's "drive toward action", in order that he might make constructive use of his feelings. Blatner prefers to call the process of controlled acting-out within the structured experience of a psychodrama enactment, acting-in. Acting-in turns impulses into insights.[45] Thus, psychodrama facilitates acting-in rather than acting-out, a process related to the integrative rather than abreactive catharsis.

The psychodrama director is trained to facilitate integrative acting-in, and to recognise different kinds of catharses. She should be able to tell when full catharsis is advisable and when to institute controls; when it is best to leave an incomplete catharsis alone, and when to work through a resistance. The trained director would recognise the need underlying certain abreactive catharses. For example it would be inadvisable for a protagonist

simply to ventilate hostility without first experiencing his dependancy or a need which might have been frustrated by a significant other.[46]

In psychodrama, as in psychoanalysis, or any psychodynamically based system of psychotherapy which recognises the influence of the past upon unresolved conflicts of the present, and the influence of the unconscious upon conscious action, the concept of resistance on the part of the protagonist is acknowledged. In the psychoanalytic sense, resistance is defined as "the trend of forces within the patient which oppose the process of ameliorative change."[47] Resistance is regarded as a defence operating against therapy.[48] Blatner feels that, as in other therapies, dealing with a protagonist's resistances forms the "core" of psychodrama. Nowhere else is the "art" of the director tested more than in this task.[49]

The protagonist's resistance usually increases as the drama approaches his central conflict. The resistance towards act-completion precedes the catharsis or affective climax. There may be a fear of risking the unknown, of discarding familiar but dysfunctional patterns of behaviour, even although these may be destructive and inhibiting to personal growth and happiness. "It is not easy to lose one's self in the moment in order to find a sense of direction."[50]

Blatner sees a focus upon non-verbal communication and imagery as two primary psychodramatic tools for helping the protagonist experience and identify internal processes and

thereafter explore their subjective meaning and purposes for him. Thus, for example, by "concretising" and enacting symbolically certain images and fantasies one might provide a vivid and externalised objective feedback to the protagonist.[51]

A method for dealing with resistances which has been widely adopted by some of the "new group therapies", such as "Gestalt Therapy" and "Encounter", is to treat various body parts in an anthropomorphic, personalised manner by concretising or maximising their activity. Areas of tension in the body, tightness of the voice, gripping of the hands, may be enacted as mini-encounters between different parts of the self.

The role of non-verbal behaviour in communication and the expression of feelings and unconscious motivation are both seen as significant in psychodrama. Moreno refers to subverbal language: "According to psychodramatic theory a considerable part of the psyche is not language-ridden; it is not infiltrated by the ordinary significant language symbols and it assumes that these silent parts of the psyche play a great role in the development of the psychoses", as well as in normal human interaction.[52]

Moving with, externalising, and explicitly portraying the protagonist's resistances help him to see how he chooses to use certain defenses and increase his awareness of his own responsibility for his behaviour.[53] Some of the most common personality "defense mechanisms" individuals use in "warding-off" anxiety and impulses are referred to as isolation of affect (the protagonist separates the

affect of emotion from an idea, or does not experience, or demonstrate emotion appropriate to a situation; intellectualisation; rationalisation (giving reasons and explanations for behaviour, rationally plausible, but not in effect connected to the unconscious feeling); projection (attributing own feelings to another); denial (lack of awareness or perception of feeling and/or reality); reaction formation (use of behaviour or expression of attitude incongruent with or opposite to the true feelings); somatisation (converting emotion into physical bodily expression); and identification with the aggressor (introjection or "interioration" of a feared person).[54]

Although insight of itself does not necessarily lead to behavioural change, conscious awareness of defense mechanisms and the direct, immediate feedback for the subject of distorted perceptions, help him to see situations in a new light and to cut loose from maladaptive repetitive responses. The new insights lead to an internal creative shift which may point the individual in an entirely new and adaptive behavioural direction. Action insights derived from participatory experience in psychodrama enactments are often multi-leveled in their influence on behaviour. Action learning, or learning through experience within the psychodrama setting has additional dimensions of therapeutic effectiveness not present in verbal modalities.

Very often in the natural evolution of a psychodrama session, the peak catharsis will deal with past situations and unresolved conflicts. Moreno recognised the therapeutic

significance for the protagonist of re-enacting previously experienced traumatic situations. A return to the past in clearing up "old business", or "cleaning out" residual feelings from incompleted relationships which perseverate internally and hinder current adaptive responses to new situations, often comprises the climactic portion of a psychodrama.

In the re-enactment, the protagonist is no longer the passive recipient of events, but the controller. Through re-enactment he gains active mastery of and freedom from the past. Psychic energy is freed from its expenditure on fixations and events of the past to be available for adaptive and spontaneous functioning in the present.

Moreno writes that: "Every true second time is a liberation from the first". Even transitory regressions have therapeutic value and form a key element in psychodrama. The protagonists play " . . . as (they) did once out of necessity in self-conscious deceit, the same life again . . . they experience it, they are master."[55]

Elsewhere Moreno maintains that: "re-experiencing the old, unsettled conflict <u>but with a new ending</u> is the secret of every penetrating therapeutic result."[56] The individual has an <u>act hunger</u>, or drive towards fulfilment of desires and impulses, which is continuously searching for opportunities for expression. "Acting-out of a situation in a controlled environment can be a preventive measure against irrational acting out in life itself."[57] Thus not only the past but also the present and the future

can be contained within psychodramatic enactment.

On the psychodramatic stage it is possible for the protagonist to express feelings which he might not have been able to in actuality. Thus in death scenes a protagonist might gain a significant release and important insights from having a "conversation" with an auxiliary playing a departed significant other. A protagonist who had, for example, a cold, punitive parenting experience, could gain some sense of relief and possibly even empathy from interacting with an auxiliary who listens with sympathy and understanding to his feelings. Real-life situations of which the protagonist feels deprived could be created psychodramatically. For example, a protagonist who was rejected at birth, with a life history of institutionalisation might experience a psychodramatic realisation of fantasied ideal home life in a series of integrative scenes following the affective catharsis. Marital encounters could be re-enacted the way a partner would have preferred an outcome. Role reversal with re-enactment often breaks the mental "set" to win on each partner's side and dissolves any "adversary system" which might have been established.[58]

This movement into an imaginary past, present, or future is a movement into what Moreno calls surplus reality:

> . . . psychodramatic therapy . . . tries to provide the patient with more reality than the struggle with living permits him to achieve spontaneously, a "surplus reality". The excess of life realization helps the patient to gain control and mastery of self and world through practice, not through analysis.[59]

The term surplus reality might also be applied to those "invisible", intangible dimensions of man's internal subjective world. Fantasy, imagination, emotions, hallucinations, and delusions might "exist" in the sense of being a "reality" as part of the individual's psychological experience. The final stages of a psychodramatic enactment especially use surplus reality and techniques of externalising and making surplus dimensions of reality manifest. Hollander feels that the final stages of the action portion of psychodrama require the inclusion of two principles, one being surplus reality and the other a purposeful, positive ending.

> Psychodrama enactment is provided for creative and productive objectives. One ethic inherent in the methodology is the suppression of destructive behavior. Therefore, no session may conclude with a destructive act, such as suicide or murder, nor may it terminate in an artificial manner. Using the surplus reality concept, the protagonist is directed toward a positive or productive closure which is feasible within his purview of life. In such closures, the protagonist experiences sensitivity training, spontaneity training, role training, and an aesthetic expression of his creative potential.[60]

Thus, using the principles outlined above, the final working through or integrative stage of the action portion helps the protagonist to achieve some sense of mastery over his problem. This might entail symbolic resolution of a completed act with a return to reality, or evaluation and integration of residual thoughts and feelings associated with a relationship and the behavioural consequences of certain acts or problems. Mastery might entail reinforcement of an expanded perspective, or development and practice of effective behavioural responses to situations,

as in role playing and role-training. This behavioural practice may only be introduced at the end, once the protagonist has explored the meaning of his emotions, ventilated and given expression to his feelings, and made some connective insights towards self-understanding. As Moreno notes: "Enactment comes first, retraining later. We must give [the protagonist] the satisfaction of act completion first, before considering retraining for behavior changes."[61]

With regard to relationship situations, it is usual for the protagonist to take "counter-roles" during the working through, to be able to evaluate his own behaviour, or to gain a measure of empathy into the "antagonist's" point of view.

In addition to role practice and role reversal, other psychodramatic techniques which might be used during the final portion are mirror, reformed auxiliary technique or future projection. (For description of these techniques see Chapter II.)

3 Sharing, Feedback, and Closure

The final phase of a psychodrama comprises what Moreno refers to as the post-action sharing.[62]

The normative emphasis during "sharing" is on supportive and personal self-disclosure of the members of the audience. Group members are encouraged to relate feelings or incidents in their own lives similar to those portrayed by the protagonist on the stage. Often their sharing is of

material "sparked" off by or remembered by association or identification with the enactment. Therapeutic group discussion might ensue. Analysis of the protagonist and his actions is actively discouraged as is any advice-giving or possibly destructive or critical comment from the group.

Once the action portion has been positively and therapeutically terminated, the protagonist sits down next to the director on the edge of the primary stage or secondary level for the sharing. Where there is no formal stage they might return to the body of the group or remain seated in front of the group.

The sharing phase serves to re-integrate the protagonist into the group. It helps to de-role him and to ease his return to the here-and-now reality of his role as group member. Symbolically, it represents his move back to the "outside community" or audience. From the protagonist's point of view this return is highly charged emotionally. He has given and revealed a great deal of himself during the enactment. His gift has been the portrayal of his subjective reality and world view, and movement-in-the-world on the stage. He might be anxious about group acceptance and group reactions to his drama. He might feel emotionally nude, exposed, and vulnerable. He might simply feel the need for support and "tender loving care". As he hears the sharing from the audience, and realises that he is not alone, that his conflicts, feelings, and problems are not unique, that they are related to by others -- he feels less vulnerable and lonely.

From the audience point of view, the sharing provides a vehicle for group members to give support to the protagonist, to communicate their identification and similarities. Not only does sharing provide a structure for the expression of feelings and audience or spectator catharsis, but it allows the various curative elements of the group as therapeutic context to activate themselves. During the actual process of self-disclosure, and simply by listening to the sharing and experiences of the audience, group members, and the protagonist, gain valuable insights and often arrive at a better understanding of their behaviour and interpersonal relationships. During the sharing and discussion phase group members become aware of their own "warm-ups" for and motivation to work on emotional material in their own future psychodramas. Sharing facilitates group cohesion and morale. The curative group factor of universalisation or affirmation of the similarities of human experience and the breakdown of isolation, as described in note 22, is encouraged to manifest itself within the sharing period.

From the point of view of the director, sharing assists her diagnostic as well as her therapeutic task. It helps her to identify "where" group members "are" in relation to their internal affective processes and to the closure or ending of the session. She herself gains new insights and information about group members. In an institutional or hospital setting valuable diagnostic material might be available for feedback to other team members or use within an adjunctive therapeutic method being employed.

The sharing phase serves as a built-in control factor in the structure of the psychodramatic system. It helps the group move from an affective to a more cognitive focus. This ensures that members are "closed" or "cooled down" from any "overheated" state before they leave the group session; that they do not exit from a session in a state of incompleteness, pain, panic or emotional shock.

The director can check whether anyone requires de-roling from an auxiliary part before he or she leaves the group. A simple suggestive imaginative procedure, such as asking the auxiliary who has been deeply affected by playing a supportive, possibly unpleasant role, to "take off your role and throw it away", or "break off your role and return to yourself" is often very helpful. The clearly delineated action space helps the de-roling process for the protagonist.

In certain instances, the director may need to summarise the main points of or learnings from the session, or deal with planning for a subsequent session. She might decide to introduce a formal closing technique or separation ritual for the ending or termination of the group. A number of closure or "sum-up" techniques, both verbal and non-verbal, have been designed for this purpose.[63]

It is in the conscious use of the systematic structure of the classical psychodrama format and its process of warm-up, action, and sharing that the power and the safety from dangers and abuses lie.

Figures 3 and 4 present Hollander's visual depiction

of the psychodrama process. His "Curve" or modified triangular model provides a paradigm for the description, review, and understanding of the psychodrama session.

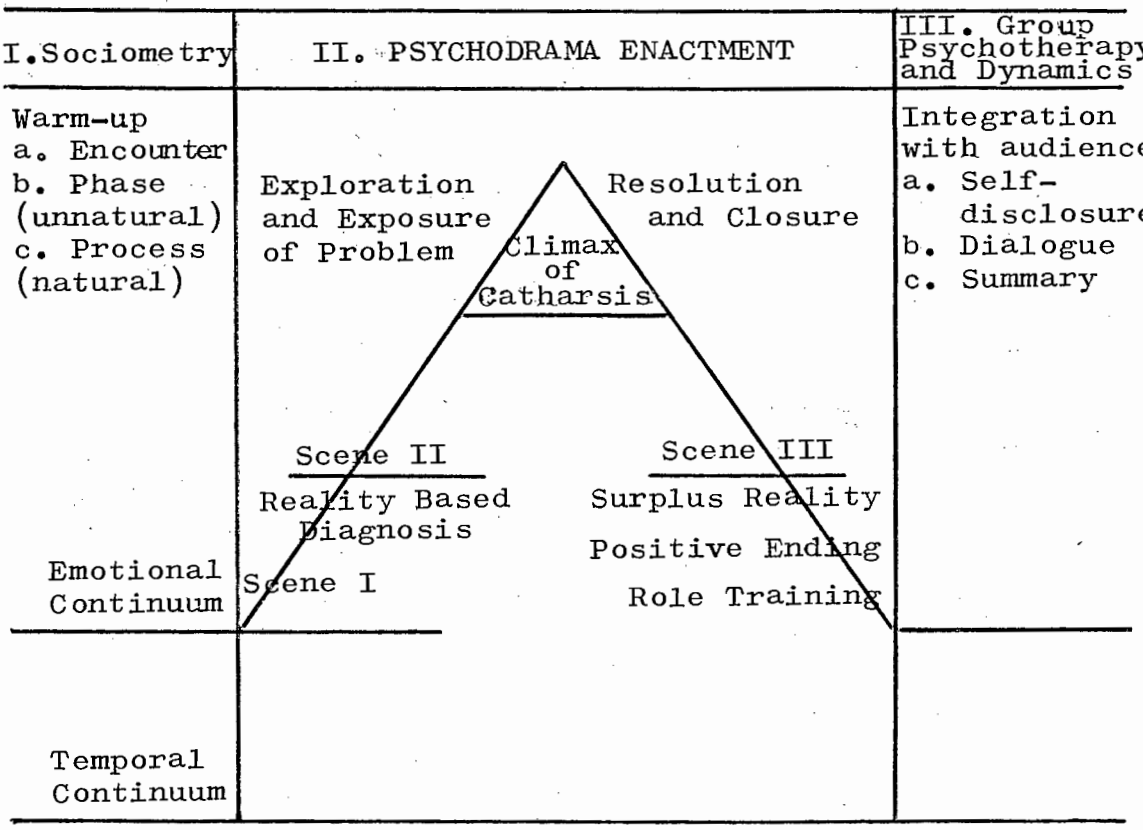

Fig. 3. The Hollander Psychodrama Curve. SOURCE: Carl Hollander, A Process for Psychodrama Training: The Hollander Psychodrama Curve, (Littleton, Colorada: Evergreen Institute Press, 1969), p. 19.

The progress of the curve may also be depicted as follows, in Figure 4.

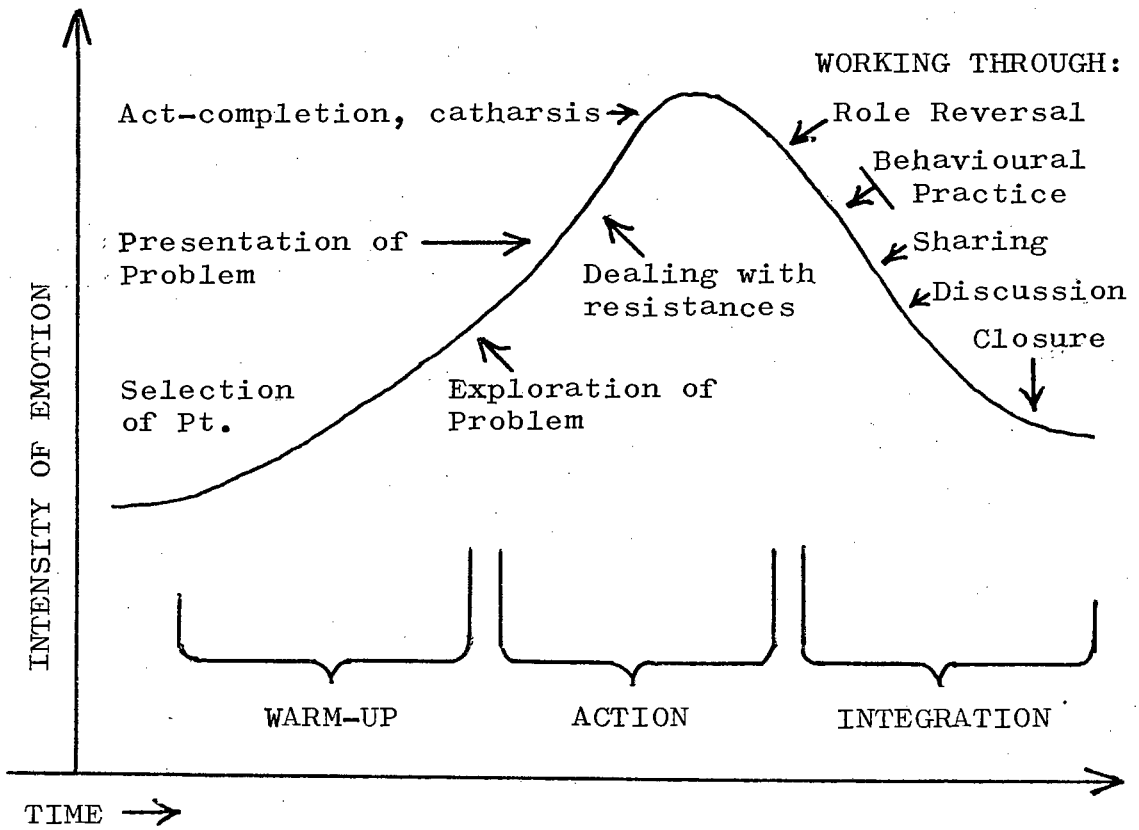

Fig. 4. The Hollander Psychodrama Curve depicting process steps, as described by Barbara Seabourne and Carl Hollander. SOURCE: Howard A Blatner, Acting-In: Practical Application of Psychodramatic Methods, (New York: Springer Publishing Co., 1973), p. 75.

D. BASIC CONCEPTS AND THEORETICAL PRINCIPLES

In this section some of the major principles and theoretical assumptions underlying Moreno's system of psychodrama are presented. This serves to supplement the descriptions of basic concepts and ideas given during the outline of the psychodrama elements and process.

1 Spontaneity - Creativity

Spontaneity, or what Moreno calls the "s"-factor, is of central psychological importance in his theory -- in terms of the constructive creative adaptation of man to and within his environment. Spontaneity in the Morenean sense is similar to the philosopher Bergson's concept of élan vital or life force. Spontaneity is a central concept in Moreno's theory of personality development and functioning.

Spontaneity is essentially an hypothetical construct defined operationally in terms of its manifestations or effects. Moreno described it as "the self-initiated behavior of man", and its most frequently used definition emphasises the factors of adequacy and novelty of human responsiveness: "Spontaneity can be defined as the adequate response to a new situation, or the novel response to an old situation."[64]

In Moreno's "creative theory of personality", spontaneity and its corollary, creativity, are inextricably bound to the concept of warm-up, which has been described in part C. of this chapter: "Warming-up begets spontaneity which in turn begets creativity."[65] All spontaneous acts have their genesis in the warm-up. Creativity is what Moreno calls a "sleeping beauty that, in order to become effective, needs a catalyzer. The arch catalyzer of creativity is spontaneity, by definition from the Latin sua sponte which means coming from within."[66] Creativity can only be defined by its "inner dynamics". Maximum creativity on a global societal level would refer to

genius functioning and the "fullest penetration of the universe by creativity"; zero creativity would refer to "a world that is entirely uncreative, automatic, that has no past or future, no evolution or purpose, absolutely changeless and meaningless."[67]

Biological creativity is manifested in evolutionary advances. Societal creativity provides a cultural context for maximum freedom, productivity, and self-realisation for all its members. In a truly creative society, or what Moreno envisaged as a "creatocracy", the end-products of the spontaneity - creativity continuum, or the "cultural conserves", are not too rigid or frozen. A cultural conserve is "anything that preserves the values of a particular culture."[68] It may assume the form of a material object, such as a book, film, building, or musical composition, or as a set pattern of behaviour or ritual, such as a religious ceremony, the performance of a play, an initiation rite, or even a conventional greeting such as "Tot siens". Cultural conserves play an important part in the continuity and organisation of societal life. However, should the members of the society cling too tightly to outmoded conserves and invest them mentally in too sacrosanct a fashion, the society runs the risk of becoming automatic, stultified, and incapable of meeting new demands. At most it might even face a form of extinction. Bischof writes that: "The human personality cannot afford to cling to outmoded cultural conserves which block the spontaneous efforts to create newer things."[69]

On the individual personal level, creativity is not

only the province of genius, of the scientist, the prophet, the musical composer or poet. The man in the street may also show creativity in his everyday life and behaviour. The housewife might transform her creativity through her cooking; the teacher with her students; and the social worker in her use of the "art" of interviewing and professional problem-solving. The truly creative person expresses his individuality and spontaneity in a constructive, adaptive fashion. New situations do not arouse too crippling an anxiety. He is able to meet unexpected or new situations in his life productively, with "adequate" or "novel" responses. Human existence is a continuously changing, dynamic state of flux. Life itself requires a series of dramatic improvisations to constantly changing sets of circumstances. The healthy individual can maintain his equilibrium in the face of change as well as he can release his spontaneity and use cultural conserves flexibly and imaginatively. The opposite of spontaneity is "robotism", or automatic stereotyped behaviour. Repetition of the same response, no matter the circumstances, is rarely creative.

Moreno differentiated three different types of spontaneity.[70] In the first there is a novel response to a situation but not one which is adequate to the situation. Moreno gives the example of a psychotic who might state that two times two equals five. Children, who are "bursting" with spontaneity, have a wide range of novel responses, not all of which, however, are of creative value. Novelty without adequacy is pathological or undisciplined

spontaneity.

The second type of spontaneity is a stereotyped variety. The response is spontaneous and adequate to the situation, but lacks sufficient novelty or "significant creativity" to be "fruitful to the situation". A comedian, for example, whose repetitive reaction to a situation might provoke laughter, becomes boring through loss of novelty.

Neither of these are true spontaneity. The third type is truly spontaneous in that the results of the action are in some way new and useful. There should be an adequate response accompanied by characteristics which are both novel and creative. This would be maximal spontaneity.

Psychodrama aims at helping the individual to function with optimal spontaneity and creativity.

Maximal Spont

2 Role Reversal

In Moreno's system role reversal is not only a specific technique, but a major principle upon which adaptive socialisation and the integrative creative functioning of self may be based. In the technique of role reversal one individual exchanges roles with another and plays his part as though he were the other; in imaginative empathetic role reversal, one tries to take the role of an other by only figuratively "stepping into his shoes" -- attempting to see his world through his eyes and image-into his experience. Although no man can completely role-reverse or "become" someone else through this process, he can at least

for limited times "break the terrible trap of always being one's self . . . We are restricted in our perceptual self-systems. We need the viewpoint of others to correct our own myopia concerning the world."[71] On a micro-social interpersonal level the process of role reversal enhances empathic ability and thus oils the wheels of social interpersonal relationships. Empathy is defined as the "imaginative transposing of oneself into the thinking, feeling and acting of another."[72] This capacity for imaginatively taking the role of the other, and feeling into his situation is important in social adjustment and relationship skills. The empathetic individual who can place himself in the psychological frame of reference of another, and understand and predict his behaviour, is far better off in interpersonal relationships and communication than someone who cannot do so.

Moreno felt role reversal to be important not only on a micro- but also on a macro-human interaction level. At the risk of sounding trite or naive, his vision could be summed up by adding to the biblical exhortation to "Love thy neighbour" -- "through role reversal". The imagined consequences of true role reversal upon intergroup and international relationships reach the Utopian. Moreno felt that man may be able to achieve a lasting peace between nations if he cultivated and maintained the capacity to reverse roles. Role reversal in this light may be viewed as the "sine qua non of a balanced society on earth."[73]

3 Empathy - Tele - Transference

The trichotomous, linked concepts of empathy, tele and transference are integral parts of Moreno's theoretical infrastructure. He differentiates between empathy, transference, and the phenomenon he identifies and names tele.

> Tele is defined as a feeling process projected into space and time in which one, two or more persons may participate. It is an experience of some real factor in the other person and not a subjective fiction. It is rather an interpersonal experience and not the affect of a single person. It is the feeling basis of intuition and insight. It grows out of person-to-person and person-to-object contacts from the birth level on and gradually develops the sense for interpersonal relationships . . . [74]

Whereas empathy is seen as Einfühlung, or a one-way subjective process of feeling into another and taking his role, in terms of ability to understand his thinking, feeling and acting, tele is seen as Zweifühlung, or a two-way feeling into and mutual understanding of and sensitivity to each other in interpersonal terms. Blatner describes Moreno's tele as a " . . . term richer than rapport and more mutual than transference and counter-transference."[75]

In his definition of tele and his writings about the concept, Moreno regards the tele factor, or "unit of telic sensitivity" -- "t" -- as basic to his theory of personality and the qualities of interpersonal interaction, as well as to group association and sociometric status. "The tele process is considered . . . the chief factor in determining the position of an individual in the group."[76]

He derived the term itself from the Greek word meaning "far" or "far off", and adapted it to denote "distance". His belief is that telic sensitivity to others and relationships begin in infancy as the baby develops ideas of nearness and distance, both within and without himself. Tele itself may be "positive", "negative", or "neutral"; and may exist for objects and things as well as for persons.

Bischof describes the growth of the telic factor in the individual, and hypothesises about its possible influence on the organic nature and structure of large groups or societies. He writes:

> (An) origin of the word is telencephalon or endbrain, the neurological term meaning "the anterior subdivision of the embryonic brain in which are developed the olfactory lobes, the cerebral hemispheres, and the corpora striata" . . . The physical distance receptors of the visual and auditory senses help him (the infant) little by little to differentiate objects from persons. This leads to his liking and disliking objects and persons, a reaction called positive or negative tele. Tele also develops into a sensitivity for real objects and for imagined objects. When tele begins in the human system, it is a psycho-organic level of expression of feeling and is inarticulate. As the human mechanisms mature, the telic sensitivity becomes psycho-social and develops to a highly articulate level.[77]

Differential "tele" for objects and symbols develops from relationship experiences with associated persons. Entire societies or cultures may be seen to emphasise tele for objects more than for persons. One society may overemphasise tele for persons and develop great emotionality in relationships or at least a person-orientation; another might emphasise objects and become material and

technologically-oriented; yet others who emphasise overtly symbolic tele might become withdrawn and contemplative, neglecting physical and personal societal aspects.[78]

One function of therapy might be seen as helping the patient or client to integrate all three telic aspects of persons, objects and symbols into a congruent and complementary whole. Tele plays an important part in psychodrama therapy. As a "unit of feeling" it is present in the interactional and sociometric processes within the psychodrama group. Some members will have stronger positive tele for each other than will others. Some members might experience mutual negative or even neutral tele. The director might be aware of her own negative tele with certain members and need to "work" on this. An auxiliary who is chosen to "double" for a protagonist might not be able to function efficiently if negative or neutral tele exists. On the other hand, the process of "doubling" (to be described in Chapter II) often encourages the growth of mutual tele as it proceeds, particularly if the auxiliary starts with a measure of empathy into the situation and feelings of the protagonist.[79] Usually, when a protagonist chooses the appropriate auxiliary for a role, the telic process is operating.

Observing the warm-up or spontaneity of the protagonist during the initial scene or scene-setting gives valuable diagnostic information as to his telic feeling, not only for significant others in his life, but also for symbols and objects. For example, the protagonist who "blocks"

in regard to exploring certain interpersonal relationships or intra-psychic material might be able to warm-up to this by first imaginatively role-reversing with a meaningful object, for example, a dog or a motorcar. One might find that in scenes involving the protagonist's dog and his car, his spontaneous productivity might be stronger and more real and alive than in other scenes in which he might feel threatened.

In the same way as empathy is a one-way, not necessarily reciprocal, feeling process, so also is transference a uni-directional mode of viewing and relating to another person. Empathy might be defined as "a feeling perception of reality leading to adequate reactions."[80] However, transference and its related equivalent, counter-transference, is a distorted perception of reality. Like empathy, it is also a one-way directional mode of relating to another person, but it is based on inaccurate perception of that person deriving from past experiences and previous relationships. Emotional connections to an imagined "similar" person are transferred to the current situation.

Freud originally described this phenomenon as "transference". His system of psychoanalysis used the development and analysis of the patient's transference to the therapist as a therapeutic tool in bringing suppressed, unconscious material to consciousness, and in helping his patients re-experience emotions connected with such material. Transference is encouraged to develop towards the psychoanalyst within the structure of the analytic mode, viz., the patient lies on a couch and does not interact

face-to-face with the analyst who tries to remain as unobtrusive as possible; providing a "blank wall" on which free associations and transference feelings may be projected. However, even this device cannot blot out the influence on both parties of the total analytic situation as an interpersonal one, influencing the interaction. As Moreno pointed out, transference is interpersonal and counter-transference (which Freud described as the effect on the therapist of the patient's influence on his unconscious feelings) also arises in the analytic situation. Thus counter-transference may be seen as a two-way situation of transference moving both ways.[81]

Working with the unreal transference and counter-transferences presents a problem to the psychoanalyst and to the practitioner using the psychoanalytic model. It is felt that Moreno's psychodramatic group therapy provides a method and structure within which transference and counter-transference effects are reduced to a minimum, dissipated, or excluded completely. The director-therapist is related to as a real person.[82]

In the first phase of a psychodrama, the protagonist may transfer feelings from other relationships onto the director. He may react to the director with feelings experienced in regard to the quality of his relationship with mother or father. However, even should the director recognise this, the movement into action as soon as possible, cutting short any verbal narration or acting-out of these transference feelings towards the psychodramatist limits the duration of this type of transference.

The second phase of the psychodrama, or action portion, provides the protagonist with substitutes for real persons and the re-experiencing of true emotion connected to the original stimuli persons. Any transference is guided back to the past situation. In addition to the re-awakening of unconscious feelings and their emergence into consciousness, the protagonist is able to see the traumatic experience of the past in a "new light".

In the third, post-enactment phase of the psychodrama, as the auxiliaries in particular, and the audience members in general, share similar experiences of conflict to those portrayed by the protagonist, their empathy stimulates a "counter-empathy" in the protagonist, and "Einfühlung" becomes what Moreno called "Zwei - und Mehr - fühlung".[83]

Authentic telic relationships and encounters based on accurate and real perceptions are encouraged in psychodrama. These in turn produce healthy creative and productive social interactions. Transference is regarded by Moreno as the "pathological portion" of tele, and tele as "a universal factor . . . operating in the shaping and balancing of all interpersonal relationships."[84] Wholesome human relationships depend on the presence of tele and thus tele may be seen as the basis of sound therapy.[85]

4 Social Atom

Growing out of the telic process is what Moreno, using the language of physics as a metaphor, calls the social atom, or "smallest living social unit". Society is seen as composed of a network of social atoms activated by

positive or negative telic relationships.

> The social atom is the nucleus of all individuals towards whom a person is emotionally related or who are related to him at the same time. It is the smallest nucleus of an emotionally toned interpersonal pattern in the social universe. The social atom reaches as far as one's tele reaches other persons. It is therefore called the tele range of an individual. It has an important operational function in the formation of a society.[86]

On a personal level, the psychological social atom comprises the minimum number of meaningful relationships needed for an individual to feel a sense of balance and stability.[87] The collective social atom refers to the minimum number of meaningful groups to which an individual belongs; and the cultural atom to the roles he plays in his culture. The state of balance and harmony between the self and his various atoms is known as sociostasis. Sociostasis equilibrium is important for the spontaneous, creative, and healthy functioning of an individual in his interpersonal life. Should this equilibrium be disturbed through a disruption in one of the "atomic nuclei", what is known as a social atom search pattern ensues, either consciously or unconsciously. Sociostatic equilibrium might be affected through the loss of a meaningful relationship, perhaps through death or separation. Collective social atoms might be disrupted through a move to another city or country, or the loss of a job. Such disruptions might severely disturb the functioning of an individual until equilibrium is regained. The search pattern might reinstate a negative or skewed relationship and not necessarily only a positive one as in Freud's repetition compulsion. The individual with enough spontaneity tries

to restore the balance or sociostasis either through replacing the lost relationship with another, or enlarging the pattern. Where spontaneity is low, and uncreative responses predominate, trauma, neurotic, and even psychotic behaviours might ensue as a result of a pathological attempt to close the atom.

Stress may occur when an individual invests too much energy and meaning into one collective, or when he exists with too few collectives so that any strain occurring in the relationships in one collective becomes traumatic.

Psychodrama has been referred to as social atom repair work in that it "seeks to repair . . . broken relationships or possibly prepare the individual to remove the [negative, hindering] relationship . . . A balanced life may . . . be described as a balanced set of collectives each containing [a] minimum number of healthy relationships. It also involves maintaining an adequate number and variety of collectives."[88]

5 Role

The concept of role and the principles of role-taking and role playing are central to Moreno's theoretical system. Moreno postulated a role theory of personality in which the self is seen as developing out of and comprising an interacting, interdynamic set of roles. He felt that the concept of role, defined as an observable "unit of 'conserved' behaviour" recognisable by the actions involved,[89] provides an empirical means for "knowing", observing, or studying the self, and that it elucidates

and objectifies the somewhat abstract psychoanalytic concept of "ego". Rather than simply rejecting the ego concept he prefers to "place it in parantheses".

> The tangible aspects of what is known as "ego" are the roles in which it operates. Roles and relationships between roles are the most significant development within any specific culture. Working with the "role" as a point of reference appears to be a methodological advantage as compared with "personality" and "ego". These are less concrete and wrapped up in metapsychological mystery.[90]

To Moreno role emergence is prior to the development of identity or self-consciousness and the social personality. "Roles do not emerge from the self, but the self may emerge from roles."[91] The newborn infant is an "open energy system" and initially narcissistic, perceiving all objects and persons as existing only for him, part of and belonging to him. The distinction between the "I" and the "you" has not yet been made. An example given is of the suckling infant who might "realise" that certain organs are parts of himself, and that others, such as the breast, are detached from himself, but he does not yet "realise" the <u>difference</u> between the two. In this way there is a fusion of the two which remains even after the separation, or removal of the breast by the infant's mother, or first "auxiliary ego".[92] This co-being, co-action, and experience in the "primary phase" Moreno refers to as the "matrix of identity" which lays the foundation for the first emotional learning process of the infant and his subsequent personality development and socialisation. The child's social self is further developed as he progresses through a series of stages involving imaginative role-taking, enactment, and role reversal. The child is regarded as

being naturally "psychodramatic" in terms of ease of access to and availability of spontaneity, creativity, and fantasy. He learns roles and role-behaviours by playing, practising and exploring them. Sociocultural influences start acting too as he obtains feedback from others as to the integration and suitability of his role-enactments. As roles are incorporated internally within his role-repertoire his "ego" or self-identity grows and expands.[93]

Originally a French term, rôle, role found its way into sociological and social psychological literature via the drama and an earlier Latin history. The Latin term "rotula" means "little wheel" and was used to refer to the scripts on scrolls which classical actors unrolled on stage. Often their roles written on these scrolls were discovered for the first time as they unfurled them. The origin and appearance of the term role playing in sociological, psychological, and therapeutic literature seems to have derived from Moreno's usage and direct transliteration of the German word Rollenspieler in his early book "Das Stegreiftheater".[94]

Moreno distinguishes between three different types of roles or "precursors of the ego".[95] In order of emergence they are:

(a) Psychosomatic roles
(b) Psychodramatic roles
(c) Social or socio-cultural roles

The psychosomatic roles are concretised by physiological, instinctual, or biological behaviour, e.g. role of eater, sleeper, or walker. The infant is thus primarily an

"eater", "sleeper", "crier", "eliminator" before his self-awareness of psychodramatic roles develops. Examples of the latter would be the child as specific individual, brother, son, "play"-animal, or fantasy figure. Once the separation between fantasy and reality has been established, the social or collective roles are differentiated from the psychodramatic, e.g., the mother, the son, a policeman, a pupil. Diagrammatically, Moreno presents this in a simple illustration indicating the "role range" of an individual comprising the three major types of role with the existence of a sector containing unresolved and unintegrated parts of the self. (See Figure 5)

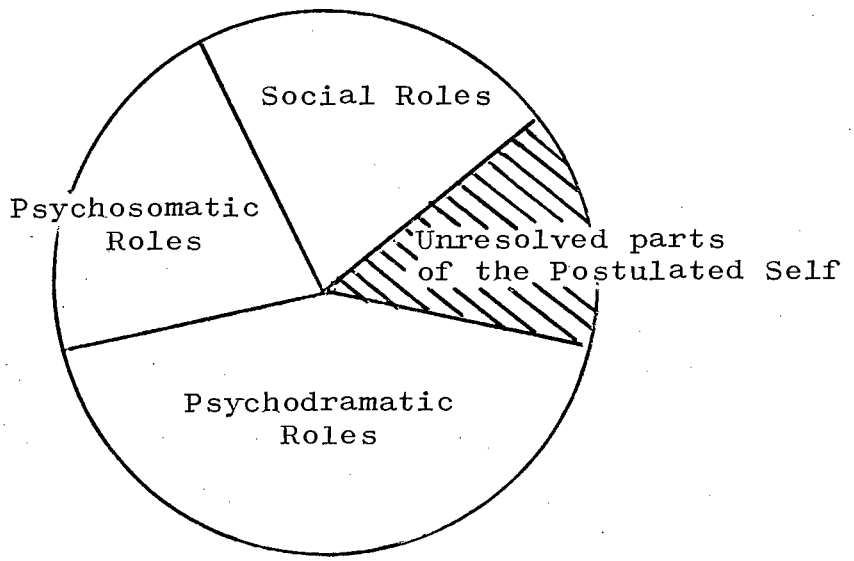

Fig. 5. Role diagram showing the "role range" of the self. SOURCE: J L Moreno, Psychodrama, Vol. I, 4th ed., (Beacon, New York: Beacon House, 1972), p. 159.

There is a large variety of Morenean principles and terms concerning his theory of role dynamics. A broad review culled from the literature includes the following presentation.

- Every role is a fusion of private and collective elements
- Social roles are usually not a single entity, but may exist as a cluster of roles, e.g. the wife

role might include a clustering of roles such as mother, companion, home-maker, cook, nurse, and so on [96]

- Knowledge of or perception of a role does not necessarily mean an ability to enact it. Nor is the enactment of a role necessarily either adequate or played without distortion
- There are often personal as well as societal expectations of role enactments. Individuals, societies and cultures differ in their perceptions of roles and their expectations of role behaviours and enactments. These differences result in differences in the performance of roles as well as in interpersonal role relationships. Friction might arise where two societies or cultures or individuals with differing role perceptions and expectations interact
- Moreno differentiates between role-taking ("the taking of a finished, fully established role which does not permit the individual any variation, any degree of freedom" for enactment and expression of individuality); role playing (which permits some degree of freedom); and role-creating (which permits the individual a high degree of freedom and spontaneity in the enactment) [97]
- An individual's role repertoire or store of potential roles may exceed those he actually activates or plays. Latent roles might be aroused; ascendant roles are those coming into active use; descendant roles are those "dying out", for example, the adolescent in a state of transition to adulthood, the patient whose therapy is about to be terminated, or the managing director who has entered his retirement. Ideal or fantasy roles, when relinquished, are said to be descendant
- Role fulfilment or role satisfaction, albeit in fantasy, surplus reality, or psychodramatically, helps man's need for act completion. Pathology, repetition of old maladaptive behaviours, may stem from an unfulfilled "ego" or "self" developed from or composed of roles which have not been activated or enacted in a satisfactory manner
- A sense of role conflict might arise within the individual as a result of the incompatibility and compatibility between several social or personal roles played or required to be enacted
- Role substitution occurs when one role is assumed in place of another
- Role identification takes place when an individual perceives and experiences another playing the same role
- Role status or the value placed on roles varies

from society to society and from one culture or subculture to another. A poet might be relatively more highly valued in one culture, and the sportsman in another. The more primitive the society, the higher the value placed on roles related to survival tends to be [98]

- Every social role has or requires a reciprocal, complementary, or counter-role. The role of husband cannot exist without the role of wife; similarly leader and follower. (This has implications for the social atom)
- Well-defined roles tend to establish stability in social role relationships; the individual knows who he is, what he is expected to do in role performance, and feels comfortable with this.[99] However, should the role be too firmly "over-defined", role rigidity in both the individual and society might result with stultifying and noncreative effects. On the other hand, insecurity and uncertainty often result from role ambiguities and lack of definition

The empirical values inherent in using these principles and in looking systematically at these patterns of roles and role relationships have been exploited by Moreno in a number of objective "tests" and methods. He and subsequent psychodrama practitioners have used these for both diagnostic as well as therapeutic purposes. Thus role diagrams, role tests, maps of social atoms, may provide valuable insights for both therapist and participant as they help to objectify, illuminate, and unravel interpersonal problems resulting from the interaction of role needs, expectations, and satisfactions. In addition to being a valuable adjunct to psychodrama, these methods and devices for exploring role structures and relationships comprise an important part of the sociometric basis of psychodrama.

Sociometry is an independent branch of the social sciences strongly influencing social psychology. Sociometry was also developed by Moreno and defined as

"the mathematical study of psychological properties of populations, the experimental technique of and results by application of quantitative methods."[100]

6 Here-and-Now

In psychodramatic enactments the principle of re-enactment in the present is used. The protagonist experiences the past or the future as though it were happening now. This aids his belief in the situation, his involvement in the action, and the benefits derived from examining a period of time, a present caught in the confluence of the past and the future, as fully as possible. Insight is gained into the reality of the expanded moment.

In his application of the time-space principle of the compressed yet expanded moment to his psychodrama therapy, Moreno was operationalising his early philosophical musings on the existential concept of the here-and-now, or hic-et-nunc. For example, in 1919 he wrote: "The meaning of the decision is in this moment, the Here and Now, even if you have lived through all the instants of the past and will live through all the instants of the future."[101]

Moreno felt that psychodrama, unlike psychoanalysis, does not work "backwards", although it uses the past. Spontaneity is: "Man in action, man thrown into action, the moment not a part of history, but history as a part of the moment."[102] In these terms, one might see the spontaneous personality as he who expresses his individuality (creativity) in the fullness of the psychodramatic moment. The psychodramatic moment might be considered as one which,

if examined like an enlarged still-life photograph, would contain in addition all the invisible, intangible dimensions of surplus reality, and the meeting of past and future.

7 Catharsis

The fundamental concepts of surplus reality; the warm-up; controlled acting-out or acting-in; and the therapeutic principles of the re-enactment of previous conflict and trauma have already been described during the outline of the sequential phases of a typical psychodrama. The principles of an integrative rather than abreactive catharsis have also been elucidated earlier in this text. To conclude this chapter, a few general comments on Moreno's perspective on the concept of catharsis will be made.

Aristotle introduced the concept of Katharsis to express the effect of the Greek drama upon its spectators. In his "Poetics" he describes the task of the Tragedy, or presentation of the completed dramatic work as " . . . to produce by means of fear and pity, a liberation from such emotions."[103] The catharsis takes place in the audience. By arousing fear and pity in the spectators they are purged of these same emotions and obtain relief. In psychodrama, Moreno, using the early concepts of catharsis, shifted the emphasis from the spectator catharsis by means of the witnessing of a conserved or written drama to an emphasis upon an actorial catharsis within the unwritten spontaneous drama.

Whereas Aristotle defined theatre as an imitation of

life, Moreno attempted to create a dramatic medium which would provide an extension of life and action. "It (the psychodrama) produces a healing effect -- not on the spectator (secondary catharsis) but in the producer-actors who produce the drama and, at the same time, liberate themselves from it."[104]

The second stream of influence on his concept of catharsis were the religions of the East. While the Greek dramatic concept localised the primary catharsis in the passive spectator, the religious concepts localised the catharsis in the self-realisation of the individual through an active catharsis. "These religions held that a saint, in order to become a savior had to make an effort: he had, first, to actualise and save himself."[105] Both the Greek and religious ideas of catharsis were synthesised in Moreno's psychodrama.

> Mental catharsis cannot always be 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 the 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.[106]

NOTES

on Chapter I

1 J L Moreno, Psychodrama, Vol. I, 4th ed., (Beacon, New York: Beacon House, 1972), p. 12.

2 Ibid.

3 Nathan W Ackerman, "Group Therapy from the Viewpoint of a Psychiatrist", American Journal of Orthopsychiatry, XIII, No. 4 (1943), p. 678. He distinguished five basic elements common to all psychotherapy, viz., (a) establishment of relationship patterns, (b) release of emotion, (c) expression of unconscious tendencies, (d) testing of reality, and (e) integration of new insight. Classical psychodrama shares these core elements in its goals and procedures.

4 Descriptions of the major psychodramatic derivative techniques are given in Chapter II. Examples of a variety of applications and usages of psychodrama and related techniques appear in Chapter IV.

5 These elements are also present, in varying degrees of definition and sharpness, in psychodramatic action processes, as well as in verbal group therapy where a theme-carrier emerges as central for a session or portion of a session, whilst other members interact verbally with him or in other ways indicate varying degrees of identification with the theme, and yet others remain silent, either internally working on the theme or simply observing and listening. The group therapist usually functions in a directorial role, guiding the process, or at times a group member might emerge as "leader" and direct the group process or facilitate interaction.

6 Moreno, op. cit., p. 12.

7 Carl Hollander, "A Blueprint for a Psychodrama Program", Journal of Group Psychotherapy and Psychodrama, XXI, No. 4, 1968, p. 224.

8 From now on, the convention of referring to the director as "she" will be adopted. The protagonist and auxiliary ego(s) will as a rule be referred to in the third person, masculine. This is simply for the sake of convenience, and is in no way anti- or pro-sexist in intent.

9 Moreno, op. cit., Introduction, c.

10 Ibid.

11 Ibid., b.

12 Where there is only one auxiliary or central figure playing opposite to the protagonist, in an enactment or re-enactment of a relationship situation or confrontation, this second person may be referred to as the antagonist.

13 The social atom is Moreno's term for the smallest unit of social relationships, and refers essentially to the configuration of persons and relationships emotionally significant to the individual, and relevant to his current psychological functioning. The social atom is not necessarily comprised solely of family members, but might also include pets, or friends, relatives, and associates (dead, or alive), for whom the individual has significant positive or negative relationships and feelings.

14 Moreno, op. cit., p. 261.

15 The technique of the double is described in more detail in Chapter II.

16 Moreno, op. cit., Introduction, c.

17 Irvin D Yalom, The Theory and Practice of Group Psychotherapy, (New York: Basic Books, 1970), p. 5. The ten curative factors which Yalom distinguishes in all types of group therapy are imparting of information, instillation of hope, universality, altruism, the corrective recapitulation of the primary family group ("social atom repair work" in psychodrama terms), development of socialising techniques, imitative behaviour, interpersonal learning, group cohesiveness and catharsis. On page 11 he writes that "altruistic acts often set healing forces in motion in group therapy." Not only may auxiliaries help the protagonist, but the process of helping the protagonist is a positive experience for the auxiliary as he realises he himself has something to offer or give to another person.

18 Howard A Blatner, Acting-In: Practical Applications of Psychodramatic Methods, (New York: Springer, 1973), p. 16.

19 Ibid.

20 Margherita Ann Macdonald, "Psychodrama Explores a Private World", Psychodrama Monographs, No. 24, (Beacon, New York: Beacon House, 1947), p. 11.

21 Moreno, op. cit., p. 261.

22 Universality, like altruism, is one of the ten curative factors in group therapy isolated by Yalom, op. cit., p. 5. He writes that many patients enter therapy feeling they are "unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses and fantasies." op.

cit., p. 10. Their sense of uniqueness is further heightened by their social isolation. After hearing other patients disclose problems which are similar to their own, patients report feeling relief and a sense of being more in touch with the world and their fellow humans than before. Not merely self-disclosure but also the accompanying catharsis and ultimate acceptance ("cohesiveness") from the group members benefits the patient. Pp. 10-11. This factor of universalisation or validation of the similarities of human existence is an important one in the final post-action sharing phase of a psychodrama.

23 Moreno, op. cit., p. 262.

24 Ibid., p. 261.

25 Martin R Haskell, The Psychodramatic Method, (Long Beach, California: The California Institute of Socio-analysis, 1967), p. 11.

26 The term irreality is used to denote enactments which are subjectively experienced as real although not happening in the real world. It might also denote elements of reality which go beyond the observable dimensions of human experience in the sense of Moreno's term surplus reality, or more than reality. Moreno uses the term irreality in Psychodrama, Vol. I, op. cit., p. 388.

27 Yalom describes how much energy may be invested by group members in the initial search for approval and acceptance. "To some, acceptance and approval appear so unlikely that they defensively reject or depreciate the group by silently derogating the other members and by reminding themselves that the group is an unreal artificial one, or that they are too special to care about a group membership which requires sacrificing even one particle of their prized individuality", op. cit., pp. 233-234. William Shutz refers to this initial concern of the individual members in the development of a group as a problem of inclusion, or commitment to the new group experience; that is, how much each member wants to be included and how much he wants to include others. This phase and a further one in which problems concerning control appear need to be worked through before a stage of affection may be reached. William Shutz, "F I R O. A 3-dimensional Theory of Interpersonal Orientation" reviewed in Tom Douglas, A Decade of Small Group Theory (1960-1970), (London: Bookstall Publications, 1970), Chapter 2, pp. 19-20.

28 Helen Northen, Social Work with Groups, (New York: Columbia University Press, 1969), p. 119.

29 Haskell, op. cit., p. 42. Carl Hollander extends the notion of the significance of the warm-up process further than the psychodrama session to encompass acts

of creativity and spontaneity in life in general. He states: "Without the necessary ingredients for spontaneity, creativity would be non-existent. The more complete the warming-up period, the greater propensity there is for creativity. Incomplete warm-up periods pre-dispose incomplete psychodramas and life-functions." In A Process for Psychodrama Training: The Hollander Psychodrama Curve, (Littleton, Colorado: The Evergreen Institute, 1969), pp. 3-4.

30 Moreno, op. cit., p. 52.

31 Ibid., p. 56.

32 J L Moreno, "Psychodrama and the Psychopathology of Interpersonal Relations", Psychodrama Monographs, No. 16, (Beacon, New York: Beacon House, 1945), p. 67.

33 Hollander refers to this as "the birth drama". A Process for Psychodrama Training, op. cit., p. 3.

34 Ibid., p. 2.

35 Hollander sees the triadic temporal-emotional processes as being "cyclic" as well as "dynamic" in the sense that each completed cycle acts as a springboard or preparation for the next. Ibid., p. 3.

36 Ibid., pp. 4-7.

37 The use of the spatial components of the stage has already been described in the previous section of this chapter outlining the basic elements of psychodrama.

38 Hollander, A Process . . ., op. cit., p.10.

39 J L Moreno, "Hypnodrama and Psychodrama", Psychodrama Monographs, No. 27, (Beacon, New York: Beacon House, 1950), p. 4.

40 Ibid., p. 9.

41 In psychoanalytic terms the process of abreaction is defined as "relieving a repressed emotion by talking about it." Webster's New World Dictionary of the American Language, 2nd College ed., (New York: The World Publishing Company, 1970), p. 4. Moreno writes that experience with the negative, unsteady and unsatisfactory effects of abreaction on its own led to Freud replacing pure abreaction in his clinical practise of psychoanalysis with the transference analysis. "Hypnodrama . . . ", op. cit., p. 9.

42 Blatner, op. cit., p. 1.

43 Walter Bromberg, "Acting and Acting Out", American Journal of Psychotherapy, XII, No. 2, 1958, p. 264.

44 Ibid.

45 Blatner, op. cit., p. 2. In this connection, Bromberg records a statement made by a schizophrenic patient who used a neologism which shed light on the inner psychic situation of acting out being investigated by Bromberg at the time. This patient declared "After all, you have to have outsight before insight." Bromberg, op. cit., p. 266.

46 Blatner, for example, points out that a "catharsis of rage is usually a catharsis of longing", op. cit., p. 68.

47 Karl Menninger, "Theory of Psychoanalytic Techniques", Menninger Clinic Monograph Series, No. 12, (New York: Science Editions, 1961), p. 104.

48 Kenneth Mark Colby, A Primer for Psychotherapists, (New York: The Ronald Press Company, 1951), p. 95.

49 Blatner, op. cit., p. 65.

50 Richard H Schreder, "Introduction to Psychodrama", an unpublished transcript of an educational videotape held by the Director of Media, Office of Medical Education, Maryland, United States, p. 28.

51 See Blatner, op. cit., pp. 64-65.

52 Moreno, "Hypnodrama . . . ", op. cit., p. 5.

53 Blatner, op. cit., pp. 63-64.

54 See, for example, Otto Fenichel, The Psychoanalytic Theory of Neurosis, (London: Routledge and Kegan Paul Limited, 1946). Anna Freud, The Ego and the Mechanisms of Defence, (London: Hogarth Press, 1937; reprint ed., International Psychoanalytic Library, 1966). Harvey J Widroe, Ego Psychology and Psychiatric Treatment Planning, (New York: Appleton-Century, 1968), pp. 43-63.

55 Moreno, Psychodrama, Vol. I, op. cit., p. 28.

56 J L Moreno, Psychodrama, Vol. II, in collaboration with Z T Moreno, (Beacon, New York: Beacon House, 1959), p. 108.

57 Ibid., p. 98.

58 Blatner, op. cit., p. 13.

59 Moreno, "Hypnodrama . . .", op. cit., p. 10. He goes on to say that "analysis might be given to the patient when necessary, but it is an adjunct to psychodrama and not the primary source of catharsis." Ibid.

60 Hollander, A Process for Psychodrama Training, op. cit., pp. 12-13.

61 J L Moreno, Psychodrama, Vol. III, in collaboration with Z T Moreno, (Beacon, New York: Beacon House, 1969), p. 234. A multiplicity of techniques is available for enabling the protagonist to try out and practise new, alternative and effective behaviours. Role training and behavioural practise fit neatly into a behaviouristic therapeutic model. Assertion training, or desensitization techniques are similar to the principles of "reciprocal inhibition" and "deconditioning" procedures; c.f. re-enactment of anxiety-laden situations within the supportive "fail-safe" context of psychodrama induces avoidance reactions; also step-by-step behavioural preparation for feared situations.

62 Moreno, Psychodrama, Vol. III, op. cit., p. 237. Hollander calls this final stage the Integration of the session. He sees it as including three steps, viz., audience disclosure of their identifications with the psychodrama enactment; group dialogue or interactive discussion amongst the group members; and summary. The summary may be given by the director, protagonist, or audience, and, if provided, helps to draw together or integrate the feelings, experiences and thoughts expressed into a congruous whole. A Process for Psychodrama Training, op. cit., pp. 15-16.

63 See, for example, Hannah B Weiner and James M Sacks, "Warm-up and Sum-up", Journal of Group Psychotherapy and Psychodrama, XXII, No. 1-2 (1969), pp. 99-102.

64 J L Moreno, Who Shall Survive?, 3rd ed., (Beacon, New York: Beacon House, 1978), p. 336.

65 Ledford J Bischof, Interpreting Personality Theories, 2nd ed., (New York: Harper International Edition, Harper & Row, 1970), p. 253.

66 J L Moreno, "The Creativity Theory of Personality: Spontaneity, Creativity and Human Potentialities", New York University Bulletin, Arts and Sciences, LXVI, No. 4, 1966, p. 20.

67 Ibid., p. 19.

68 The term cultural conserve comes from the Latin verb conservare, to keep.

69 Bischof, op. cit., p. 257.

70 Moreno, The Creativity Theory, op. cit., p. 20.

71 Bischof, op. cit., p. 251.

72 Rosalind F Dymond, "Personality and Empathy", Journal of Consulting Psychology, XIV, No. 3, (1950), p. 343.

73 Bischof, op. cit., p. 251.

74 Moreno, Psychodrama, Vol. I, op. cit., pp. 238-239.

75 Blatner, op. cit., p. 38.

76 Moreno, Psychodrama, Vol. I, op. cit., p. 239.

77 Bischof, op. cit., pp. 241-243.

78 Ibid., pp. 242-243.

79 See, for example, Zerka T Moreno, "The Double Situation in Psychodrama", Journal of Group Psychotherapy and Psychodrama, I, No. 4, (1947), pp. 436-446.

80 Gretel A Lentz, "Transference, Empathy and Tele, The Role of the Psychodramatist as compared with the Role of the Psychoanalyst", Journal of Group Psychotherapy and Psychodrama, XXIV, No. 34, (1971), p. 112.

81 Moreno, Psychodrama, Vol. II, op. cit., p. 5.

82 Leutz, op. cit., p. 115.

83 In connection with the advantage of psychodrama over psychoanalysis as regards transference, Leutz says: "The psychoanalyst has to struggle with transference phenomena in the 'real' patient-therapist situation; his way out is to steer away from a real person-to-person relationship in the therapeutic situation thus making it particularly unreal. The psychodramatist, by letting the patient play his conflicts, constructs the therapeutic situation semi-real to begin with. However, he does not end up in an entanglement of feelings which are invalid. After the patient's experience of past relationships on the stage, and simultaneous recognition of the transference phenomena, he is free to engage with him in a direct person-to-person relationship based upon adequate perception of their specific roles and psychic structures as well as on justified confidence in the reality of their relation." op. cit., pp. 115-116.

84 Moreno, "Hypnodrama . . . ", op. cit., p. 4.

85 Gordon W Allport, "Discussions of the First Lecture", in Moreno, Psychodrama, Vol. II, op. cit., p. 15.

86 Moreno, "Psychodrama and the Psychopathology . . . ", op. cit., p. 10.

87 James Vander May, "Social Atom Exercise", unpublished paper, mimeographed for teaching purposes, undated, p. 1.

88 Ibid., p. 2.

89 Moreno, Who Shall Survive?, op. cit., p. 689.

90 Ibid., pp. 75-76.

91 Moreno, Psychodrama, Vol. I, op. cit., p. 157. Ann E Hale classifies the Morenean postulate that the self emerges from the roles a person has, has had, or seeks, and the Morenean idea of personality functioning as follows: "As a person begins to relate to others the personality becomes defined; however, not only has each person in the relationship a personality, but the relationship itself produces its own reality; a meeting and merging of role perceptions and role expectations which result in actions ranging from submersion of the self, to the highest degree of freedom and creativity in relating. Moreno had found that two healthy people could produce an unhealthy relationship, and that two 'sick' people could produce a healthy relationship. In order to understand this phenomenon and to treat patients with personality or other mental disorders he began to explore the patient's relationships with significant others. His early research led him to develop a role theory of personality." In "The Role Diagram Expanded", Chapter V of Conducting Clinical Sociometric Explorations: A Manual for Sociometrists and Psychodramatists, currently in preparation for publication, (Beacon, New York: Beacon House).

92 See, for example, Moreno, Psychodrama, Vol. I, Ibid., pp. 58-62.

93 c.f. J L Moreno and Florence B Moreno, "Spontaneity Theory of Child Development", Sociometry, VII, No. 2, (1944), pp. 89-128.

94 Moreno, Psychodrama, Vol. I, op. cit., p. 354.

95 Ibid., p. 77.

96 Ibid., p. 174.

97 Ibid., pp. 354-355.

98 Alton Barbour, "Psychodramatic Role Theory", unpublished paper, 1975, p. 2. Mimeographed for teaching purposes at the Moreno Institute, Beacon, New York.

99 Ibid., p. 3.

100 Moreno, Psychodrama, Vol. III, op. cit., p. 270. Sociometry is essentially the objective measurement and diagrammatic representation of interpersonal interactions. Moreno gave the name socionomy to "the science of social laws" which was seen as comprising sociodynamics or "the science of the structure of social aggregates, of single groups and of group clusters"; sociometry or "the science of socius measurement"; and sociatry, "the science of social healing", in "The Sociometric System", Chapter 14, The Sociometry Reader, J L Moreno, ed., (Glencoe, Illinois: The Free Press, 1960), p. 127.

101 J L Moreno, "The Concept of the Here and Now, Hic et Nunc Small Groups and their Relation to Action Research", Journal of Group Psychotherapy and Psychodrama, XXII, No. 3-4, (1969), pp. 139-140.

102 J L Moreno, "The First Book on Group Psychotherapy 1932", with a Foreword by Walter Bromberg, 3rd ed., Psychodrama and Group Psychotherapy Monographs, No. 1, (Beacon, New York: Beacon House, 1957), p. 21.

103 Moreno, Psychodrama, Vol. I, op. cit., p. 29.

104 Ibid., p. xiv.

105 Ibid.

106 Ibid.

CHAPTER II

MAJOR DERIVATIVE FORMS AND BASIC PSYCHODRAMATIC TECHNIQUES

A. MAJOR DERIVATIVE FORMS OF PSYCHODRAMA

1 Sociodrama

Whereas psychodrama is individual-oriented, sociodrama is essentially group-centred. Instead of focusing upon the life situation of a particular protagonist, a sociodramatic enactment would explore a problem connected with his role, or his roles played in the drama, or it would focus upon the problems people have as members of a class, category, or social group.[1] The subject-matter is socio-cultural rather than psycho-social.

Moreno derives the term from twin roots -- "socius", meaning the associate or "other fellow", and "drama", meaning action. "Sociodrama would mean action in behalf of the other fellow."[2] Psychodrama is a "deep action method dealing with interpersonal relations and private ideologies", whereas sociodrama is defined as a deep action dealing with "inter-group relations and with collective ideologies."[3]

A sociodrama might involve the whole group present in the action, or a part of the group, with the audience deriving benefit from identifications with the players

portraying collective experiences.[4]

Sociodramatic enactments could employ any of the primary techniques used in psychodrama and comprise similar elements and format. The enactments are usually unrehearsed and spontaneous, although scripted sociodramas or prepared enactments to illustrate social themes might be employed in certain circumstances, e.g., to stimulate discussion. Because sociodrama deals with collective rather than personal elements of a role, it is an ideal modality to use in community contexts, inter-group relations, and educational, teaching, and training purposes -- also when private and personal material is not considered appropriate for exploration.

In terms of its relationship with psychodrama, a sociodrama might serve as a warm-up for a more individual-centred psychodrama. It could provide the impetus and point to a personal need which an individual member of the group might wish to explore. On the other hand, the subject-matter of a psychodrama might illustrate, or evoke the need for, a sociodramatic session involving all, or a number of the members of the group.[5]

2 Axiodrama

Axiodrama is Moreno's term for a derivative form of psychodrama which deals with spiritual and religious material. The subject-matter explored might comprise ethics, ultimate values, and issues such as life and death, prayer and meditation.

3 Role Playing

Role playing as a technique, aside from its appearance as a "natural" phenomenon in the process of socialisation and social interaction is a major derivative form of psychodrama with a by now institutionalised format and variety of uses. Although as a phenomenon and technique it is part of the systematised deeper psychodrama method, it stands on its own as a technique or methodological tool in education, training, and therapy. Its most frequently used definition is the "temporary stepping out of one's own present role to assume the role of another individual or of oneself at another time."[6]

The terms "role playing" and "psychodrama" are often incorrectly used as if they were interchangeable. This creates confusion about their accurate meanings and the distinctions between them. (Figure 6 gives an outline of their points of relationship, similarities, and differences.) Role playing and psychodrama are two distinctly different modalities. Indeed, psychodrama may be viewed as a method, whereas role playing is a technique. Role playing is generally oriented towards specific behavioural problems and is more superficial than psychodrama. It does not attempt to explore or solve in-depth psychosocial problems.[7] Psychodrama may encompass a broader range of problems than may role playing. Psychodrama may also direct its attention to personality change, as well as deeper emotional contexts, whereas role playing restricts itself to behaviour change. Role playing usually comprises the enactment of social or collective rather than individual, private, psychological roles. These latter

roles more often comprise the enactment material for psychodrama.

Unlike psychodrama, role playing does not require as much skill and training experience for its effective application. Its most usual goal is "the working out of alternative and more effective approaches to a general problem."[8]

The format most commonly used in role playing is one in which brief sketches, or unscripted scenes are enacted by a number of role players drawn from the group. This is followed by discussion. Repetition of the enactment, and further discussion of the behavioural approach or methods used in dealing with the problem situation might also be used. The role playing might be spontaneous, with role players and situations arising from the group warm-up as in psychodrama; however most often it is structured, with the situation to be enacted as well as the roles and players assigned by the group leader.[9]

Role playing enables participants to explore situations similar to those in real life and to try out different behaviours and new approaches to problem contexts. It is used to help provide behavioural practice, insight, and awareness in a "fail-safe" context and its value, as in other action modes, lies in its close-to-life and learning-doing nature. Role playing promotes group cohesion and solidarity; can often stimulate discussion; and may be used as a warm-up to a psychodrama session. The role playing sessions in contrast to the psychodrama in

this study employed mainly the structured style, with some use of psychodrama techniques such as role reversal, doubling, and "empty chair". Many of the sessions concentrated on behavioural and assertion training.

4 Role Training

Role training and role playing are closely related and at times equivalent. The term refers to that form of role playing in which skills, practice, and behaviour training predominate. Role training helps participants acquire and try out social skills and role behaviours; enables them to practise for anticipated future situations, e.g., rehearsing a job interview; and assists them in moving from one role to another, for example, making the transition from hospital patient to member of the community. Role training helps to increase the behavioural repertoire and range of response of the individual, thereby enhancing "ego"-functioning and self-concept, flexibility, and adaptiveness. Role training aims at helping individuals fulfil and play their life roles more adequately and satisfactorily.

Like role playing, role training is a flexible and adaptable technique. It also forms part of the action portion of a psychodrama session. Role training is particularly effective in professional skills training where practice in, say, interviewing, history-taking, or giving support is required.

PSYCHODRAMA	ROLE PLAYING
DIFFERENCES: (continued)	
Oriented towards redoing the past, or freeing persons from effects of previous traumatic situations, e.g., encourages active mastery of events previously passively responded to. May also deal with anticipated future	Oriented towards future situations, and rehearsal of specific behavioural responses or approaches to anticipated situations. Ordinarily not directed to the past
Oriented towards personality and relationships	Oriented towards specific behavioural problems. Concentrates on social skills, behavioural modification, practise, and training for social interaction
Deals with effect of past on present behaviour and psychodynamic picture. Deals with intra-psychic as well as interpersonal problems	Usually concentrates on interpersonal interactive situations, and not on intrapsychic material, e.g., working out of effective alternative behaviours
Deals directly with protagonist's personal life history and private problems. (Involves all levels of psychosomatic, psychological, psychodramatic, and social roles)	Usually focuses on aspects of the individual's social roles, rather than private psycho-social reality
Very direct method. May be exposing. Has built-in ways of dealing with exposure, and through warm-up and sharing diminishes any potentially threatening aspects	More indirect. May be less exposing. Initially less threatening in terms of individual's defenses
TRAINING:	
Intensive post-graduate training required for practise of method	Skill in using technique more easily acquired
More restricted in usage than role playing due to need for specialised training	Specialised training not required. May more easily be integrated into professional armamentarium; therefore more widely used

PSYCHODRAMA	ROLE PLAYING
TRAINING: (continued)	
Supervised practise of method essential. Self-knowledge and understanding also essential for user	Supervision in use of technique unnecessary although some exposure to it is advisable
RELATIONSHIP:	
Role playing techniques comprise part of the whole psychodrama method. Role training in particular is often specifically used in the final stages of psychodrama sessions	Psychodramatic elements are present to a greater or lesser extent in all role playing enactments
Techniques derived from the psychodrama method may be applied in role playing and role training situations	Historically, and in its format, role playing may be regarded as being a derivative of psychodrama
APPLICATIONS:	
Therapy (in terms of personality change), diagnosis, information, education, personal growth, and training situations in which personal self-disclosure is appropriate, and acknowledged to be of value	Therapy (in terms of behavioural change), diagnosis, observation, information, education, personal growth, industry and management training, and professional skills training in which personal self-disclosure is considered inappropriate and unnecessary

5 Remedial Drama

Drama as therapy employs the principles and methods of the field known as "Child Drama", "Developmental Drama", or "Creative Dramatics".[10] It is a form of therapeutic drama different from, although closely related to, psychodrama and especially to Moreno's early spontaneity theatre for children.

Unlike drama-as-theatre, creative drama uses improvisation, role playing, fantasy, games, dramatic expression and enactment, movement, dance and mime in facilitating personality development, sensitivity, self and other awareness, spontaneity, and creativity. There is no use of scripted plays or emphasis on "the voice beautiful" and "carriage proper". Although personal problems and personality differences emerge within this medium, they are not the focus. Unlike psychodrama, and role playing where the individual is consciously enacting personal problems or relating enactments to personal issues, creative drama is a more indirect "one-remove" projective medium.

Other active and expressive therapies such as music therapy, art therapy, movement and dance therapy are also related to the original work of Moreno. In America and Europe they are widely practised as adjunctive therapeutic methods and require specialised training for their professional application.

Creative drama, theatre games, music and movement, as well as role playing and sociodrama may all be used as warm-ups for psychodrama and later the action phase of a psychodrama where appropriate.

B. BASIC PSYCHODRAMA TECHNIQUES

In this section, the most frequently used psychodrama techniques other than the major derivative forms (role playing, role training, and sociodrama) will be described.[11]

1 Self-presentation

This technique may be used at the beginning of a series of group sessions or in a protagonist's first enactment. An individual, or each member of the group in turn, may be asked to talk about himself and tell the group what he considers to be important to him at the time. He might present himself in action, i.e. whilst moving around and enacting something; or perhaps give a non-verbal presentation of who he is or how he feels. He might set up empty chairs to represent people or objects and talk to or through them.

There are many ways of making self-presentation interesting, anxiety-reducing, and psychodramatic. The individual might present himself by describing an object in his home, e.g., "I am a painting on R's wall in his lounge. He bought me whilst he was still married and living in Paris . . . " Or he or she might "become" an animal, e.g., "I am S's cat. She has forgotten to feed me lately. I think there is something on her mind . . . "

The technique may be varied to suit the nature and composition of the group. For example, an active self-presentation might be difficult for members new to psychodrama to do, or for withdrawn, depressed, or uncommunicative patients. On the other hand, a non-verbal method might prove comfortable for them and informative to members. A group of alcoholic patients might prefer a more familiar verbal mode which is non-threatening to its members. An active mode might be useful with children or young people.

The technique helps to identify presenting problems and illuminate the self-perception of patients and their problems. It also expands the group members' own understanding of their peers.

A useful variation of this technique is for the individual to present himself in the role of a significant other.[12] Very often this is easier for certain protagonists than presenting themselves in their own roles. It provides information as to who is emotionally meaningful for the protagonist and often how that person perceives the protagonist -- or how the protagonist perceives that person's perception of him. This method helps the protagonist to present personal material in a non-threatening way and provides an opportunity for him to experience staying in another person's role.

2 Role Reversal

Role reversal is a primary psychodramatic technique, and, as has been discussed in Chapter I, also a fundamental theoretical principle of Moreno's method. Its major philosophical premise underscores its value in increasing empathetic awareness of the other and enhancing sensitivity to the self and interpersonal relationships. As a technique, role reversal provides as concrete a way as possible of actualising the metaphorical process of "putting oneself into the shoes" or situation of another.

In the technique of role reversal, an individual in an interpersonal situation exchanges parts and physical positions with the other involved. Thus A would take the

role of B and vice versa. Any distortions or perception of "the other" in interaction may thus be "brought to the surface, explored and corrected in action."[13]

Role reversal may be used in the beginning of a psychodrama enactment for warm-up purposes or to obtain information required by the auxiliary. It is most frequently used for therapeutic change as an integrative technique after the affective climax or actorial catharsis has been reached. (A rejected daughter would be unable to profit from the full value of the technique until she has expressed her anger at the rejecting parent and articulated her longing for love. Only then would she be in a position to role reverse, and from the reversed position possibly understand the causes of her parent's behaviour.)

Moreno writes:

> The patient has "taken unto himself" with greater or lesser success, those persons, situations, experiences and perceptions from which he is now suffering. In order to overcome the distortions and manifestations of imbalance, he has to re-integrate them on a new level. Role reversal is one of the methods par excellence in achieving this, so that he can re-integrate, re-digest and grow beyond those experiences which are of negative impact, free himself and become spontaneous along positive lines.[14]

3 Soliloquy

Soliloquy is the name given to a psychodramatic technique in format similar to the confidential "asides" of Shakespearian actors to the audience. In content, however, it is unscripted and spontaneous.

Soliloquy comprises the protagonist's talking out loud or verbalising his thoughts or feelings. It helps him

to explore and clarify feelings and might relieve emotional "blocking" of content and help his warm-up to a scene or enactment.

The technique may be used at the beginning of a psychodrama during the protagonist's warm-up or during the action as a monologue in situ.[15] The protagonist might be asked to soliloquise whilst walking on the lowest level of the therapeutic stage, or the perimeter of an action area. In this way he prepares for his lead-in to a scene and the technique provides a way of externalising his inner thoughts and feelings while he, for example, might be driving to an important interview or walking home from work.

When soliloquy is used within the ongoing interaction during a scene the director usually instructs the protagonist (and/or auxiliary) to turn his head to one side whenever expressing what he is thinking or feeling but not saying to the other. This convention is helpful in indicating when he is soliloquising as well as revealing his internal process to director, auxiliaries and audience, and sometimes to himself. In a variation of soliloquy, both parties in a relationship soliloquise during a scene. The concurrent expression of covert and overt dialogue, thoughts, and feelings is helpful in marital and couple psychodramas. Gaps, distances, and differences in perception of events, intentions, and the reality of what actually happened in interaction are brought to the fore and illuminated.[16]

The director might ask the protagonist to soliloquise aloud whilst playing the other in role reversal. This is helpful in expanding the protagonist's perception and understanding of the other.

Another use of the technique is for the protagonist to soliloquise after an enactment to give an idea of how he felt during a particular scene and to provide the opportunity for him to reflect upon his feelings during the experience. In directorial training the student director might be asked by his supervisor to provide his soliloquy during a session to illuminate his rationale for introducing a particular intervention.

An auxiliary functioning as what is known as a "double" might also be sent in to the action to facilitate the protagonist's own soliloquy and help him explore and express his feelings during an enactment.

4 The Double

Doubling is a psychodramatic depth technique which helps not only to facilitate a protagonist's expression of feeling, but also to intensify his involvement in a scene.

In essence, the function of the double is to represent the protagonist's "inner self" in helping him to explore internal conflicts and to express what he might be thinking or feeling, but not saying. The auxiliary ego playing the double places himself behind and slightly to the side of the protagonist. (Approximately a 30^{o} angle is the most efficient position.) In this way he can observe clues from the protagonist yet remain unobtrusive.

He can be close enough for the protagonist to experience him as his shadow, to feel his support and interdependence, and for tele to develop between them. (For a description of tele, see previous chapter. Tele refers to a reciprocal flow of feeling between two people, and is defined by Moreno as "two-way empathy", or "the simplest unit of feeling transmitted from one individual towards another.")[17]

The double duplicates the actions of the protagonist, "mirroring" him by adopting his physical stance and posture, and similar facial expression, vocal tones and pitch, gestures and non-verbal movements. This convention enables the double to move empathetically into the subjective experiential and feeling world of the protagonist and thereby help him to reach deeper levels of expression. The double speaks, as the subject, in the first person, i.e. "I think", "I feel", "we should". The double represents the " . . . invisible 'I', the alter ego with whom (the protagonist) talks at times but who exists only within himself."[18]

Blatner feels that because the expression of the protagonist's deepest emotions is one of the major values and purposes of psychodrama, and because the double technique is effective in bringing out emotions, it may well be referred to as "the heart of psychodrama."[19]

He distinguishes three general purposes of the double in a psychodrama, i.e. stimulating, supportive, and clarifying and interpretive functions.[20] The double serves in several ways:

(a) He stimulates interaction by facilitating the portrayal of the protagonist's psychological experience to its fullest range

Some methods for achieving this consist of the double emphasising or "amplifying" statements made by the protagonist; dramatising the emotional content of an attitude or communication; ventilating affects which the protagonist indicates verbally, or verbalising and/or dramatising observable non-verbal communications made by the protagonist.

(b) He provides support for the protagonist in order to enable him to take more risks in exploring his internal dynamics and feelings, and in entering the enacted interaction on stage as fully and completely as possible

A supportive double might be assigned to a protagonist with whom the latter may interact and discuss feelings and reactions emergent during the psychodramatic action. The presence of a double, even if relatively silent and non-verbal, is helpful in allaying feelings of isolation and vulnerability where the protagonist is exploring particularly painful or distressing episodes

(c) He acts as a vehicle for giving suggestions and interpretations of events and feelings. As double, he might also suggest alternative behaviours and ways of handling situations. This process is most productively achieved if a positive tele has been set in motion between the double and his subject [21]

It is important that the director establish a norm within which the protagonist, or subject, is free to disagree with, modify, or expand upon statements made by the double.[22] It might be precisely within the process of disagreeing with the double that the protagonist makes a significant connection with his own feelings, or has a "flash" of insight into his behaviour

The director has the choice of using either of two conventions in terms of the subject's and auxiliaries' responses to statements or actions produced by the double. In the first, only the subject may use and respond to any statement made by the double. This is regarded as a private communication to him alone. Should it require a response from other participants in the drama, the protagonist must repeat it. In the second variant, the statements

of the double are taken as an open communication for all, and are considered as a valid expression of the protagonist's feelings, unless specifically contradicted by him.

Blatner[23] points out that the former convention, in which the protagonist repeats statements made by the double, reinforces the necessity for the former to take responsibility for what transpires during the action. He feels this is indicated for use with the more passive protagonist. The second convention, in which the other participants may take up and respond to whatever the double says, has the advantage of speeding up the interaction.

The double is most effective when portrayed by a trained auxiliary ego. However, very often the sensitive member of the group who is empathetic to the situation of the protagonist or who can establish a productive and mutual flow of tele with him may be every bit as effective. The process is more often than not helpful for the group member who is doubling in that the process itself may contribute towards strengthening a capacity for empathy, and reinforcing a sense of altruism and self-worth in having been of help to another group member.

Where no trained auxiliary is available, it is helpful to employ a technique one may refer to as <u>spontaneous doubling</u>. Instead of assigning a particular double from the audience, or having the protagonist choose one, spontaneous entry of members of the audience into the action on the stage when they feel moved to do so is permitted.

The use of this method should depend upon the purpose,

nature, and composition of the group. Advantages of this method are that it allows members new to psychodrama to become acquainted with the doubling technique and to mobilise their participation; it also helps the director to discern warm-ups, identifications, and projections of the group members. Disadvantages are that a measure of control over auxiliaries is lost and that these warm-ups, identifications, and projections might in fact interfere with the process for the protagonist.

Spontaneous doubling is not usually employed in strictly classical psychodrama. Doubles are chosen either by the protagonist or the director. It is felt that, to be effective, the double needs time to warm up to his or her subject and for a telic sensitivity and mutuality to be built up. It is felt that the perception or view of the action from the audience situation is a different one from that on the stage; that the motivation which impels an audience member to double might stem from a different kind of insight and experience than that which is built up on the stage, and might be counter-productive. However, it is acknowledged that the audience member or spectator might see or "pick up" something in the ongoing action missed by the director or auxiliaries and, if allowed to, might indeed be a productive and effective double. A one-way empathetic insight experienced by a spectator can easily transform itself into a telic rapport.

In training centres and psychodrama institutes in North America where the classical Moreno tradition is followed, directors may encourage audience members to

indicate their desire to double by raising a hand. In this manner it is felt they can exert control over the entry of a double into the action, and have the final authority to accept or refuse the offer of a voluntary double depending upon their assessment of the dynamics of the action on the stage and any planned dramatic line of production.

Should a double not prove able to establish any empathetic communication or discover negative or neutral tele with the subject, he can ask to remove himself from the action, or the director or the protagonist can ask him to leave the stage and be replaced. Such an event is pursued in ensuing group discussions or "processing" of the session.

In the multiple double technique, several auxiliaries may serve as doubles for the protagonist. This variation of the technique lends itself to many uses. For example, each double might represent the subject at different periods of his life; in a sociodramatic enactment or when issues and themes are being explored which affect a number of group members the technique is also useful. It is useful too in exploring or clarifying ambivalent or positive and negative feelings experienced in regard to a relationship or concern, and in making decisions.

In the divided double format, each auxiliary plays one part of the protagonist's psyche, or self.

5 The Mirror

In the mirror technique, an auxiliary ego presents

the behaviour of the protagonist, who steps out of the scene to observe. In this way he is able to see how he appears to others, reflected in the mirror of the perceptions of the group members.

Should the protagonist object to the representation of himself, group consensus may be sought as to whether the "mirror" was accurate in his portrayal of the subject. Another group member or auxiliary might more accurately duplicate his verbal and non-verbal behaviour.

The mirror technique is useful in demonstrating how individuals come across to others; in self-confrontation and producing self-awareness. A "mirror" who focuses on the non-verbal concomitants of a message given by the protagonist might give him a valuable insight into why he provokes certain reactions in others through his communications. The mirror technique might be used to dramatise that <u>what is said</u> in an interaction, viz., the <u>content</u>, is often less important as a stimulus than <u>how it is said</u>, viz., the <u>manner</u>, style or process of the communication.[24]

The mirror technique may be used in rather a behaviourist aversive technique in place of videotape feedback in showing patients in drug or alcohol treatment centres what their behaviour was like on admittance, when under toxic influence. It may also be used with schizophrenic or very withdrawn patients.[25]

Haskell describes how a non-communicating individual may be stimulated or provoked to communicate by use of the mirror technique.[26] The auxiliary ego, having carefully

observed the subject's behaviour, portrays him on the stage in his presence and that of the group members. As soon as the subject indicates his awareness of being mirrored, perhaps by his reaction of amusement, or a verbal comment, the auxiliary begins to misrepresent him in an exaggerated and provocative manner. This usually arouses the subject to protest and thereby begin his communication with the director and the group.

In the integrative phase of a psychodrama enactment, when role playing and behavioural practice for future situations are being used, members of the group or auxiliary egos who have been playing parts may demonstrate their solution or mode of approach to a particular problem or situation. The protagonist could himself then mirror, or try out one or more of the demonstrated alternative methods of action.

Playing a mirror role might be helpful for the group member as well as the protagonist in that it helps to sharpen observational and empathic skills. Mirroring is part of the doubling technique, and simultaneous mirroring is a useful task for an auxiliary-in-training as a preparation for learning how to double.

6 Future Projections

An entire psychodrama might be set in the projected future; or parts of the action, and most frequently the final scene of a drama, might deal with an anticipated future time or situation. Situations suitable for future projection can range from complex affect-laden interpersonal

relationships through rehearsing for a job interview to practising specific behavioural skills.

The technique may be employed to clarify and give the protagonist insight into his goals and objectives in the situation. It might help him to understand and identify feelings and to bring out dimensions of the situation of which he would otherwise have remained unaware. This technique used in conjunction with others such as double and auxiliary chair is also helpful in decision-making.

The technique is useful diagnostically. It helps to give an idea of how the protagonist views the future and may be used in assessing his prognosis, both by himself and director-therapist. A future-projection enactment might influence the content and direction of future psychodrama explorations and/or the course of individual therapy.[27]

Yablonsky[28] emphasises that the future situation used in this technique should be one in which the protagonist actually expects to participate. In addition, he points out that the effectiveness of the situation depends on its significance and meaning for the protagonist as well as the extent to which the director and supporting auxiliaries can project him into the future. He feels that an intense warm-up is most effective for the use of this technique, and further, that the psychodramatic action will influence the subject's behaviour in the "real-life" situation.

The practising of new behaviours which is possible within the context of a future projection helps to deal

with fears and anxieties concerning an important anticipated life situation. The rehearsal for it, and insights gained, prepare the protagonist for the most positive and effective presentation of himself when the real-life situation arises. "He will know the life situation better as he has 'been there' before psychodramatically."[29]

7 The Auxiliary Chair

In this technique, an empty chair is used to represent a significant other whom the protagonist addresses as though present. Parts of the self, values, or abstract symbols may also be "placed" in the chair or chairs during an exploration.

The technique was originally created by Lippitt during her work with disturbed children.[30] She found that some particularly sensitive children were unable to respond objectively to live auxiliary egos. Their presence appeared either to augment or inhibit the children's aggression. The use of an empty chair proved valuable as a projective device, and freed the protagonist from being influenced by the auxiliary. The use of the auxiliary chair has been widely applied since then either on its own during an enactment, or in combination with one or more of the primary psychodramatic techniques such as role reversal, soliloquy and double.

The technique may be used both as a warm-up and a closure technique. Blatner[31] describes an application of the method in selecting a protagonist for a particular session. An empty chair is placed in front of the group

and the director asks the members to visualise someone important to them sitting in the chair. When the image is clear in terms of what this person is doing, wearing, and so on, the member raises a finger. Once most members have indicated seeing someone, the director asks who this is. When someone responds, he may be asked to sit in the chair and "be" that person, or he may be asked what he has to say to whomsoever he sees in the chair. This may lead to an interchange and further enactment, for one or more members, or move straight into a psychodrama.

As a closure technique, the auxiliary chair is useful if many audience members have identified with the protagonist's theme or problem. For example, every member in turn can come up and address the protagonist's significant other in the chair; or place their own equivalent person evoked for them during the drama in the chair.[32]

The auxiliary chair may be substituted for an auxiliary, or used when a protagonist has difficulty in relating to a significant other during a scene. It is also effectively used during a monodrama or psychodrama à deux,[32] when no group is present, as for example during individual, one-to-one therapy. Two empty chairs might be employed; the protagonist playing himself when seated in one, and moving over to the second when playing the role of the significant other. Both within a group and in an individual setting the use of the auxiliary chair or chairs is helpful in facilitating and externalising the protagonist's exploration of himself, different roles, relationships, or the implications of significant life

decisions.

A useful approach is to employ a number of auxiliary chairs to represent the persons in a protagonist's social atom. An exploration of this nature, using role reversal and soliloquy, is often helpful during the course of a session, but also as a warm-up to and guide for psychodramatic exploration. This technique of social atom with empty chairs may provide valuable insights both for the protagonist and the director.[34]

8 Sculpturing or Action Sociogram

Sculpturing is a technique related to the auxiliary chair in that persons, or live but silent auxiliary egos, are used to represent persons, qualities, or values.

The protagonist "sculpts" or arranges auxiliary egos in symbolic or characteristic poses, stances, heights, or distances which represent their essential meaning to, or relationship with him, in terms of his personal perception and experience.

The protagonist might step out of the scene, substituting an auxiliary for himself should he be included; or he might stand on a table or move up to the balcony in a psychodrama theatre in order to observe and reflect upon his sculpture. The protagonist could give each auxiliary a characteristic line of dialogue to say and start interacting with them as they "come to life".

This technique is most helpful diagnostically in concretising and vivifying information and interpersonal

dynamics. It is therapeutic as well as diagnostic and provides valuable insights for the protagonist during the process of sculpturing as well as when observing the completed sculpture. It is particularly useful in family therapy contexts and in psychodrama training. It may also be used to facilitate the exploration and understanding of intra-group communication and is helpful in sociodramatic enactments.

In group-centred explorations in the variant described and named by Seabourne[35] the group action sociogram is a dramatised, active version of Moreno's sociometric device known as a sociogram (a paper and pencil depiction of group relationships). In this technique group members explore their perceptions of and feelings about each other through sculpting or indicating choices or distances.

9 Dream Technique

In psychodramatic dream enactment, the protagonist reenacts a dream rather than talking about it.

He is warmed-up to the sleep situation by reconstructing his activities prior to sleep and thereafter taking his place in a simulated bed. He closes his eyes and is encouraged to think about the dream. Once he has reconstructed it, he rises from the bed and represents the dream, or significant portions of it, in action. Auxiliary egos are chosen to play the various characters and symbols of the dream.

A unique feature of psychodrama dream therapy is that

the protagonist is given the opportunity to change or re-direct the course of the dream. The director does not analyse or offer any interpretations of the dream material; it is usually left to the protagonist to make his own connections and draw insights from the re-enactment and active experiencing of the dream.

10 Symbolic Realisation

In this technique, the enactment of symbolic processes using soliloquy, double, reversal, or mirror helps towards their clarification for the protagonist.

11 Concretisation

This is a technique in which feelings which might be metaphorically expressed are actualised concretely. It provides a visual and actual depiction of feelings and relationship situations. This in turn aids clarification. It also helps to re-evoke previous feeling states and emotional memories.

12 Maximising

This is the use, usually by auxiliaries or double, but also by the subject, of the principle of exaggerating, increasing, or "maximising" the emotional content of a communication or attitude.

13 Physicalising

This technique comprises the non-verbal dramatisation of words and gestures to aid clarification and expression of feelings.

14 The Magic Shop

This technique may be used with a specific protagonist during a psychodrama as his individual warm-up to the action; or it could be used to select a protagonist, or as a total group warm-up. It is an improvisational fantasy technique which is assessed as being valuable in helping individuals to define their hierarchy of values and goals and to provide insight into their behaviour and the consequences of certain courses of action. As with all the other techniques, it also has a simultaneous diagnostic value.

An imaginary "shop" is set up on the stage or action area and the director or a group member plays the role of shopkeeper. The "shelves" are "stocked" with imaginary, abstract or non-material items such as hopes, dreams, ambitions, ideas, and values. A specific protagonist or group member strongly motivated to obtain a desired item, enters the shop and bargains with the shopkeeper. First of all, the shopkeeper, using the appropriate sales idiom, clarifies specifically what it is the protagonist wants. Then the price is negotiated. No item may be sold for money, only bartered in exchange for other values or valued non-physical aspects of the customer's life. These he surrenders as the price for the desired quality. It is in the bartering process that the protagonist and/or group members have the opportunity to evaluate the price they are willing to pay for that which they want. In exploring what they are willing to relinquish in exchange for what they desire, significant diagnostic material and insightful gains are often obtained.

The technique may be expanded and continued into action once a preliminary bargain has been struck. For example, the protagonist could participate in a scene trying out his newly-acquired quality, or may see how he does without that which he has surrendered.[36]

15 Reformed Auxiliary Technique

A technique often introduced as closure to an enactment is known as the "reformed auxiliary". The technique gives the protagonist a psychodramatic opportunity to experience what he did not have in life. Thus, for example, instead of a harsh, rejecting parent, a new auxiliary plays the role of an accepting, communicative, and understanding one in the way the protagonist would have wished his parent to be -- a fulfilment of desire in a controlled setting invoking surplus reality. (By surplus reality Moreno meant fantasy, or a "new and more extensive experience of reality."[37]) The same auxiliary could, in certain indicated circumstances, play both roles, viz., the real parent and the reformed one, or an auxiliary could be sent in to function as the ideal parent.

For all three variations of this technique, the director follows certain indications and counter-indications in introducing their use. For example, should the experience of reality have been particularly harsh for the protagonist, it would be advisable to have an auxiliary other than the one who portrayed the negative person. Where the protagonist experiences strong ambivalence in regard to the significant person, it might be considered advisable to use the same auxiliary in both roles so that the protagonist

may find some sense of integration with the other. In this way a resolution of the past may evolve in the form of acceptance of what has been and cannot be changed.

Role reversal with the reformed auxiliary or ideal also helps resolution and acceptance. However, with a depressed patient, once cathartic anger has been released, it is often inadvisable to use role reversal with the other. Since depression is often the result of internalised anger, one avoids placing a depressed protagonist in the role of the oppressor. The painful relationship may not be able to be fully encountered until the self-concept is strengthened. A technique such as future projection might be more effectively used -- moving into a future positive scene to help connect the individual to something beyond himself.

16 Monodrama

In monodrama the protagonist plays all the parts in an action exploration himself, with or without auxiliary chairs.

17 Psychodrama à Deux

This term is Moreno's name for psychodramatic enactments in dyads.[38] Two persons with experience of psychodrama might use the technique for self-exploration; or it might be employed within a training setting. More usually the term is used to refer to psychodramatic enactments with the director and subject alone, not involving any auxiliaries, group members or the use of the stage. The

classic format of warm-up, action, and discussion is usually followed.

18 Warm-up Techniques

Besides self-presentation, the magic shop, and auxiliary chair, there are a large number of warm-up techniques which may be used at the beginning of a session. These are guided interaction "starters" which help to warm members up to specific themes, facilitate interaction, relax them, put them at ease, lower anxiety and release spontaneity.[39] For example, as an introductory exercise, the director may ask each member of a group new to each other to find a partner and get to know him. After a few minutes the members return and introduce their partners to the group.[40] Another technique is for the group seated in a circle to share something about themselves and perhaps state how they are feeling in a sentence or one word.[41]

Non-verbal exercises, body movement, dance, games, creative drama, role playing, and sociodrama may all be used as warm-up techniques for a psychodrama session.

NOTES

on Chapter II

1 Martin R Haskell, An Introduction to Socioanalysis, (Long Beach, California: The California Institute of Socioanalysis, 1967), p. 14.

2 J L Moreno, Psychodrama, Vol. I, 4th ed., (Beacon, New York: Beacon House, 1972), p. 352.

3 Ibid.

4 c.f. Ibid., pp. 363-366.

5 For example, a psychodrama dealing with an individual's unpleasant experience in a hospital might spark off a strong sense of social outrage amongst members of the audience, and "warm" them up as a group to personal identification of their own which they feel they would like to explore and express collectively in action.

6 Rosemary Lippitt and Anne Hubbell, "Role Playing for Personnel and Guidance Workers: Review of the Literature with Suggestions for Application", Journal of Group Psychotherapy and Psychodrama, IV, No. 2, (1956), p. 89.

7 Fig. 6 presents a comparison of role playing and psychodrama. (It is obvious that there are always psychodramatic elements in role playing and vice versa.)

8 Howard A Blatner, Acting-In: Practical Applications of Psychodramatic Methods, (New York: Springer Publishing Co., 1973), p. 10.

9 Appendix 10 gives illustrative examples of the type of role playing used in the William Slater Hospital, and in this study.

10 c.f. Richard Courtney, Play, Drama and Thought, 3rd ed., (London: Casselly, 1924); Sue Jennings, Remedial Drama, (London: Pitman's Publishing Co., 1973); Peter Slade, Child Drama, with a Foreword by Dame Sybil Thorndike, (London: University Press, 1954); Brian Way, Development Through Drama, (London: Longman, 1967).

11 Martin R Haskell states that, according to reliable estimates at the time he was writing, over 200 psychodramatic techniques were in use which had been developed by Dr J L Moreno, Z T Moreno, members of the staff of the Moreno Institute and other psychodrama practitioners. The Psychodramatic Method, (Long Beach, California: The California Institute of Socioanalysis, 1967), p. 86.

12 Ann E Hale, "The Use of the Significant Other as a Self-Presentation Exercise". Unpublished paper, mimeographed and distributed for teaching purposes by the Moreno Institute, Beacon, New York, (1971), p. 1. This technique of interviewing the protagonist in the role of "the other" was used during my own study at the William Slater Hospital. The impression gained was that it appeared useful in terms of warming the patient up for action; helping to give information to the auxiliary; and providing the candidate with psychodynamic material and diagnostic clues. It seemed also to serve as a form of role reversal for the protagonist in which he could view himself early on in the drama from the point of view of the antagonist.

13 Zerka T Moreno, "A Survey of Psychodramatic Techniques", Psychodrama and Group Psychotherapy Monographs, No. 44, (Beacon, New York: Beacon House, 1969), p. 6.

14 J L Moreno, Psychodrama, Vol. III, in collaboration with Zerka T Moreno, (Beacon, New York: Beacon House, 1969), p. 238.

15 Zerka T Moreno, op. cit., p. 1.

16 Ibid. Zerka T Moreno calls this portrayal of side-dialogues and side-actions the therapeutic soliloquy technique, as distinct from the soliloquy technique, although both serve therapeutic ends.

17 J L Moreno, Who Shall Survive?, (Beacon, New York: Beacon House, 1978), p. 314.

18 Zerka Toeman (Moreno), "The 'Double Situation' in Psychodrama", Journal of Group Psychotherapy and Psychodrama, I, No. 4, (1947), p. 436.

19 Blatner, op. cit., p. 24.

20 Ibid.

21 Zerka Toeman (Moreno), "The 'Double Situation' . . . " op. cit., describes the subtle interweaving of feelings and the development of mutual and reciprocal tele during a session in which she herself "doubled" for the protagonist. Initially the subject, or protagonist, afraid of what she might reveal, was resistant to the double. After a while, responding to the accuracy of the double's empathic statements, the subject began to warm-up to and accept the double as part of herself. Within their subsequent communication, the empathy displayed by the double stimulated a counter-empathy, or mutual tele-phenomenon which intensified and grew, and eventually flowed freely backwards and forwards in what seemed to be a most therapeutic manner. Moreno writes "the subject stimulates the double to an idea or action, . . . in reverse, the double stimulates the subject to an idea

or action. The closer the double gets to the subject, the more the subject warms up and reveals further experiences. The most intimate personal experiences of the subject's are thus highly intensified.", p. 442. She further points out that it is not necessary for the double to be of the same sex as the protagonist. "Double situations with mixed sexes have been produced effectively and with the subject losing the sense of the presence of a member of the opposite sex and fully accepting the double in terms of a representation of him- or herself.", p. 443.

22 Blatner, op. cit., p. 24.

23 Ibid., p. 26.

24 Ibid., p. 60.

25 See, for example, Zerka T Moreno, "A Survey . . . ", op. cit. She states that the mirror may be used "when the patient is unable to represent himself in word and action as, for instance, in catatonia, or after psychotic episodes or shock therapy which produced residual or pseudo-amnestic states.", p. 5.

26 Haskell, The Psychodramatic Method, op. cit., p. 90.

27 Ibid., p. 92.

28 Lewis Yablonsky, "Future-Projection-Technique", Journal of Group Psychotherapy and Psychodrama, VII, No. 3-4, (1954), p. 305.

29 Ibid.

30 Rosemary Lippitt, "The Auxiliary Chair Technique", Journal of Group Psychotherapy and Psychodrama, XI, No. 1, (1958), pp. 8-23.

31 Blatner, op. cit., p. 45.

32 Tom Speros calls this technique "The Final Empty Chair", personal communication.

33 J L Moreno, Psychodrama, Vol. II, in collaboration with Z T Moreno, (Beacon, New York: Beacon House, 1959), p. 232. See also, for example, Haskell, The Psychodramatic Method, op. cit., pp. 96-103.

34 Shirlee Gomer, personal communication.

35 Barbara Seabourne, "The Action Sociogram", Journal of Group Psychotherapy and Psychodrama, XVI, No. 3, (1963), pp. 145-155.

36 Blatner, op. cit., p. 41.

37 Ibid., pp. 124-125. Also see Note 38, infra.

38 Moreno, Who Shall Survive?, op. cit., p. 85. To

Moreno, infrareality, or a situation of reduced reality, exists in a situation such as a psychoanalysist's office, where ideas, rather than actualised behaviour, are discussed; and where the doctor-patient situation is "not a genuine dialogue, but is more of an interview, a research situation, or a projection test." Actual reality, Moreno describes as the reality of everyday life and interactions, whereas surplus reality represents "the intangible dimensions of intrapsychic and extrapsychic life, the invisible dimensions in the reality of living that are not fully experienced or expressed." J L Moreno, Chapter 9, in Harold I Kaplan and Benjamin J Sadock, Eds., Comprehensive Group Psychotherapy, (Baltimore: The Williams and Williams Company, 1971), p. 463. (For other descriptions of surplus reality see also Chapter I of this study.)

39 c.f. Hannah Weiner and James M Sacks. These authors present a variety of warm-up techniques as well as techniques which serve to "sum-up", or condense the essence of the session's experience and also provide a sense of closure for the group members. "Warm-up and Sum-up", Journal of Group Psychotherapy and Psychodrama, XXII, No. 1-2, (1969), pp. 99-102.

40 Blatner, op. cit., pp. 38-39.

41 Weiner and Sacks, op. cit., pp. 88-89.

CHAPTER III

HISTORY AND TRAINING

A. HISTORICAL BACKGROUND TO PSYCHODRAMA

Although the roots of psychodrama may be traced back to the earliest forms of dramatic expression and to catharsis through movement and ritual, the history of classical psychodrama as a systematic method of therapy is essentially linked with the biographical history of its originator, Dr J L Moreno.

Moreno was born in Bucharest, Rumania, on 19 May 1892 and died at the age of 81 years at Beacon, New York, on 14 May 1974. In his life-time he had made numerous significant and pioneering contributions to the fields of psychiatry, psychotherapy, philosophy, sociology, and the modern "human potential" movement.

When Moreno was five years old, his family moved to Vienna, Austria. He relates a playful anecdote of childhood which reflects his active imagination and hints at the future directions his life was to take:

> The sources of psychodrama are to be found in my childhood games and youthful experiences. One Sunday afternoon, while my parents were out, it so happened that I and some of our neighbours' children decided to play at "God" in the enormous cellar of the house in which I lived. The first thing was to build our Heaven. To this end, we collected every available chair and piled them up on an enormous oak table until they reached to the ceiling. I now mounted my

> heavenly throne -- mine "The kingdom, the power and the glory" -- while my angels "flew" round me singing. Suddenly one of the children called out: "Why don't you fly too?" Whereupon I stretched out my arms and . . . one second later lay on the floor with a broken arm. So ended my first psychodrama, in which I had filled the dual role of producer and chief actor.[1]

Originally a student of philosophy, and later a faculty member at the University of Vienna (1910-1912), Moreno went on to study medicine and psychiatry. He was interested in theology and religion, and the well-springs of his thought and ideas about spontaneity and creativity are embedded in cosmological, interpersonal, and existential themes.

In 1911 he observed and started to catalyse the play of children on an informal basis in the Meadow Gardens of Vienna. This preliminary experience provided many of the insights and principles upon which his later method of psychodrama was to be based. It also marks one of the origins of creative child and improvisational drama. Moreno would gather children around him and relate stories and folk-tales. He noted how the children would spontaneously enact the stories and myths, and how personal themes and feelings were expressed through their improvisatory role playing. He observed the social interaction and groupings which were facilitated and saw acts of hostility and aggression diminish over a period of time. Initially starting with known stories and scripted plays, they went on to enact spontaneous plays based on material provided by the children themselves. Moreno introduced educational topics too. For example, a "lesson" on trees

was followed by the children "becoming" various types of trees and observing them at first hand in the Gardens. This marks an early example of drama-in-education, and learning-by-doing and participant experience rather than passive listening.

Later on, in 1921, Moreno staged the first psychodrama at the Komoedianhaus, Vienna. The following year he founded his Theatre of Spontaneity (Das Stegreiftheater, 1921-1923). Originally employing professional actors and then untrained participants, Moreno adopted some of the formal structures and conventions of theatre and married them to his own burgeoning ideas of therapeutic principles and spontaneity-creativity. He used no scripts and only a minimum of "props". He would appear on stage and "warm" his audience up to a theme by discussing selected items of current news. This technique he called The Living Newspaper (Die Lebendige Zeitung). At first actors, then subsequently members of the audience, would enact news items, and a post-enactment discussion would ensue. Moreno observed how topic choice as well as the manner in which parts were played seemed to be affected by personal problems. Perceptions of events seemed also to be distorted by the role player's own needs and experiences. During this experience he found that the enactments and subsequent discussions resulted in catharsis or relief from personal anxieties and stresses for both the actors and the audience. He continued to use similar formats to deal with community, national, and international news events, as well as individual, marital, and small group problems.

This practical development of the psychodramatic method followed, and was based upon his early work in the fields of literature, philosophy, religion, group therapy, and sociometry. In his twenties, during the years 1914 to 1921, Moreno wrote poetry and was productive in literary and creative activities.[2] He edited a literary journal, Daimon, whose contributors included Franz Kafka, Max Scheler, and Martin Buber.[3] Moreno's writings at the time expounded upon key ideas of his, such as the concept of role reversal and the encounter, spontaneity, creativity, interpersonal sensitivity, and the here-and-now. Many of his early ideas and concepts as well as his technical innovations are to be found today in the literature and practice of the "human potential movement", modern "action" therapies, social psychology, and in family therapy and the principle of the therapeutic community.

For example, the founder of the modern Gestalt therapy approach, Fritz S Perls, was influenced by psychodrama techniques. Monodrama forms a central core in his creative therapeutic approach. Of him Eric Berne wrote:

> In his selection of specific techniques, Dr Perls shares with other "active" psychotherapists the "Moreno problem": The fact that nearly all known "active" techniques were first tried out by Dr J L Moreno in psychodrama, so that it is difficult to come up with an original idea in this regard.[4]

A similar point is made by A H Maslow, a leading figure in the humanistic psychology field, who writes as follows when referring to new developments in education and psychotherapy: "I would like to add one credit-where-credit-is-due footnote. Many of the techniques . . . were

originally invented by Dr Jacob Moreno . . . "[5]

William Schutz, a leading figure in the encounter group movement wrote as follows

> Virtually all of the methods that I had proudly compiled or invented [Moreno] had more or less anticipated, in some cases forty years earlier . . . Leuner's original article [on guided imagery] has [sic] appeared in [Moreno's] journal in about 1932, and he had been using the method periodically since. . . I invite you to investigate Moreno's work . . . Perls' Gestalt Therapy owes a great deal to it. It is imaginative and worth exploring.[6]

Whilst still in medical school, Moreno and a number of physicians initiated self-help groups amongst prostitutes in Vienna. This form of social action is one of the earliest recorded examples of modern community psychiatry and constitutes one of the early beginnings of group psychotherapy.[7]

In 1917, after receiving his medical degree from the University of Vienna, Moreno worked at a refugee camp called Mittendorf. Here he researched the cultural and group structure and dynamics in the settlement and suggested a sociometric scheme for its reorganisation. He used the term Sociometry for the first time during this work, to refer to the measurement of interpersonal relationships and intra-group structures.

In 1925 Moreno emigrated to the United States of America where he continued to practise psychiatry and to develop and refine his ideas and methods of sociometry, group psychotherapy, and psychodrama. In 1928 he applied psychodramatic techniques with children at the Mount Sinai

Hospital in New York. In 1929-1930 he ran Impromptu Theatre at the Carnegie Hall, New York, combining psychodrama and group therapy. In 1931 he conducted a sociometric study in Sing-Sing Prison, and from 1932 to 1938 a long-term study at the New York Training School for Girls, Hudson, New York. In 1932 he coined the terms group therapy and group psychotherapy[8] and had devised programmes to be applied in prisons, mental hospitals, and schools. In 1936 the Moreno Sanitorium was established in Beacon, New York. This comprised a hospital, training institute, and psychodrama theatre. In 1937 he edited and published his first journal, Sociometry. Other journals to be edited by him were Sociatry (later to become Journal of Group Psychotherapy and Psychodrama) and the International Journal of Sociometry and Sociatry. Moreno wrote prolifically and was active in a number of interdisciplinary fields including psychiatry, social psychology, social anthropology, sociology, philosophy, education, and group dynamics. He was one of the first persons to use electrical recordings of therapy sessions and to write about the therapeutic and evaluative potential of television.

During the Second World War, the military services adopted Moreno's role-playing techniques in personnel selection and management, and Moreno contributed to the development and growth of the use of group therapy in military and veterans' hospitals.

In the 1940's psychodrama was first applied in the treatment of alcoholics. Its use in prisons and in religious and pastoral counselling in education and the

mental health field increased.

By the 1950's role-playing and psychodramatic techniques were being widely used in business and industry. Moreno had first used psychodrama in business training in a programme conducted by R H Macy's departmental store in 1933. Until World War II, psychodrama and role playing had been relatively little used in industry. However, after World War II, industrial trainers increasingly used role playing. Norman L F Maier was chiefly responsible for bringing role playing into popularity in management training and supervisory developments,[9] this wide usage being retained until today. Maier developed "structured" role playing for business application by synthesising a case study method with psychodrama.

Psychodrama was also linked to the history of the T-group or sensitivity training movement initiated at the National Training Laboratory at Bethel, Maine, U S A, in 1946. The three founders of the laboratory, Leland Bradford, Ronald Lippitt, and Kenneth Benne, had been exposed to and influenced by Moreno's methods of psychodrama, and all three had used role playing in community education and social change projects.[10]

> The direct development of the training laboratory came from the collaboration of three men: Leland Bradford, Ronald Lippitt and Kenneth Benne. All three had an educational background in psychology, experience in working with community education projects, and involvements in numerous national projects dealing with major social problems related to human relations. They had been exposed to and influenced by J L Moreno's methods of psychodrama and had experimented with various role-playing procedures in community educational projects directed toward effecting social change.[11]

Their early work had been published in journals edited by Moreno.[12]

B. TRAINING FOR PSYCHODRAMA

Classical psychodrama is a powerful therapeutic tool, and specialised training in the method is essential to guard against its being abused or anti-therapeutically used.[13] However some of the basic principles and elements of the method; and psychodrama derivatives such as role playing, role-training, and sociodrama; and psychodramatic techniques such as role reversal, mirror, soliloquy, and "empty chair" may be extracted and effectively adapted for use by professionals in the "people-helping" fields who have had less intensive training. However, even in such instances prior experiential training in these techniques and practice under supervision is highly recommended.

Social work training and background is ideally suited to the requirements for use of psychodramatic techniques. The personality requirements for, and the ethical considerations and practice principles of both are highly congruent. Naturally, not every personality type is going to be suited for, or motivated to, use action modes -- however, those social workers who are will find skills in these techniques of immense value in a variety of settings.[14] A post-graduate training in psychodramatic skills and derivative techniques should considerably broaden and strengthen the technical armamentarium and personal resources used by the social worker in solving problems.

There is no psychodrama training available in South Africa and, as yet, no fully qualified psychodramatist. However, post-graduate training in psychodrama is available at a number of centres and institutes in the United States, and in England and Europe. The Moreno Institute, or World Center for Psychodrama and Group Therapy in New York, is the major training institute. In addition, there are other institutes in the United States which offer training programmes acceptable to a set standard of accreditation. Two universities in the United States offer Master's programmes in psychodrama.[15] These comprise course work, clinical practice and a written project. However, the Master's degree specialisation fulfils accreditation requirements only partially, and students are still expected to attend a psychodrama institute for further study, training, and practical experience. Some hospitals or psychiatric centres which have qualified psychodramatists in charge of psychodrama departments or working on the staff offer in-service training to staff members and some students. A number of these programmes are recognised towards final accreditation for psychodrama qualifications.

All the major centres follow a similar model for training, emphasising requirements in three major areas:

1 Personal growth and development, e.g., what is seen as important for the practitioner are personal authenticity, spontaneity, empathy, self-awareness and sensitivity to others with a professional sense and disciplined use of self[16]

2 Theoretical knowledge and understanding of psychodrama and its related field, sociometry, are also considered essential

3 Practical handling and intervention skills in the use and application of techniques and method of

> psychodrama, and understanding of the potential, indications and contra-indications of the specialised psychodramatic principles, elements, techniques and process methodology, form the third major area for training

In addition to the specialised psychodrama knowledge of theory and techniques, psychodramatists are expected to have knowledge and understanding of psychotherapy, psychology, group process and dynamics, communication theory and non-verbal communication. (In his book, Blatner recommends that psychodrama directors should also be acquainted with futurology, humanistic psychology, and the "human potential" movement.[17] He feels that a director should have a framework of personality theory in which to operate and that the director's study in theory should be an ongoing process throughout his life.)

The model for psychodrama training is essentially experiential, with evaluation, feedback, and supervision from qualified directors or advanced students. The student is expected first to participate in all the major psychodrama roles such as protagonist, auxiliary ego, double, and audience member. He then begins to direct short scenes, mini-dramas, and role-playing situations under supervision before moving on to assume directorial responsibilities under supervision.

There are four training levels, each with a required minimum of skills, theory, and personal growth criteria. These are known as:

(a) Auxiliary ego
(b) Assistant director
(c) Associate director

(d) Director

The director is required to submit a thesis covering an aspect of psychodrama theory or practice prior to obtaining certification. The minimum period for psychodrama training at the director level is two years inclusive of "back home" practical experience.

NOTES

on Chapter III

1 Cited in Howard A Blatner, Psychodrama, Role-Playing and Action Methods: Theory and Practice, unpublished mimeographed collections of articles, many written by Blatner himself, September 1970, p. 123.

2 Moreno's early works were written in German, and include the following:

J L Moreno, Homo Juvenis (1908)

————————, Das Koenigreich der Kinder (1908)

————————, Die Gottheit als Komoediant (1911)

————————, Die Gottheit als Autor (1918)

————————, Die Gottheit als Redner (1919)

————————, Das Testament des Vaters (1920)

————————, Rede Uber Dem Augenblick (1922)

————————, Das Stegreiftheater (1923)

————————, Rede Vor Dem Richter (1925)

For this listing of Moreno's more literary writings of the early 1900's see J L Moreno, in collaboration with Z T Moreno, Psychodrama, Vol. II, (Beacon, New York: Beacon House, 1959), p. 212. The writings between 1920 and 1925 were anonymously published by Gustav Kiepenheuer Verlag, Potsdam. The earlier writings were published in the magazine Daimon (1918-1920) which Moreno edited.

3 Howard A Blatner, Acting-In: Practical Applications of Psychodramatic Methods, (New York: Springer Publishing Co., 1973), p. 140.

4 Eric Berne, "A Review of 'Gestalt Therapy Verbatim'", American Journal of Psychiatry, CXXVI, No. 10, (1970), p. 164.

5 Abraham H Maslow, letter to the Editor, Life magazine, 5 August 1968.

6 William Schutz, Here Comes Everybody, (New York: Harper and Row, 1971), Introduction, as cited by Blatner, Acting-In . . ., op. cit., p. 108.

7 Blatner, op. cit., p. 140. Also see J L Moreno, Who Shall Survive?, 3rd ed., (Beacon, New York: Beacon House, 1978), pp. xxviii-xxx.

8 See J L Moreno, "The First Book on Group Psychotherapy, 1932", 3rd ed., Psychodrama and Group Psychotherapy Monographs, No. 1, (1957). Also see Raymond J Corsini who views Moreno as "probably the most

important individual in the history of group psychotherapy." Corsini points to three major contributions Moreno made to group psychotherapy, viz., (a) the introduction of a theory to account for group structures and operations (i.e. sociometry), (b) the introduction of a new method of therapy in groups (i.e. psychodrama and deep action methods), (c) his efforts as an "indefatigable exponent of the group therapeutic movement", Methods of Group Psychotherapy, (New York: McGraw Hill Book Co., The Blakiston Division, 1957), p. 15.

9 Wallace Wohlking and Hannah B Weiner, "Structured and Spontaneous Role Playing: Contrast and Comparison", in Role Playing: Its Application in Management Development, ed. Wallace Wohlking, (New York: Cornell University, 1971), p. 1.

10 Louis Gottschalk and E Mansell Pattison, "Psychiatric Perspectives on T-groups and the Laboratory Movement: An Overview", American Journal of Psychiatry, CXXVI, No. 6, (1969), pp. 823-839.

11 Hendrik M Ruitenbeek, The New Group Therapies, (New York: Avon Books, 1970), pp. 18-19.

12 Ibid., p. 19. Ruitenbeek notes "that the Bethel leaders published their early findings between 1938 and 1955 in the journals of the Moreno Institute: Sociometry and Group Psychotherapy. Kenneth Benne himself acknowledged in his book Human Relations in Christian Change this debt to Moreno". Ibid.

13 Psychodrama is most effective when skilfully and sensitively used by a trained psychodramatist. Fortunately, in most instances, the "tool" is as "good" as its user. It adapts to the level of skill and expertise of the director using it. In other words the extent of abuse is in one sense controlled by the limitations of the director. The adage which says "he might not do any good, but he won't do any harm either" applies here, in other words the protagonist might benefit, but not as much as he could under the direction of a trained, skilled practitioner. Another major control of abuse lies in the experiential and self-regulating nature of the method. Because the protagonist is essentially self-directing in action, unless he is pushed in an exceedingly counter-therapeutic manner, he will usually gain something simply from the enactment process itself. Further control lies in the fact that the method usually follows the level of motivation and anxiety of the protagonist. The director should be led by him. He cannot be "pushed" further than he wants to go. It would seem that the protagonist will only allow himself to go as "far" or as "deep" as he wants to, or is able to go. Psychological defense mechanisms will usually be called out to protect the protagonist from pressure, and from unethical, selfish

users of the method.

14 Applications of psychodrama and psychodramatic techniques considered to be relevant for social work training and practise are reviewed and presented in Chapter IV of this study.

15 Lesley College, Massachusetts, and the University of Kansas, Arkansas.

16 In this regard, Blatner writes of the importance of personal qualities, in addition to technical proficiency, in the psychodramatist: "The psychodramatist, like the true psychotherapist or teacher, is an artist in that he must synthesize what he knows with what he is", op. cit., p. 134.

17 For a picture of the trends and emphases in the "human potential movement", and in humanistic psychology see, for example, Charlotte Buhler, "Basic Theoretical Concepts of Humanistic Psychology", American Psychologist, XXIII, No. 4, (1971), pp. 378-386. Abraham H Maslow, Toward a Psychology of Being, (Princeton, New Jersey: D Van Nostrand, 1962). Rollo May, Love and Will, (New York: Norton, 1969).

P A R T T W O

PSYCHODRAMA AND SOCIAL WORK APPLICATIONS WITH SPECIAL REFERENCE TO ALCOHOLISM

One man as a therapeutic agent of the other,
one group as a therapeutic agent of the other.

J L MORENO,
"Application of The Group Method to Classification", 1931-32.

CHAPTER IV

REVIEW OF PSYCHODRAMA APPLICATIONS RELEVANT TO SOCIAL WORK

A. INTRODUCTION

In this chapter some possibilities for psychodrama applications within the framework of social work methodology, training, and practice are suggested. Journal articles, monographs, and book reports which describe various uses of psychodrama and psychodramatic derivatives and techniques are summarised. The literature reviewed in the final section has been selected in terms of its applicability to the fields of practice in which social workers are known to be active. Applications relating to work done in the field of alcohol treatment will be reviewed in Chapter V.

It is felt that psychodrama techniques are eminently suitable for use by a profession which deals with psychosocial problem-solving, and which aims at the "enhancement of the social functioning of individuals."[1] The participatory, experiential nature of the psychodrama modality enhances client involvement in the problem-solving process. Being both flexible and adaptable, psychodrama may be applied to a wide variety of types of clients and their multiply-determined problems. If integrated with the more commonly used verbal and cognitive approaches, it is my

and explore the role of an ancestor or family member in order to understand their influence exerted upon his present-day behaviour and conflicts. Family "myths" or the messages, overt and covert, given to protagonists could also provide fertile themes for exploration and understanding. (This approach would appear particularly pertinent working within African cultures where ancestors play a major role in determining client behaviour.)

2 Social Group Work

In its classical form, psychodrama, as has been described, is a group therapy and in its goals has much in common with the method of social work known as group work.

Konopka defines social group work as

> . . . a method of social work which helps persons to enhance their social functioning through purposeful group experiences and to cope more effectively with their personal, group, or community problems.[9]

Historically, social group work has its roots in the early labour and settlement movements of the nineteenth century, and in twentieth century social work settings providing informal education, leisure-time and recreational services. In contrast, the group psychotherapeutic methods have their early historical origins in medical and clinical practice.[10]

Group therapy may be further differentiated from social group work in that its focus is the individual rather than the group, and on pathological rather than normal processes. For example, group therapy places

primary emphasis on "curing individual pathology", and on ameliorative "repair" of pathology or on personality change. Clinically-based diagnoses are employed. Social group work, on the other hand, emphasises individual personality growth and the realisation of potentialities within the social context of the development of the group-as-a-whole.[11] A commonly accepted definition of group psychotherapy is that of Corsini, who sees it as consisting of "processes occurring in formally organized, protected groups and calculated to attain rapid ameliorations in personality and behaviour of individual members, through specified and controlled group interactions."[12]

Group therapists require an extensive, in-depth knowledge of personality theory and psychopathology as well as of the use of group process. Whereas this was not always so, currently social workers receive far more knowledge and understanding of these areas and processes in their undergraduate training and in post-graduate specialisms. Many more social workers have moved from conducting group work in primarily recreational and community settings and are working instead in a variety of clinical and treatment-oriented settings. Psychiatric social workers in particular have an in-depth post-graduate training in psychiatric and psycho-pathological dynamics. Increasingly, social workers are gaining experience in and understanding of the therapeutic process both in their practice and through post-graduate supervisory experience. Some training courses also require participant individual and/or group therapy, or group experience to further develop

understanding and sensitise students to intra- and inter-personal dynamics.

Although group work in community and recreational life is still a vital and valid social work function, it is perhaps the therapeutic form of group work which is closest to the traditional group therapy model and the aims of classical psychodrama. This is what Vinter calls "the treatment group"[13] or what Papell and Rothman refer to as "the remedial model" of social group work.[14]

The remedial model is a clinical model focusing on the treatment of the so-called "malperforming" individual within the context of a "formed" group. Membership is pre-determined and group composition selected on the basis of diagnostic assessment. The social worker functions as a "change agent" using the traditional sequence of study, diagnosis and treatment to approach the problem-solving. The group programme is chosen for its therapeutic potential, and the groups are most often run within a structured agency or institutional setting.[15]

Papell and Rothman describe two other major social group work models in their paper. These are the social goals model and the reciprocal model. Each of the three models vary in respect of their function, and focus on the individual, the small group, and the larger society. The social goals model stresses "provision and prevention"; the remedial model "restoration and rehabilitation"; and the reciprocal model attempts to reconcile the two.[16]

Historically, the social goals model is the earliest.

Key concepts in this model are social consciousness, responsibility and awareness. It functions "to create a broader base of knowledgeable and skilled citizenry" and assumes "a unity between social action and individual psychological health."[17] Meaningful social participation of individuals and the potential of every group of individuals for effecting social change are emphasized. An essential purpose of the model is to help individuals to develop their personal potential within a group on a task related to social and community betterment. It may be regarded as a form of group work within community life. Because it incorporates the community context so integrally into its perspective, the social goals model might be seen to be closely related to the goals and processes of community work and inter-group relations. Psychodrama derivatives such as sociodrama and role playing are recommended for use within group work conforming to this model.

The reciprocal model focuses on the relationship between individual and society, and views the group as the context within which both individual and societal functioning may mutually be enhanced. It is the reciprocal, interdependence between the two which is emphasised in this model. The group system is central; viewed as a microcosm of society. The social group worker functions as a mediator in helping clients and agency find common ground. The major focus for social work diagnoses is on the current ongoing "here-and-now" interactions in the group. The entire construct is one of a mutual aid system serving the symbiosis of individual and society. It is envisaged that

social workers using a reciprocal model might use role playing or psychodramatic techniques for facilitating aims and in clearing up deadlocks in communication and misunderstandings, or for finding an overall solution to seemingly irreconcilable viewpoints between mutual and inter-dependent systems. Techniques such as role reversal, externalisation of inner feelings through soliloquy or doubling might help resolve inter- and intra-group conflict; open channels of communication; and facilitate self- and other-awareness. Through role training, alternative courses of action may be explored and rehearsed within the relative safety and cohesion of a group.

These latter applications might be useful, too, for the social worker using a social goals model. Alternative plans for social action and their remifications and possible consequences may be explored and rank-ordered within the 'as-if', 'fail-safe', almost laboratory-like, preparatory microsocial context of the group. Sociodrama, role playing and dramatised enactments of social issues and concerns would seem ideally suited to enhancing the aims and effectiveness of the process within a social goals model. Participation in and witnessing of a relevant sketch or enactment would stimulate involvement in and discussion of a topic or concern. Role playing following a discussion or the viewing of a film might also increase participation and involvement. These action methods not only illuminate content, but also enhance the process by providing a common focus and experience for group members, thus strengthening group solidarity and cohesion, and

increasing the possibility of effective social action being undertaken.

Classical psychodrama, being traditionally a therapeutic group method, is probably closest to the remedial goals model in social group work. Not only may the classical format be used by a social worker specially trained in psychodrama, but the social worker using the therapeutic or remedial model may employ any of the psychodramatic forms or techniques within the ongoing process of a treatment group wherever appropriate. For example, in ongoing group work when a deeper exploration of intrapsychic phenomena seems called for, or when interpersonal phenomena or relationships require concrete clarification or demonstration, psychodramatic techniques are useful.

Action techniques might help to facilitate required emotional expression; or enable traumatic events of the past to be re-enacted or explored for many of the same aims and sense of mastery and re-integration which the classical format has. In a group employing primarily the discussion mode, the role-playing medium or any form of dramatisation might help to illuminate the subject being discussed, and to clarify issues and distortions. In addition, it is considered that, if appropriately used and timed, it will facilitate interaction and draw out the positive, therapeutic and emotive elements in a group. In a remedial group employing primarily activities, role playing, sociodrama, dramatic enactments or psychodrama techniques might usefully serve as programme media.

Client considered "hard to reach" or "reluctant" may be motivated to do therapeutic work by watching others representing themselves and their situation. Action techniques are also valuable in working with clients who have minimal verbal skills.

For many years, social group work with children and adolescents in recreational, community, institutional or residential settings has used creative dramatics, drama games, improvisation of situations, story-telling, play-making, play-production and presentation, psychodrama, sociodrama and role playing as specific programme media.[18] The use of drama as programme in social work provides benefits similar to those of Moreno's early spontaneity work with children in Vienna. (See Chapter III.) Wilson and Ryland write:

> The dramatic medium is an invaluable one for personal and social growth because of the opportunity it gives not only for expressing one's own personal experiences and feelings but also for understanding and appreciating the motivations of others through assuming various roles.[19]

These authors describe, for example, an improvised enactment of the story of Cinderella in a racially mixed group of ten-year old children. One of the smaller white girls was chosen to play Cinderella, whilst two black girls opted for the roles of the wicked stepsisters. Over and over again, they repeatedly practised the first scene where the stepsisters mistreat Cinderella, finding a variety of ways of making Cinderella do the household drudgery. They explained that they wanted to get this scene perfect before going on to the visit of the Fairy

Godmother. The scene in which Cinderella receives gifts from the Fairy Godmother was evaded. In this way the black children had an opportunity within the structure of the fairy tale to express the resentment they felt towards the white group. Reversing a social situation familiar to them helped to release repressed feelings of hostility.[20]

Dramatic games, such as charades, word games, circle games involving the five senses, imagination, memory and concentration are valuable in building up and strengthening abilities as well as in releasing tension. These may be used with adults as well as children and are often employed as structured warm-up techniques in psychodrama groups and for strengthening group cohesion. Through role playing, adolescents can practise for and explore situations of concern to them such as dating, boy-girl relationships, and interaction with parents or authority figures. Children may try out different social roles and learn about their relationship to the social environment in which they live.

Programmes employing psychodrama, sociodrama, role playing, creative dramatics, non-verbal methods, improvisation, and movement may also be used in group work with adults, with similar process benefits accruing. Shuttleworth,[21] for example, describes his use of these methods in work with chronic schizophrenics in a mental hospital in England. He found that, in a group meeting once a week, these activities helped to overcome the effects of long-term institutionalisation. These effects included passivity, a lack of independence in general, and dependence

on staff in particular. Although grossly bizarre schizophrenic symptoms remained, the programme helped participants relearn previously held social skills and to regain contact with the outside world. Shuttleworth found that physical warm-ups and non-verbal exercises involving movement were especially valuable not only for muscular coordination but also in counteracting the physical effects of medication, inactivity and lack of exercise.[22]

Nitsun, Stapleton and Bender[23] conducted an experimental study to investigate the efficacy of movement and drama therapy with a group of long-stay schizophrenic patients in yet another mental hospital in England. They too found that the non-verbal interactions and body movement elements in their drama programme seemed significant in contributing to the advantages of the action methods over traditional verbal group therapy. Their experimental design matched a group of twelve patients in the drama therapy programme with a control group of twelve patients undergoing verbal group therapy. The study was conducted over 22 weekly one-hour sessions. The patients were between 25 and 49 years of age; had been hospitalised for two or more years; and showed no evidence of organic illness or mental subnormality. They all had schizophrenic symptoms such as flatness of affect, thought disorder, withdrawal, disturbance of body image, and speech and psychomotor functioning disorders. Both groups were assessed by means of clinical and social ratings and psychological tests prior to and after the sessions.

The results indicated general improvements in both

groups, suggesting a generalised effect produced by the extra attention given to the patients. However, certain changes were specific to the drama and movement group. These were an increased awareness of the bodily self; greater acknowledgement of impulses and feelings stemming from the more primitive part of the personality; an improvement in social ease and self-motivated social contacts; and an increased capacity for socially appropriate behaviour. Despite the under-emphasis on verbal discussion, changes were also found on verbal as well as non-verbal intellectual tasks.

The Shuttleworth report and Nitsun et al. study have been described here because of the multi-media dramatic programmes both used, these programmes being so similar to those used by and recommended for use by group workers with children and adolescents. Although neither of these studies used classical psychodrama per se both of these reports suggest fruitful avenues of work and exploration by social workers employed in large mental hospitals and institutions. The chronic long-stay patients in these settings are so often "forgotten" -- not in the sense of not receiving treatment, but as Luiz and Hotz put it, "in terms of again realizing whatever potential they had."[24] Active rehabilitation efforts are usually directed towards the short-term patients. Luiz and Hotz[25] feel that the lack of resocialisation or rehabilitation of these chronic patients as a long-term goal has tended to create the typical "institutionalised" patients so familiar to those working in the field. The challenge of rehabilitating

such patients might be met by social workers helping to resocialise them in groups using role playing and dramatic media. These methods need not be restricted to children, adolescents or adult schizophrenics, but it is envisaged how groups using creative drama, non-verbal methods and psychodrama derivatives can form part of a group work programme in a variety of settings. (The survey of the literature later in this chapter provides more examples of field applications in group work with hospitalised psychiatric patients.)

Galper[26] describes how non-verbal communication exercises can be used in groups in order to help members look at and confront the dynamics of the group process. He feels that the use of such techniques should be considered for application in community action groups, settlement house groups, and halfway houses, as well as groups in "total" institutions.

Non-verbal techniques and body work may consciously be applied within ongoing group work and in psychodrama and role playing. Methods from movement and dance therapy, encounter and bioenergetic groups may effectively be used too. Moreno himself emphasised the importance of observing and working with non-verbal and subverbal aspects of human communication and awareness. He writes that "according to psychodrama theory, a considerable part of the psyche is not language-ridden, it is not infiltrated by the ordinary significant language symbols."[27] When an auxiliary ego doubles for or role-reverses with a protagonist, or when a mirror "stands-in" for the protagonist in a scene, they

character in a sketch or improvisation
- helping to promote self-understanding
- promoting attitude change, the breakdown of cultural and ethnic stereotypes and prejudice'
- promoting the attainment of positive social values

It would seem that the potential applications of psychodrama and derivatives in the group work field are manifold, restricted only by the imagination, sensitivity, and skill of the social work practitioner.

3 Community Work

Community work is the third major method of social work and focuses upon the community rather than the small group or individual as the unit for self help. The term community work is used to refer to what might earlier have been called community organisation and development and covers all forms of community planning for and co-ordination of services.

For a definition, one might look to Ross, who describes community organisation as

> . . . a process by which a community identifies its needs or objectives, orders (ranks) these needs or objectives, develops the confidence and will to work at these needs or objectives, finds the resources (internal and/or external) to deal with these needs or objectives, takes action in respect of these, and in so doing extends and develops co-operative and collaborative attitudes and practices in the community.[29]

It has already been described how action methods may stimulate personal involvement, motivation and participation in problem-solving, and aid the formation of interpersonal cohesive bonds and mutual awareness and

sensitivity. Therefore, the potential use of such techniques in terms of the community organisation process described by Ross is indicated.

In common with casework and group work, community work shares many central values and operational principles and processes. For example, the process of fact-finding, exploration of needs and objectives and the rank-ordering of such; or the process of social study, diagnosis and resultant action or treatment, is generic to all three methods. The functioning of the social worker as a catalyst and resource in promoting self-help, as well as the values laid upon client participation and involvement in the helping process are similar whether the "client" is an individual, a group, or a community. Thus many of the same psychodramatic action methods as suggested for use in casework and group work may be employed for similar purposes in helping the community and the community worker achieve their common mutual objectives.

It seems to me that sociodrama, with its emphasis on the collective aspects of role, role playing, and role reversal, would be the most useful and appropriate of the action methods to apply within community work.

Moreno, as has already been presented in Chapter II, defined sociodrama as "a deep action method dealing with inter-group relations and collective ideologies."[30] He saw the group-as-a-whole being the "proper" subject of sociodrama. He further pointed out that whereas the "psychodramatic approach deals with personal problems

principally and aims at personal catharsis; the sociodramatic approach deals with social problems and aims at social catharsis."[31]

Sociodrama, and sociometry (or the measurement of group relationships) in Moreno's widest vision were to be used as tools for treating entire groups of people and even societies as part of what Moreno called sociatry, or that discipline which could help groups deal with the imbalances and needs within them.[32] Moreno envisaged sociatry as being the societal equivalent of psychiatry. Instead of using individualistic psychiatric concepts such as neurosis or psychosis, sociatry would address itself to socioatomic processes such as sociosis.[33] A sociotic or "sick" society would be one in which there is disequilibrium between the groups comprising it. The aim of sociatry would therefore be

> . . . prophylaxis, diagnosis and treatment of mankind, of group and inter-group relations and particularly to explore how groups can be formed which propel themselves into realization via techniques of freedom without the aid of sociatry or psychiatry. The secret aim of sociatry, and of all science, is to help mankind in the realization of its aims and ultimately to become unnecessary and perish.[34]

This philosophy is sympathetic to the aims of the social worker who helps people, whether individually, in groups or communities, to help themselves. The social worker functions as an enabler, a catalyst who sets a process in motion which will be one in which he or she will ultimately not be needed -- a process which has as its major aim client self-reliance and propulsion.

In terms of some action specifics in community work, one might imagine, in addition to spontaneous sociodramatic enactments, the staging of structured role playing situations, or scripted sociodramas dealing with salient social and community issues followed by discussion to stimulate the community members' awareness of needs, and arouse their motivation to take action regarding certain problems. Sociodramatic and role playing techniques may assist community members to rank order and assess alternative plans of action and their possible consequences, or the implications of non-action.[35]

It is envisaged that sociodrama, role playing and role reversal would be helpful in intergroup relations and in defusing situations of tension and conflict. These methods might help the members of one group understand and draw closer to another group by recognising their essential common characteristics, wishes and behaviour, and help to break down cultural and ethnic stereotyping. Playing the role of the "other" group members, exploring in action, or witnessing an enactment can be every bit as helpful and effective as role reversal with the actual "other".

Florence B Moreno[36] used psychodramatic role playing in a neighbourhood setting for resolving ethnic, class and interpersonal prejudice and misunderstanding. Her aim was to develop a feeling for the deeper meaning of the facts underlying bias and prejudiced attitudes, through helping families experience or witness the re-enactment of situations and playing the role of the other. Her work was based on the phenomenon in which close identification of

parents and children often result in the adults reacting to the attitudes and behaviour of their neighbour's children to their own children as though they and the other's parents were personally involved. This tends to build up tension and ill-feeling and heightens prejudice and negativity without either "side" examining the facts.

Florence Moreno brought parents and children together for action sessions. Children who were in conflict with each other role-reversed in the enactment of conflict situations. In the subsequent discussion and reflection parents became aware of the fact that their children were in fact playing out their unspoken prejudices, or their disapproval of the children playing together. The sensitivity of their children to these "hidden" attitudes of their parents emerged. The parents themselves were brought into the scenes and interacted, role-reversed and explored each other's problems and concerns. An outcome of the project was greater empathy and understanding on the part of both children and parents. Parents were more willing to have their children play with and visit each other. Attitudes softened and became more realistic. Although no follow-up study is reported, Florence Moreno points out that the psychodramatic learning requires to be followed through in actual life situations in order to become meaningful.

Hanson,[37] in working with a number of communities, used a sociodramatic format in which community members and key figures enacted a previously rehearsed series of related episodes concerning community life. "They are true

sociodramas in that they are concerned with both exploration and catharsis; they were a collective experience involving nearly all of the people of each community either as participants or spectators."[38] The subject-matter of the sociodramas ranged from issues of community planning to community problems in human relations and intergroup life. His programmes led to constructive social action being taken and he went on to use a more spontaneous form of community sociodrama. Although the Florence Moreno and Hanson projects were undertaken almost three decades ago, their processes and purposes would be as relevant for current modern local issues and community tasks and problems.

J L Moreno himself used sociodrama in Black-White; Jewish-Gentile; capital-labour relations.[39] Tensions arising from the misunderstanding of role requirements and the effects of actions upon each other in intra- and inter-community relations can be eased through role playing clarification. Sociodramatic methods use a democratic format and, as has been previously mentioned, are in keeping with the ethos and values of community participation, responsibility and self-determination. In working with leadership training, certain values may be transmitted and attitudes changed. For example, French[40] found that role playing was effective in sensitising autocratic Boy Scout leaders to becoming more aware of democratic styles of leadership.

It has also been mentioned that group participation and involvement is stimulated and encouraged by active

role playing methods which also foster feelings of group solidarity. Borgatta[41] found that role playing within a discussion group encouraged the participation of members who normally did not take part in discussions. In another study[42] he found that role playing helped participants feel freer in exploring ideas and convictions, or agreement and disagreement with issues, than those who were involved in discussions only with no participation in role playing.

4 Social Welfare Agency Administration

Sociodrama, role playing and role reversal may effectively assist the process of agency administration. It is envisaged that these techniques may be helpful with the objectives of in-staff training programmes; staff development and individual professional growth; clarification of agency policy and limits; in planning; and in relationships with the client community served and with boards of management and committee members.

These methods may be used for facilitating intra-agency staff cohesion, positive relationships and communication, and in meetings and conferences to clear up interpersonnel problems, tensions and misunderstandings. Interpersonnel difficulties in enacting roles may be illustrated, defined, and rectified; as may distortions in role perceptions and their consequences upon services rendered.

It is also envisaged that these psychodramatic techniques may be helpful in examining and learning about the actual process of administration itself, and possibly in

formulating theory and in stimulating innovations.

5 Social Work Research

Action methods are vivid and observable, and may serve as ideal laboratory media for investigating human phenomena and behaviour and in exploring social work methodology and issues of concern. The subjective quality of observation in research may be reduced by having a number of researchers observe and interpret data as well as by repeating situations or topics under focus for verification and validation. Because situations found in the field may be re-enacted or reproduced on a psychodramatic or sociodramatic "stage", the limitations of time, expense, and difficulties in controlling the variables of a real-life situation are cut down to a minimum. A great deal of multilevel information is available in a contained and fairly controlled environment, and the medium lends itself admirably to the use of recording devices such as closed circuit television for repetition of experiments and the analysis of data.

C. SOCIAL WORK EDUCATION AND TRAINING

On an impressionistic basis, from a search of social work literature, role playing rather than psychodrama or sociodrama, seems to be the most frequently used action technique in social work education, primarily on casework courses where students practise interviewing skills, and prepare for their entry into practical field work placements. One method is for the students to role play in

pairs, with one student enacting the role of client and the other the social worker. (This helps students feel into and beyond the role of the client as he or she is perceived within the limitations of the way in which they present themselves in the casework situation.) The class is usually given the opportunity to observe the role players' behaviour and thereafter to discuss the enactment and to relate the dynamics seen to be at work to casework theory and principles. Where videotape equipment is available, the role-playing participants obtain visual feedback as well.

It is felt that role play, role training, sociodrama, soliloquy, role reversal and other psychodramatic techniques could be more extensively and fruitfully employed in the education and professional training of social workers. The four major curriculum areas and objectives which could be served are seen as

- knowledge of human behaviour
- acquisition of specific skills and techniques
- social work values and orientations
- self-growth and development

Twelve major values of the role playing and psychodramatic action method for social work education may be extracted from articles dealing with the training of social workers, nurses, therapists and industrial workers. These are described below.

1 The <u>flexibility</u> of the method in adapting to a variety of training needs and teaching objectives is one of its major values

2 The <u>irreal</u> quality of the method (i.e. although role playing is an "as-if real" situation, it is subjectively experienced as being close to life, and the feelings which are elicited are real)[43,44]

3 The modality illuminates and illustrates in a vivid fashion aspects of human behaviour and dynamics. It enables class and textbook material, concepts and principles to come alive in a manner which verbal media cannot achieve

4 The live, realistic dimension facilitates learning, as does the experiential participation and observation of situations produced in a concrete fashion

5 The method encourages the active participation and emotional involvement of students, and consequently stimulates the motivation which is essential to successful learning

6 The holistic, experiential and three-dimensional nature of the method which incorporates cognition, affect and action releases real feelings and emotions which can be channelled into constructive learnings related to social work principles and processes. Students are far more likely to remember such learning and be affected by the impact made upon them through their participant experience

7 The modality helps to bridge the gap between verbal explorations of knowledge and principles presented (by means of reading, case records, lectures and seminars) and the traditional learning-by-doing of social work students in their practical field work placements. It serves as an ideal transition medium for the passage from theory to practice

8 The method provides a realistic "fail-safe" setting in which behaviours and techniques may be practised without any danger of harm or negative effects upon actual clients because of mistakes or ineptitude. The students can always "try again" in a safe, supportive and contained situation free from the fears or anxieties provoked by the real situation outside. Transfer-of-training to the real situation is more effectively facilitated

9 Immediate feedback and correction is available; from the participant's own self-consciousness or awareness of mistakes; from the audience observations of actions and reactions; and from the teacher or social work lecturer or instructor[45]

10 The medium provides an excellent opportunity for learning about students, observing and assessing their strengths and weaknesses, training needs and areas which need working on. This is ideal for student supervision. With supervision increasingly being conducted in group contexts as well as individual sessions, role playing methods offer pertinent potential uses and values. They solve the problem created by the influence of introducing a supervisor to sit in on student-client interviews in the field, and do away with the necessity for working with intermediary written case recordings of student interviews, group or community meetings. Direct assessment of performance is possible. In addition, role playing in a group supervisory

context enables student peers to provide support and encouragement to their fellows and to learn from them at the same time. Focused learning and observations of specific verbal and non-verbal cues, and interpersonal dynamics and principles is possible

11 Psychodrama, sociodrama, role playing and role reversal develop student empathy for possible client situations and feelings which may be quite different or removed from any the student has experienced

12 The method enhances the self-awareness and self-knowledge which is essential to the social worker since it obviates abuse or mishandling of situations due to the projection of personal needs, transferences or prejudices or the lack of awareness of personal reactions aroused within the client situation[46]

Treudley[47] describes the use of role playing techniques in casework training and in the practising of interview skills. She found that they supplemented practical field work and gave the students the opportunity to put textbook knowledge into practice. Use of the method helped to lower student anxiety and to deal with fears about the work situation. Realistic practice and familiarity with what she refers to as the "orthodox mechanism", i.e. structures, procedures and course of a modal interview, was provided. The method gave an opportunity for students to learn about the effect of their own personalities and behaviour upon the total client-worker situation and to become aware of how significant this was. In addition, Treudley found that she was enabled to obtain a clear picture of the students' abilities.

Hagan and Wright[48] report an application of psychodrama and role playing techniques which suggests interesting possibilities for current use of the method not only with students but also with voluntary workers and social

work aides and assistants. These authors set up training programmes of one month's duration each for Red Cross volunteers who were brought in to reduce the pressures upon over-loaded social workers in a large mental hospital in America during World War II. Their programmes comprised a balanced curriculum of theoretical, clinical and practical work. Incorporated into this were four three-hour psychodrama sessions. These were conducted by a trained psychodramatist with the assistance of an experienced auxiliary ego and several hospital staff members. All the volunteers were university graduates who had had at least two years of some work experience after their university education.

The psychodrama sessions were originally intended to serve as an aid to teaching the "art of the interview". However, the authors found that they had more holistic and widespread effects than originally anticipated. Their initial conclusions after a few preliminary programmes were that psychodrama was an effective, experiential and non-didactic method for use with students required to learn the specifics of heightened interpersonal relations in a rapid space of time; that the volunteers acquired skills without any "harm" to patients; that supervisors and fellow students had immediate perceptions of interaction; that integration of the knowledge base of human relations with the students' own interpersonal experience in the sessions could be achieved; that because of its spontaneous, realistic nature, psychodrama discouraged the use of psychiatric jargon which could easily have confused the students in the limited time available; and, finally, that

the psychodramatic role playing situations could be graded in accordance with individual student needs. In written evaluations submitted at the end of the course, students expressed their feelings that the psychodrama was the most effective of the teaching methods they had experienced.

Approximately fifteen years later, describing the history of psychodrama at this particular hospital, St Elizabeth's, Washington, which is now a leading therapeutic training centre, Overholser and Enneis acknowledge the work done by Hagan and associates such as Wright and Herriott in educational programmes using psychodrama. They state that it was through the impetus received by the method at St Elizabeth's Hospital that psychodrama "became an important teaching tool in many schools of social work throughout America."[49]

Barron[50] found that role playing sensitised training counsellors for interviewing in the field. She too found that the realistic practice opportunity provided served not only to bridge the gap between formal study of principles, methods and techniques and practical application, but also to function as a "clinical laboratory" in which interpersonal skills and intervention approaches could be experimented with and practised.

In a more recent article, Swell[51] describes how valuable she found role playing in casework teaching. Her findings are very similar to those of the earlier articles reviewed. She found, for example, that in addition to intellectual learning of casework content, the experiential involvement by students in role playing increased their

empathy for clients. She found role reversal particularly useful in this regard. She too found role playing an effective medium in helping students rehearse for the reality of practice in the field. Students could experience a "trial run" of specific situations such as a first interview, an intake interview, the conducting of a social history, dealing with termination, handling an angry client, a withdrawn, silent, or tearful client. The conducting of home visits, family and conjoint interviews could also be anticipated and rehearsed for.[52]

Role playing was helpful in demonstrating client psychodynamics and the use of defences. For example, class members observing the role play enactments were able to use verbal, non-verbal and affective clues given by the participants in developing an understanding of defence mechanisms and their underlying meanings.[53] Swell writes:

> Practitioners and teachers know that the process of casework is alive and exciting. Paradoxically, to students, the principles related to this process at times may seem flat and amorphous.[54]

She feels that role playing resolves this paradox and adds a new dimension to supplement classroom teaching. The active, participant nature of the modality heightens and speeds up learning experiences and increases student motivation. Cognitive and affective integration of learning is facilitated simultaneously with specific content and educational objectives.

The social work teacher can structure situations and focus upon specific elements and material through role

playing. In this way integral concepts and principles may be experienced in a lively, concrete manner. For example, in casework, the principles of individualisation, purposeful expression of feelings, controlled emotional involvement, acceptance, the non-judgmental attitude, client self-determination, and confidentiality might be experienced through role playing situations.[55]

As with casework, so too may group work and community work principles and content be taught through the medium of psychodrama and role playing techniques. This has the added advantage of enabling the student's personal development to move apace with his learning of theory and methods. The use of a participatory verbal group experience for sensitising members to the group process, for example, is extensively employed in training centres in human relations and group work for a number of professional fields.

Papell[56] describes the planning for, and application of weekend sensitivity groups in an American school of social work. (One of the three group leaders used a process style influenced by psychodrama and his training at the Moreno Institute.) An evaluation of the participant students' experience revealed that their learning lay in two major areas. The first was related to their experiencing what it meant to be a member of a group, and the second to the effect which a worker has upon the group. Student participation sharpened the learning of concepts which had previously theoretically been taught.

Working in the occupational therapy field, Maynard

and Pedro[57] designed a one-day experiential course in group dynamics which they found helped participants become more aware of their interaction in a group setting, and their impact upon others.

In an experiential group using primarily sociometric and psychodramatic methods, Mann[58] found these techniques effective in teaching introductory group dynamics, and in achieving goals such as evaluation of interaction and the learning of skills in guiding and controlling group interaction.

Goldberg and Hyde[59] used sociodrama in a hospital setting to train inexperienced psychiatric personnel prior to their placement on the wards. Personnel comprised social workers, doctors (psychiatrists), psychologists, nurses, attendants and volunteers. An interesting feature of their programme was that patients were included in the sessions.

A spontaneous form of role playing problems, with role reversals and adherence to the classical psychodramatic format of warm-up, action and discussion was used. The writers found that the presence of patients in the sessions was most beneficial both for themselves and for the personnel in terms of learning. The "warm and spontaneous" atmosphere achieved in the group enhanced the rapport between personnel and patients, and a mutual and reciprocal system of altruism resulted. Patients were aware of staff efforts to help them, and in their turn made sincere attempts to help staff members. This in turn

stimulated the staff to increased efforts to help patients. Staff empathy for patients' needs was facilitated and a tolerance for personality characteristics and mannerisms was increased.

Staff tested a variety of approaches to patient problems in the enactments. These approaches and the insights derived from them were found to be easily transferred to actual ward behaviour. Personnel, in particular, found that the participation, involvement and identification required of them by the sociodramatic method allowed catharsis of fears and hostility, further facilitating empathy, and freeing them for spontaneous and effective behaviour.

Kulcsar[60] also describes an application of psychodrama as a training tool in a combined therapist-patient group. He used a modified version of classical Moreno psychodrama, retaining techniques such as double, role reversal, and mirror. He found that participation in his programme developed many of the qualities he feels are demanded of a psychotherapist; for example, empathy and an "I-Thou" mutuality. The "as-if real" quality of the dramas "transgressed the limits of transference and counter transference", and promoted a new understanding of human interaction. Interhuman action rather than material was analysed. He concludes " . . . what the individual supervisor can attain only with repeated efforts, the psychodrama teaches automatically."[61]

Stein[62] used psychodrama to help student and qualified nurses resolve their own anxiety and tensions aroused

by their emotional and physical reactions to their hospital work with patients. He found that, in addition, his programmes taught individual and interpersonal dynamics, and improved the students' ability to "read" verbal and non-verbal communication cues objectively. The role playing exploration and practise of situations boosted the students' confidence in dealing with actual situations. This report suggests a fruitful avenue for work with medical social workers and students in hospital and medical placements.

A possible application for student selection is suggested by Kay's[63] study of professional role requirements. She looked at the common elements and requirements in terms of personality and training demanded of the "good doctor" role, and concluded that psychodrama could be used for the evaluation of personal aptitude for entry into medical training and practice.

Many of the suggestions for use of scripted sociodramas and spontaneous enactments in community work practice may be employed in classroom teaching. For example, Abels[64] describes how the enactment of a play dealing with housing problems was used to demonstrate the roles of workers and tenants in a community. He found that the students were not only made aware of the history of public housing, the roots of tenants' unions, and approaches to "ghetto" dwellers, but also in the process of reading and enacting their parts, moved towards a deeper understanding of the feelings of persons in similar, actual situations. Hendry[65] describes a project in which experiential

D. FIELDS OF APPLICATION

In this section studies, articles, and reports of work using psychodrama and derivatives in some of the fields in which social workers are active are described. This is by no means an exhaustive and complete review; however it is felt that, within the framework of this study, it is sufficient to provide an idea of trends and uses which will be of relevance and interest to the social work field.

In the mental health field, the use of sociodramatics, role playing, movement and creative drama with hospitalised schizophrenics has already been described in the section of this chapter dealing with group work. (See Shuttleworth and Sesame group studies.) There are a number of reports of the more classical psychodrama format being successfully applied with hospitalised patients. One of particular interest to social workers is that of the work done by Polansky and Harkins.[68] Polansky is a Professor of Social Work and Sociology, and Harkins a Psychiatric Social Worker. The programme which they ran at a private psychiatric hospital was mostly staffed by social service personnel, a matter, they write, of the "interest" of the members of their social work department rather than of any hospital policy. They present the results achieved in their ongoing psychodrama group after six years. The group was comprised of approximately 15 to 20 hospitalised psychotics or patients with character disorders. Three staff members at a time were present and the group met once a week for a one-and-a-half hour session. The authors

describe their initial sceptical, experimental attitude in starting this programme; their persistence as they achieved new results with patients which they had not been able to achieve in other ways; and their final conviction that "psychodrama is a powerful modality in the psychotherapies which has not had the widespread application its potentialities warrant." Although neither a panacea nor a nullity, as a mode of treatment psychodrama "can be helpful to a substantial proportion of patients a large proportion of the time -- which is about all one can say about any of the psychotherapies."[69]

Major features of the method which impressed these authors, who are psychoanalytically oriented, were the depth and intensity of the feelings expressed by the protagonist and others; the communication available at both action and imagery levels; the clarification achieved for both therapist and patient; and the "regression in the service of the ego on behalf of therapeutic change." They concluded that:

> . . . the psychodramatic situation may be exploited to bring powerful intrapsychic forces into play. When these can be harnessed, striking results may be achieved with some patients in the direction of eventual cures. We do not see the aim of psychodrama as univocal. The psychodramatic situation is especially characterised by its versatility and its range of communication possibilities. A broad spectrum of psychotherapeutic aims can be pursued, depending on the readiness of the patient, and the evolving competence of the staff involved.[70]

Rabiner and Drucker[71] used psychodrama with hospitalised schizophrenics. They ran a series of sessions with 30 patients as a clinical trial to determine its effect in

terms of the total hospital regime. Manifest problems were verbalised and patients saw how others shared common concerns. The patients themselves were interviewed and the majority felt the psychodrama had been beneficial. Hospital staff could not discern any harmful effect on behaviour for those patients who had found the psychodrama experience disturbing. The authors conclude that psychodrama is a useful adjunct to a total therapeutic regime.

Parrish[72] also describes a psychodrama group of chronic schizophrenic female patients run over a two-month period. Psychodrama was chosen as the medium for treatment since it was considered suitable because of its non-verbal component for teaching patients with communication difficulties. Staff members involved in the sessions were the author, a director of Social Service, a social worker who acted as auxiliary ego, and two volunteers. Although the study was not scientifically conducted with the comparison of a control group, what was considered as remarkable progress was made by 20 of the 32 patients. No definitive statement could be made as to the amount of "movement" or improvement by patients due to the psychodrama, or to drugs on which they were placed at the onset. However, no similar improvements were found in a group of patients placed purely on drug therapy without psychodrama.

Harrow[73] found that psychodrama was effective in enhancing the role-taking ability of schizophrenic patients in terms of their greater facility for social interaction and ability to enter relationships, and in terms of their orientation towards reality.

The enactment of plays written by patients proved helpful in their socialisation and treatment. Apart from its therapeutic use, psychodrama was of diagnostic value with the patient being seen in the midst of his interpersonal relationships in realistic situations.[74] In another British application, a modified form of sociodrama was experimented with in a large group of about 40 to 50 patients drawn from long-stay, short-stay and day departments of the hospital.[75] Relaxation and movement was used in addition to a music-making technique of creating "sound pictures" from simple objects such as bottles and tins. The total group was divided up into small groups which chose a subject and rehearsed a sound enactment which was then tape recorded. This technique appeared to stimulate a group feeling. (These activities are related more to a creative drama format than to sociodrama.) The so-called "sociodramatic" situations enacted by the group members were chosen by personnel participating in the exploratory project. The authors were "impressed with the /resultant/ group dynamics" within and without the sociodrama group and the way the group was able to solve and contain its own problems.

These experiences with psychodrama and modifications in mental hospitals point to the scope open to social workers in large mental hospitals where group work is often restricted to serving the more integrated "healthier" patients. Hollander[76] describes an active and professional psychodrama programme which serves a variety of different units in a large mental hospital as well as the geriatric

section. The psychodrama staff comprise 33 trained directors and the programmes aim at diagnosis, treatment, rehabilitation, planning and staff training and problem-solving. Warner[77] describes a similarly functioning centralised psychodrama department in a small, private psychiatric centre. Two patient groups of approximately 12 members each are held weekly. Private sessions are also held for individual patients which might be attended by members of the patient's family and his psychiatrist or social worker. Staff training sessions are also held. Warner feels that psychodrama meets the needs which personnel working in the mental health field have for personal growth and helps increase their sensitivity, flexibility and creativity in their work. For the patients, psychodrama is an advantageous treatment modality in a hospital run on therapeutic community lines essentially involved in crisis intervention. Psychodrama provides a synthesis for the various treatment modalities used. "It can help the patient focus on who he is and where he is, as well as where he has been or where he might be going. The psychodramatic experience is always vivid. Thinking, feeling and action are evoked within a problem-solving situation of relevance and urgency to the patient." Moreno himself used classical psychodrama and the psychodrama theatre incorporating his nursing staff as trained auxiliaries with psychotic patients.[79]

In settings with children, workers have found therapeutic as well as diagnostic values in using psychodrama and derivative techniques.[80] Bodwin[81] for example, using

psychodrama in a psychiatric clinic, describes its helpfulness in aiding an eleven-year old girl patient express feelings, gain insight, and work through complex problem material pertaining to her family situation. Bruch[82] also working in a psychiatric clinic treating children, reports a case study in which psychodrama was used with an eight-and-a-half-year old boy who presented with a facial tic and partial paralysis of his upper right arm following vaccination. He found that the psychodrama speedily helped to facilitate a supportive relationship, and aided the discharge of tension. After a time the psychodramatic re-enactment of the traumatic vaccination episode was undertaken. The boy's symptoms disappeared and on follow-up 18 months after treatment he was still symptom-free.

Although no formal assessment of results was made, using behavioural indices as criteria, Lockwood and Harr[83] found that psychodrama, employed within the context of an ongoing group emphasising a play therapy medium, was of "clear" therapeutic value. Their group comprised 8 children, ages 9-10 years, whose emotional disturbances ranged from mild adjustment reactions to active psychotic pathology. The common denominator in the group was each member's feeling of being an "outsider". When the psychodrama sessions were introduced, the group was already a cohesive one. The therapists had found that traditional play therapy, although productive, was proving insufficient as sole medium for the expression and resolution of conflicts. The children, on the other hand, were not yet able to deal with problems on a verbal psychotherapy level.

Psychodrama was seen by Lockwood and Harr as an "attractive possibility" for combining play and verbal modalities in concentrating on the sources, foci and precipitants of disturbance. A classical form of psychodrama was used, with warm-up, scene-setting, action and discussion, and with other children participating as auxiliaries in support of the protagonist.

Psychodrama's formal value as a diagnostic tool was investigated by Whitman[84] who found a relationship between the projective Thematic Apperception Test and improvisation techniques. Both revealed some mutual consistency in the analysis of personality.

Starr[85] used psychodrama to good effect in treating children's problems by involving the entire family. Sullivan[86] found psychodrama "invaluable" as a therapeutic and diagnostic tool in working with large numbers of children's groups in a child guidance clinic. She found that each child typically went through an initial period of resistance to the psychodramatist as adult. This was expressed aggressively and handled in a variety of ways, depending upon the child. Following this period was one in which the child's free spontaneity was encouraged by the psychodrama therapist. The child was allowed to select his own topics of conversation, express his own insights, and choose his own play and companions for play. Initially a neutral level was maintained in which the child's problems were not emphasised. Then Sullivan describes the introduction of a variety of standard situations which were set up for the child to enact, with other children

functioning as auxiliaries or members of an audience. The situations covered a range of interpersonal relationships between child and family, child and friends, and child and society in general. These were helpful in providing specific diagnostic information as to how the child handled and reacted to certain situations. On the basis of this information a planned therapeutic series of enactments was carried out, encouraging certain expressions of behaviour and utilising material discovered in the exploratory stage. Sullivan found that "almost without exception the children treated became more socially adaptable and a reasonable solution to their problems was reached in a far less time-consuming way than would have been possible with other therapeutic methods."[87] The decision as to whether to treat a child using this psychodramatic system was based upon an interview with the psychiatrist, the results of psychological tests, and a psychodramatic social questionnaire. The parents of any child treated on the programme were also brought into concurrent therapy.

Shugart and Loomis[88] describe a preliminary study which combined the use of psychodrama with play modalities in helping parents of hospitalised schizophrenic children learn how normal, healthy children think in situations, relationships, and play. The authors' hope was that by helping the parents become sensitised to the normal child's feelings and thinking processes, these parents would gain insight and understanding in the handling of their own children. This goal was achieved. Parents who were seen by the authors as resistant, guilty, frustrated and

hopeless, and often obsessively identified with their ill child benefited a great deal. Together the parents developed a sense of group cohesion, learned how alike their children were, and consequently experienced relief and support. Their feelings of isolation and guilt were minimised and their ability to handle broader community attitudes increased. There was what the authors referred to as a significant "carry-over" of insight gained and material covered in the psychodrama sessions to casework interviews conducted with the parents. This helped the casework process considerably by opening up areas for the exploration and examination of feelings. The groups were diagnostic as well as therapeutic on a variety of levels involving emotional release and the gaining of insight. An opportunity was provided for observing the parents' habitual ways of reacting to and handling their own children. The group met once a week for a two-hourly session over an eight-month period.

Strean[89] also used a psychodramatic form of role playing to help facilitate the therapy of parents of emotionally disturbed children. The parents were themselves emotionally distressed, and the role playing helped them to establish less pathological patterns of interaction with their children during and after the programme of therapy.

Psychodrama and role playing have been taken into the home and family environment. Blake,[90] for example, found that by using psychodrama in the child's own home and involving his parents in the working through of everyday

conflicts and in promoting social learning, the child and his parents both benefited. Blake found that the children's sensitivity increased; they were enabled to see "the world" from different points of view, and the learning of new social skills was facilitated. Twitchell-Allen[91] used role playing in her own domestic situation to good effect. She maintains that, if competently instructed, many parents could acquire the role playing skills necessary to handle common crises and problems. For example,

> Without getting into too deep emotional areas, a large number of parents could alleviate everyday tensions and anxieties more effectively through role playing than they are at present through punishing, or tense moralizing, or diffuse sentimental comforting. Through role playing, parents on their part, have been seen to derive a new satisfaction in their relations with their children.[92]

In an article on role playing in the home, Knowles[93] also describes a personal use of role reversal in his family, and its helpfulness in clearing up sibling, parent-child, and peer-group tensions and conflicts. Lippitt[94] too found psychodrama in the home useful in working with children. Whereas discussion of another's feelings did not change behaviour, the active playing of the role of the other seemed to change the child's behaviour. J L and Zerka Moreno describe the uses of role playing, role reversal and doubling in the upbringing, personality development, socialisation and disciplining of their son Jonathan.[95]

The implications of the work described above by Blake, Twitchell-Allen, Knowles, Lippitt and the Morenos hold interesting possibilities for family therapists and child

guidance workers.

In the field of mental retardation, psychodrama and role playing have been found to be useful and beneficial. Brandzel,[96] for example, used role playing to help prepare handicapped youths for job interviews and skills practice. Sarbin[97] feels that role playing is ideally suited for evaluating and training mentally defective persons, in terms of social interaction, the practical tasks of everyday life, and for work. Based on his assumption that the so-called feeble-minded might be stimulated through psychodrama and role playing to react intelligently to social situations and to expand their social knowledge and role capacities, he conducted a two-month project of role playing with a group of young institutionalised retardates. Twenty-two males and females whose ages ranged from 16 to 28 years, and whose IQ's spanned a range of 57 to 84 met for eight weeks, three mornings a week. Although his was not a formal study of the efficacy of the medium, Sarbin felt that, on the basis of his observations during this programme, his original hypothesis was borne out. He concludes that similar programmes and the scientific verification of his hypothesis would contribute towards improved theoretical formulations as to the psycho-social nature of "intelligent" and "non-intelligent" behaviour, reduce the number of institutionalised retardates, and solve the socio-economic aspects of the "problem" of the retarded. The action media revealed that the feeble-minded are not "obliged" to act "stupid, without self-expression, without spontaneity."[98] Using an experimental approach Tawadros[99]

found that spontaneity training and psychodramatic enactment of situations was valuable with feeble-minded children in helping them to develop social intelligence in dealing with everyday life situations. It also helped them to become familiar with the roles and functions of various occupational, professional and official persons in the local community. He found that the training facilitated the children's general creativity and was valuable as a diagnostic tool for the therapist.

The applications of psychodrama in fields of interest to social workers are indeed varied and wide-ranging. Eliasoph,[100] for example, used a combination of group therapy and psychodrama in the treatment of adolescent drug addicts. He found the psychodrama valuable in promoting a "fuller expression of feelings, and attitudes towards self, towards others, towards treatment, and . . . freer interaction between the group members."[101] An enhanced awareness of distortions in and expectations from interpersonal relationships resulted. Eliasoph also valued the effect he saw psychodrama had in raising the level of patient participation in their therapy sessions. The situations enacted ranged from family relationships to dealing with "pushers" of drugs and with the addicts' attitudes towards and feelings when taking drugs.

In working with adolescents, Lebovici[102] found psychodrama valuable as a diagnostic and therapeutic tool, and describes its impact. Godenne[103] found that psychodrama in adolescent outpatient therapy groups, if introduced during the initial sessions, was useful when utilised

frequently as an adjunct during subsequent meetings. Psychodramatic enactment helped members tell the group what was happening in their families without feeling defensive about revealing "secrets" and talking about problems at home.

Zerka Moreno[104] describes the use of psychodramatic role playing in a well-baby clinic, helping mothers release anxieties and become more understanding and relaxed in handling their babies. As part of the process, trained auxiliary egos and group members played the role of baby, demonstrating and articulating in surplus reality the infant's needs and presumed feelings. Steinmetz[105] found that a combination of group discussion and psychodramatic role playing helped unmarried girls in a maternity home gain insight into their problems and try out methods of interacting with their family and friends. The medium also helped them to adjust to the home itself.

Role reversal, soliloquy, "sculpting", and doubling are seen as potentially useful in marital counselling and couples' work. J L Moreno[106] also found that an engaged couple was helped by acting out roles such as housekeeper, provider, lover, and emotional companion in order to explore and clarify the problems of adjustment which might arise in marriage. His report indicates a possible use which social workers in marriage guidance might make of role playing.

Riessman[107] suggests that role playing is valuable for use with low-income groups because he feels it is

congruent with a "do", or action style rather than "talk"; it tends to reduce the role distance between the worker and the economically-disadvantaged person; it gives the worker the opportunity to learn about the client's culture from the "inside", e.g., through role reversal; it changes the setting and tone of what might appear to a low-income person as an "office-ridden, institutional, bureaucratic, impersonal, foreign world"; and it facilitates verbalisation in the educationally deprived person.[108]

Finally, the indications are that psychodrama and its derivatives could usefully be applied by social workers in the field of crime and corrections, and the rehabilitation of the offender. Moreno himself contributed a great deal towards this field, and the history of group therapy and psychodrama is closely allied to this source. For example, in 1932 Moreno presented a group psychotherapy plan for prisons to the American (New York) National Committee on Prisons and Prison Labour.[109] Growing out of this he researched his ideas at Sing-Sing prison and used them whilst a psychiatrist at the Hudson Training School for Girls, a correctional institution. At Hudson, Moreno used sociometry and psychodrama for diagnosis and therapy. As a result the incidence of temper tantrums, stealing and aggressiveness declined and there was a reduction in the number of runaway girls. Role training was used and, prior to discharge, "exit tests" were given based on the family, work and community situations the girls were expected to face once "outside" the institution.

Many of Moreno's early proposals and recommendations

were later put into practice by therapists and others working in prisons and institutions. Lassner,[110] for example, used role playing with groups of prisoners. Participants found they were able to look at themselves from another's point of view. They gained understanding as to the causes of their behaviour and were enabled to begin to face the realities of their life situations. Yablonsky[111] used role playing, role-training, and psychodramatic techniques with parolees to rehearse for and explore social situations they were likely to face once released from prison. In a study of the effectiveness of psychodrama in a correctional institution, Herman[112] found a tendency for boys who had participated in ten weekly psychodrama sessions to stay less time in the institution than did a control group who had not participated in the psychodrama. A statistically significant number of the experimental group appeared on the "Honour roll". There were also fewer defections amongst the experimental group.

After fifteen years of experience in penal systems, trying out and observing a wide variety of types of group methods, Corsini[113] concluded that psychodrama was the one method which achieved what he saw as "deep" individual treatment. He feels that the active participatory nature of the method and its insistence on reality is the key to its effectiveness.

An unusual application in the penal field was described in "Time" magazine.[114] Prisoners serving sentence participated in enactments of prison life before an audience of judges in a psychodrama workshop. As a result

of the workshop, three judges volunteered to be admitted to prison for a day and experienced institutional "outrages" which confirmed prisoners' views and complaints that "rehabilitation" and "correction" were misnomers for the actual process of stripping away prisoner identity and rights.

Sharon Hollander[115] describes the effectiveness of "sociatric" services including psychodrama rendered to prison inmates involved in drug offences. She found that the psychodramatic process allowed

> . . . life to come into the prison. It provides an avenue for the men to deal with their social atoms, and to spontaneously experience their feelings, creativity and alternatives for their lives. They learn that their incarceration, addiction and unlawful activity is directly related to their inability to fully experience themselves, develop social linkages, and find emotional intimacy with others.[116]

She believes that "rehabilitation is providing people with opportunities to develop viable social atomic systems that can allow them to experience their own spontaneity, creativity and power."[117]

E. CRITICISMS AND CONTRA-INDICATIONS

In my review of the literature I found no critical writing, empirical studies of criticism, or of negative results or reports of casualties resulting from psychodrama. This could be due to the fact that most people writing about psychodrama are practitioners who are skilled in the method, or are professionals who have positive regard for the method.

What I did find, however, was documentation of the common fears or criticisms of psychodrama which are often voiced by critics, but not written about. One such documentation has been made by Blatner.[118] Another is that of Kreitler and Elblinger.[119] These authors concede the possibility that such fears or criticisms might be valid if psychodrama is improperly used. However, with the lack of scientific validation or even documentation of improper use, these criticisms appear to reflect a lack of understanding of the principles and process of the classical method and a resistance to what might seem "new" or different to the critic's own standpoint or method with which he or she is comfortable.

Another source of literature I found deals with the indications and contra-indications of using the method with certain categories of persons and under specified circumstances. This body of literature seems to be designed for the psychodrama practitioner, and points to the pitfalls which might be experienced during training and possible sources of abuse arising from inadequate training.

Blatner's list of the ten most commonly held "reservations" about psychodrama is a comprehensive one, viz.,

- A fear of <u>acting-out</u> associated with the meaning of action in psychodrama
- A fear that enactment may lead to <u>loss of control</u> and <u>precipitate psychosis</u> or violent behaviour
- A criticism that psychodrama seems <u>unnatural</u>
- That it is <u>directive</u>
- A reservation about the usefulness of <u>action rather than verbal methods</u> to clarify group views
- A perception of action techniques as "<u>gimmicky</u>"
- Reservations from persons who have only seen

psychodrama being directed by insufficiently trained directors

- A criticism which regards the involvement of the use of "role" as artificial
- A suspicion that enactment distorts the protagonist's conflict
- Criticism of the lack of controlled experimental studies in the field[120]

Blatner answers these reservations in the following manner. Firstly, as regards the meaning of action in therapy, the question persons have is whether enactment is equivalent to acting-out in the sense of "antitherapeutic discharge of neurotic tensions through behavior which repeats an unconscious psychic situation" when the subject acts out instead of "remembering" fully with "appropriate attending emotions".[121] Blatner states that there is often an erroneous inference that this "remembering" should be verbalised and not enacted, since verbalisation appears to involve the "conscious" ego. However, he feels that the issue is not one between verbalisation versus enactment, but whether, as he puts it, the "remembering is done within a therapeutic framework".

> Thus, psychodrama is not equivalent to acting out because the enactment takes place within the self-observing context of individual or group therapy. The "acting" occurs in the therapy and would better be called "acting-in" . . . The unconscious and preconscious material can be brought into awareness and examined by therapist and patient.[122]

As regards the fear of loss of control, Blatner points to the "subtle norm" in American society which distrusts action and affect. (One might extend the existence of this norm into Western society in general.) Enactment is seen as acting, as connected with the theatre and as somewhat

frivolous and unreal. In addition the Freudian influence in society tends to lead people to perceive excitement and movement as belonging to childish and primitive areas of life opposed to the cognitive and verbal spheres of behaviour. Acting in therapy is, often mistakenly, associated with impulsivity.

Psychodrama, as has previously been noted in Chapter I, page 26, encourages controlled or therapeutic acting-out. The method provides a connection between the simple discharge of tension, the abreactive catharsis of emotion and the integrative understandings. Acting-out takes place within a recreated situation, the situation to which the feelings, often unexpressed at the time, belong.

Regarding the fear that the anxiety generated in a psychodramatic situation by an intense catharsis or the expression of conflict might lead to a psychotic breakdown or violent behaviour, Blatner feels that there is no reason to expect that this should in fact happen. He points to the supportive presence of the group, the use of timing, and the confidence and skill of the therapist.

> As in verbal therapies, the problem is not whether to generate anxiety, but rather how to structure this essential process in therapy. The channeling of anxiety is done through the use of proper timing and the maintenance of some effective coping strategies which are available as alternatives to the old patterns which must be renounced.[123]

He feels that the presence of a group which communicates their willingness to stay with the protagonist in his despair is important. Particularly if they are cohesive and confident they can help the protagonist who

fears his own loss of control.

Blatner points out that the experience of anxiety in any form of psychotherapy is related to the context of therapy and the "social field" of the subject. He reminds the reader that an experience of anxiety, if associated with a sense of abandonment or of the sense that others fear loss of control, might intensify, or exacerbate, the anxiety. There are built-in controls or safeguards to this happening in psychodrama, viz., the self-knowledge and training required by the classical psychodramatist, and the supportive norm encouraged by sharing and group cohesion. Blatner feels that with a supportive group and skilled director, the idea of avoiding upsetting a protagonist is antitherapeutic.

In this connection, it is of interest to refer again to the article by Kreitler and Elblinger. They point to the fact that anxiety is frequently the source of progress and self-realisation. The aim should not be to eliminate anxiety but to make use of it and to overcome it. "The eruption of anxiety will have the use that the therapist makes of it."[124]

The fear of anxiety is often the fear of arousing anxiety in the self. These authors feel that psychodrama can be especially useful for dealing with anxiety in the therapeutic situation "provided only that the therapist is not driven into anxiety himself by that of his patient and by his suddenly being confronted with unexpected and to him entirely new material".[125]

> Only if the patient realises that even in the extremities of an anxiety situation the contact between him and his therapist is not interrupted, will he develop a confidence in his therapist and later on in his own ego, that confidence which enables him to get over his anxiety.[126]

In their experience of psychodrama, Kreitler and Elblinger feel that scenes which could have been said to cause harmful anxiety could be blamed on the anxiety of the therapist or of an auxiliary ego, and that these people in turn were affected by exaggerated warnings against anxiety.[127] (The classic psychodrama training process takes cognizance of the importance of having the director understand his own process. The self-knowledge objectives of the training include the premise that a director who has not explored his or her own pain, anxiety, fear, anger, etc. will not be able to lead a protagonist through his.)

The third commonly encountered objection to psychodrama, viz., that it is "unnatural", might be regarded as stemming from a normative approval of the "naturalness" of the verbal model of psychotherapy. Blatner suggests that, although verbal interchange is more familiar to most people, involvement in the media of action opens up rich and new ways of experiencing.[128]

The criticism that psychodrama is directive, implying manipulative, might stem from the observed <u>activity</u> of the director. As Blatner points out, to be directive in the sense of requesting a protagonist to try out an activity is not equivalent to being directive in the sense of imposing a focus or interpretation. The trained psychodramatist will always respect the protagonist's choices and readiness

to explore areas suggested to him by the director.[129]

As regards the criticism that conflicts within a group should not be dealt with by action modes, it is felt that, on the contrary, whereas verbal discussion can reinforce individual perceptions and terms of reference, action produces a shared experience to clarify different sets and is a catalyst for verbal discussion.[130]

Concerning the accusation of "gimmickyness", the well-trained, self-aware psychodrama director should not use techniques for their own sake. This perception of the use of techniques as an interference with an honest and genuine relationship between therapist and patient, Blatner views as being linked with criticisms from persons who have perceived psychodrama to be boring to the audience, awkward for participant and destructive of protagonist self-esteem. Once again, Blatner refers these criticisms to inadequacies in the director observed rather than to the method itself.[131]

The eighth criticism observed by Blatner, viz., that any use of <u>roles</u> is artificial and "phony" could arise from a misunderstanding of the concept of role as a unit of behaviour. Role is often mistakenly identified with dissimulation or falseness. Blatner feels that role is, on the contrary, compatible with a model of man as spontaneous, involved, and self-actualising.[132]

As to the ninth criticism, Blatner counters that there is indeed less distortion in psychodrama than in other methods as past events are relived in action, releasing sense-memories, and inducing involvement and the relaxation

of defensive moves around the events.[133]

In response to the tenth reservation, Blatner calls on responsible workers in the field of psychodrama to subject their activities to the rigours of theoretical and empirical research.[134]

Wolson[135] also discusses clinical evidence concerning the danger of precipitating "breakdowns" in psychodrama and the management of loss of impulse control in psychodrama when it is about to, or actually does occur. He too states that it is the fear of inducing "psychotic decompensation" in fragile patients which is the greatest concern among critics of psychodrama.[136]

He writes that he himself in his experience as psychodrama director in in-patient hospital programmes, has not seen patients decompensate or become psychotic in psychodrama. He has seen exceedingly fragile or vulnerable patients portray protagonists with no subsequent worsening of their psychopathology. Indeed, judging from ward reports he feels that these patients seem to become more motivated to confront their problems and to socialise with others, and that there is an observed carry-over of this motivation to their individual therapy.[137]

What might be considered as the "most dangerous phenomenon" to occur in psychodrama was loss of impulse control with respect to the expression of <u>anger</u>. This, however, occurred in only four out of 150 cases Wolson treated with psychodrama. He states that "these uncontrolled expressions of anger were remarkably abrupt and were

managed completely within the psychodrama session."[138] What might be termed "psychotic" was a momentary lapse of reality testing at the same time as the expression of emotion was taking place. The patient behaved as though the hostility were directed at his real life opponents and not auxiliary egos. In other words, for that moment, the two merged. This lapse of reality testing did not, however, extend beyond this momentary point and no bizarreness or thought disorder remained after the session. This sort of momentary transference effect was in fact part of the therapeutic process for the patient. The criticism that facing and living through in action traumatic episodes or feared incidents will break down defenses and flood the patient with dangerous or threatening impulses stems, Wolson feels, from a lack of understanding of the enactment process. He agrees with Moreno that it is precisely this confrontation, this reliving which is liberating and reduces anxiety and psycho-social problems.[139]

Wolson concludes that the clinical competence of the psychodrama director is of primary importance in managing the loss of impulse control effectively. Ward-staff should also be kept abreast of all developments in psychodrama so that it does not become an isolated aspect unintegrated with the rest of the patient's hospital experience.[140] To maximise the therapeutic potential of the occurrence of loss of impulse control the director needs to be acutely sensitive to the patient's capacities to tolerate stress and regression; to be self-observing when emotionally upset; and to be responsive to external controls and

limit-setting techniques. (He suggests that staff members should be present who are able to control patients -- against their will if need be.)[141]

What is important for patient selection for psychodrama, Wolson feels, is not the specific diagnostic category or diagnosis of "fragility" or "ego-strength", but the assessment of whether the patient can attend to and participate meaningfully in the process without being too anxious, combative, out of touch with reality, or disruptive. For example, severely uncommunicative, frightened or withdrawn schizophrenics or exceedingly excited persons in manic flights would be considered unsuitable for psychodrama.[142]

As regards certain categories of persons for whom psychodrama is contra-indicated, Blatner also feels that patients or clients who are likely to be unusually demanding should be carefully evaluated prior to inclusion in a psychodrama group. Other factors which he feels should be considered in the selection process of both hospital and outpatient groups are whether the potential group member is likely to dominate the group's attention if caught up in a life-crisis without another source of help such as individual therapy; whether the potential member is attending against specific advice of a therapist; whether the potential member has a supportive network of family or friends to return to after the groups; whether he or she has been coerced into attending the group; and whether he or she is clear about the level of self-disclosure and participation likely to pertain in the group.[143]

Blatner also cautions against using physical contact with adolescents or groups who are not used to the norms of encounter methods. For these persons the use of touch or hugging might assume a "distinctly sexual and/or threatening significance".[144] The director should also be aware of personal vulnerability when working with co-workers or persons who are related to each other in professional or occupational roles.[145] The professionally aware director running private groups should ensure access to follow-up psychotherapy for group members and have a "back-up" network, e.g., psychiatric support to provide medication, hospitalisation and other forms of crisis intervention when needed.[146]

In a note on indications and contra-indications for acting-out in psychodrama, Moreno writes that it is contra-indicated for use with suicidal or homicidal patients, unless precautions are taken to protect the patient from himself, and the patient is being seen in the context of a supervised hospital community. Such patients may be so warmed-up to enacting in reality that the psychodramatic enactment of fantasies may simply support and prepare the patient to carry out the suicidal or homicidal act in life. Certainly such enactments are, he feels, contra-indicated when working from settings such as day hospitals, offices or extra-mural clinics.[147]

Seabourne[148] too, cautions on the need to avoid the practice aspect of such fantasies when working in in-patient programmes. When psychodramatic work is done with such patients she underlines that it is important to

separate fantasy from realistic consequences. The patient could be helped to communicate his or her message in alternative ways. The protagonist may watch auxiliaries doing a homicidal scene, or in role reversal be the "murdered" other. The important element in such work is to enact the consequences of the feared or fantasised act. The suicidal patient may find the desire to be alive again, and realise the absoluteness of the act. The homicidal patient who enacts scenes of arrest, trial and imprisonment might realise the high price to be paid for the act.

In conclusion, it would seem that education about the principles involved in the use of the psychodrama method and its techniques, and an insistence on prescribed approved training for those using the full classical method, are the best safeguards against improper uses of the method. Moreno himself seemed to take it for granted that classical psychodrama would only be practised by a skilled, trained, director.[149]

NOTES

on Chapter IV

1 Marjorie Murphy, "The Social Group Work Method in Social Work Education", in A Project Report on the Curriculum Study, XI, Werner W Boehm, Co-ordinator, (New York: Council on Social Work Education, 1959), pp. 39-40.

2 Howard A Blatner, for example, points out the "discovery" by the fields of education, psychotherapy and industrial relations of the benefits of programmes integrating participatory, experiential learning with the more verbal, cognitive analysis of problems. He feels that psychodramatic techniques may effectively be used in any field which requires the exploration of the psychological dimensions of a problem. The psychodrama methodology would require to be modified to meet the needs of the respective practitioner's personal style, role and abilities. Acting-In: Practical Applications of Psychodramatic Methods, (New York: Springer Publishing Co., 1973), p. 98.

3 Florence Hollis, Casework: A Psychosocial Therapy, (New York: Random House, 1964).

4 Ibid., pp. 213-215. The congruence of these aims with those of psychodrama as outlined in the beginning of Chapter I of this study might be recognised.

5 Gordon Hamilton, Theory and Practice of Social Case Work, 2nd ed., (New York: Columbia University Press, 1951), pp. 245-248.

6 Hollis, op. cit., pp. 96-98.

7 J L Moreno, "Interpersonal Therapy and the Psychopathology of Interpersonal Relations", Sociometry, I, No. 1-2, (1937), pp. 9-76.

8 The problem situation to be explored, and the personality type of the client should guide the choice of alternatives employed. Care should be taken, when using the psychodrama à deux format, not to confuse the role of caseworker with the roles played in the life and "mind" of the client. J L Moreno writes that "the psychodramatist in private practice frequently prefers to employ his own nurse as an auxiliary ego to maintain his identity as director unimpaired", in collaboration with Z T Moreno, Psychodrama, Vol. II, (Beacon, New York: Beacon House, 1959), p. 232.

9 Gisela Konopka, Social Group Work: A Helping Process, 2nd ed., (Englewood Cliffs, New Jersey: Prentice-Hall, 1972), p. 23.

10 Scheidlinger describes the early sources of group psychotherapy as Pratt's group session for tuberculotics (1905); Moreno's psychodrama (1911); Lazarus's group treatment of persons suffering from dementia praecox (1919); Schilder and Mender's psychoanalytically-oriented groups (1930); Slavson's group therapy with children and Lowry's work with mothers. Saul Scheidlinger, "The Concepts of Social Group Work and of Group Psychotherapy", Social Casework, XXXIV, No. 7, (1953), p. 292. Corsini moves even further back to date the sources of group therapy in ancient forms of religious healing (600 B C - 200 A D), and to Mesmer's form of animal magnetism (1776). Of the modern forerunners of twentieth century group therapy, he feels Moreno was the most important. Raymond J Corsini, Methods of Group Psychotherapy, (New York: McGraw Hill Book Co., The Blakiston Division, 1957), p. 15.

11 See Scheidlinger, op. cit., p. 293.

12 Corsini, op. cit., p. 5.

13 Robert D Vinter, "An Approach to Group Work Practice", Chapter 1 in Robert D Vinter, ed., Readings in Group Work Practice, (Ann Arbor, Michigan: Campus Publishers, 1967), p. 4.

14 Catherine P Papell and Beulah Rothman, "Social Group Work Models: Possession and Heritage", Journal of Education for Social Work, II, No. 3, (1966), p. 66.

15 Ibid., pp. 66-67.

16 Ibid., p. 67.

17 Ibid.

18 See, for example, Gertrude Wilson and Gladys Ryland, Social Group Work Practice, (Cambridge, Mass.: Houghton Mifflin Co., 1949), pp. 284-302.

19 Ibid., p. 302.

20 Ibid., p. 289.

21 Roy E Shuttleworth, "Psychodrama in the Rehabilitation of Chronic Long Stay Patients", Self and Society, I, No. 4, (1973), pp. 7-11.

22 A sociodramatic situation which Shuttleworth found useful was one in which group members were allowed to examine their feelings towards treatment and the institution by playing the roles of staff members during a staff conference. Op. cit., p. 10.

23 R M Nitsun, J H Stapleton, and M P Bender, "The Sesame Research Project of Drama Therapy with Long-Stay Schizophrenics at Goodmayes Hospital, Ilford, Essex,

(February to July 1970)". An unpublished report issued by Sesame, London, 1974.

24 H A Luiz and P B Hotz, "The Long-Stay Psychiatric Patient: A Rehabilitation Challenge", Rehabilitation in South Africa, XX, No. 1, (1976), p. 3.

25 Ibid.

26 Jeffrey Galper, "Nonverbal Communication Exercises in Groups", Social Work, XV, No. 2, (1970), pp. 71-78.

27 J L Moreno, Who Shall Survive?, 3rd ed., (Beacon, New York: Beacon House, 1978), pp. 86-87.

28 Ibid., p. 87.

29 Murray G Ross, Community Organization: Theory and Principle, (New York: Harper, 1955), p. 92.

30 Moreno, Who Shall Survive?, op. cit., p. 87. Also in J L Moreno, Psychodrama, Vol. I, 4th ed., (Beacon, New York: Beacon House, 1972), p. 352.

31 Moreno, Who Shall Survive?, op. cit., p. 88.

32 Ibid., p. 379.

33 Ibid.

34 Ibid.

35 See, for example, J L Moreno, "Sociodrama: A Method for the Analysis of Social Conflict", Psychodrama Monographs, No. 1, (Beacon, New York: Beacon House, 1946).

36 Florence B Moreno, "Psychodrama in the Neighbourhood", Sociatry, I, No. 2, (1947), pp. 168-178.

37 Bert Hanson, "Sociodrama in a Small-Community Therapy-Program", Sociatry, I, No. 1, (1947), pp. 92-96. Also c.f. Bert Hanson, "Sociodrama: A Methodology for Democratic Action", Section 20, in Robert Bartlett Haas, ed., Psychodrama and Sociodrama in American Education, (Beacon, New York: Beacon House, 1949), pp. 159-175.

38 Hanson, "Sociodrama in a Small-Community . . . ", op. cit., p. 93.

39 See, for example, J L Moreno, "Sociodrama", Section 8 in Psychodrama, Vol. I, pp. 315-383; J L Moreno, "Sociodramatic Approach to Minority Problems", Journal of Group Psychotherapy and Psychodrama, V, No. 1-3, (1952), pp. 7-19; and J L Moreno "Sociodrama: A Method . . . ", op. cit.

40 J R P French (Jr), "Retraining an Autocratic Leader", Journal of Abnormal and Social Psychology, XXXIX,

No. 2, (1944), pp. 224-237.

41 Edgar F Borgatta, "Analysis of Social Interaction and Sociometric Perception", Sociometry, XVII, No. 1, (1954), pp. 7-32.

42 Edgar F Borgatta, "An Analysis of Three Levels of Response: An Approach to some Relationships among Dimensions of Personality", Sociometry, XIV, No. 4, (1951), pp. 267-315.

43 Irreal is a term used by French to describe the fact that role playing, although a "dramatic play-like activity . . . paradoxically /is/ also very concrete and realistic." John R P French (Jr), "Role Playing as a Method of Training Foremen", in Group Psychotherapy: A Symposium, a publication comprising the papers read at the American Psychiatric Association Meetings, 31 May, 1932, J L Moreno, ed., (Beacon, New York: Beacon House, 1945), p. 421.

44 Corsini calls this phenomenon of subjectively experiencing the reality of role playing or psychodrama, the principle of veridicality. He gives the example of trained pilots learning on simulated airplane cockpit apparatus. The motors run, dials move, the "plane" pitches and in every way the verisimilitude of the planned experience has a subjective reality for the pilot participating in it. Sometimes role playing might be flat; however when role playing is "successful" it is a psychologically realistic experience. "Only those who have actually experienced such events can fully understand the almost unbearable excitement of the therapeutic instant in role playing . . . role playing cannot only become real, it can become the most real moment of a person's life. The patient may break through his artificial facade and come to a 'meeting' with another that transports him from his usual reality to a new dimension of meaning." Raymond J Corsini, Roleplaying in Psychotherapy, (Chicago: Aldine Publishing Co., 1966), pp. 16-17.

45 In relationship to this point about feedback, Bavelas found that whilst using role play in industrial training settings, an individual group member often made the same mistakes that he had previously been observed to have made unconsciously whilst on the job in the real-life work situation. However, the difference was that after the role playing enactment, such individuals would spontaneously point out to himself and others the errors he had made. In other words, he was conscious or aware of the errors he had made. Alex Bavelas, "Role playing and management training", Sociatry, I, No. 1, (1947), pp. 183-191.

46 Pioneeress of social work, Mary Richmond fails to appear dated some sixty years later. She wrote: "What /the social worker/ thinks of human nature is bounded by what he is." Social Diagnosis, (New York: The Russell Sage Foundation), 1917, reprint ed., 1956, p. 376.

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CHAPTER V

ALCOHOLISM AND PSYCHODRAMA

A. INTRODUCTION

In this chapter some of the major characteristics of alcoholics and features of the problem of alcoholism, relevant for purposes of this study, are presented. Following this is a review of the literature on work done using psychodrama with alcoholics.

B. ALCOHOLISM

1 Alcoholism Defined

People with alcohol problems range from those who drink periodically in order to lessen anxiety, to escape reality, or cope with the demands of everyday life, to those who are completely dependent psychologically and physically on alcohol for daily normal functioning and who have withdrawal symptoms of physical and mental distress if they cease imbibing alcohol even temporarily.

Fox defines alcoholism as

> . . . a behavioural disturbance in which the excessive drinking of alcohol interferes with the physical or mental health of the individual. It is usually accompanied by a disturbance in the interpersonal relationships within the family, in the work life, and in the social environment. It is also an addiction, which means that there is both an emotional and a physiological

dependence on the drug alcohol.[1]

The psycho-physiological dependence and the effect of problem drinking on individual psycho-physical social functioning is contained in most modern definitions of alcoholism.[2] For example, the American Psychiatric Association classification of mental disorders reserves the category alcoholism for "patients whose alcohol intake is great enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning."[3] They recognise three types of alcoholism, viz., (i) episodic excessive drinking, in which a person who may be recoginsed as alcoholic drinks to the point of intoxication at least four times a year;[4] (ii) habitual excessive drinking in which a recognisable alcoholic may become intoxicated more than a dozen times a year or, even if not intoxicated, be seen to be "under the influence" of drink more than once a week; (iii) finally, alcohol addiction, which is the diagnosis reserved for persons who are so dependent upon alcohol for their normal functioning that they are unable to go one day without drinking and display withdrawal symptoms if alcohol is discontinued.[5]

The medical model which views alcoholism as a disease or set of symptoms is the most commonly accepted mode of looking at the problem. For example, in 1972 the United States Department of Health, Education and Welfare in a special report to the Government defined alcoholism as "a primary, progressively pathological, constitutional reaction to alcohol ingestion: psychological symptoms are

secondary, derivative, and progressive regardless of pre-morbid psychosocial antecedents."[6]

The advantages of the medical model are that it helps practitioners in their diagnosis and treatment: it helps to de-stigmatise alcoholism from former notions of moral disapprobation: and aids both the alcoholic's own acceptance and societal acceptance of the problem of alcoholism. It also stresses the treatment goal of complete abstinence from alcohol. A potential disadvantage of the disease concept is that it may ignore psychological, emotional, or spiritual problems. Another disadvantage is that certain individuals might feel absolved from investing their own personal responsibility and motivation in the treatment process. They may rationalise that because they are "sick" they cannot help drinking, and do nothing to attempt abstinence. However, modern treatment methods take into account psycho-social factors and motivation. A <u>psychiatric</u> or <u>psychotherapeutic medical</u> model is the most holistic way of looking at alcoholism, i.e., one which comprises both a physical and a psychodynamic perspective.

As implied in the definitions cited, alcoholism has high physical, emotional, and economic costs for the individual affected, his or her family, and the society at large. Physically the alcoholic suffers as his tolerance to liquor increases apace with larger amounts he now takes. Gastritis, malnutrition, vitamin deficiency as a result of loss of appetite for food, cirrhosis of the liver, peripheral neuritis, amnesia for recent events, all take their toll. Psychosis could result from chronic alcoholism. In

many cases personal suffering, feelings of remorse, hopelessness, degradation, social isolation, and depression might end in suicide. Kessel and Walton state that many alcoholics kill themselves.[7] They cite a Sandinavian study of 220 male alcoholics which found that 7% of the subjects killed themselves during a five-year period after hospitalisation. Yet another study they cite records that the suicide rate amongst male alcoholics admitted for treatment to a London hospital was 86 times as high as the rate for men in the same age groups in the general London population.[8]

The costs extracted in terms of family life, the misery and anguish produced in the quality of marital and family-child relationships are usually high. Apart from the common absence or disruption of any warmth or intimacy required for communication, and the self-destructive spiral along which the course of unchecked alcoholism travels, the emotional frustrations the alcoholic feels are often taken out when drunk in violence and rage to those close to him or her. Society too suffers from the loss of the potential contribution the alcoholic could make as a fully functioning human being were he not ill; from loss of employer productivity and absenteeism due to drinking bouts; and from the incidence of drunken driving and road accidents.

2 Incidence of Alcoholism

In a paper presented at the First International Conference on Alcoholism in South Africa, the Secretary for

Social Welfare and Pensions pointed out that although it is generally accepted that alcoholism is a severe social problem in South Africa, there was no scientific study providing accurate statistics of the incidence.

> Nobody really knows what the incidence of this phenomenon in the South African society is. Literature on the subject either candidly admits that the extent of the problem is not known or contents itself with estimates obtained by applying the one or other formula developed by the one or other expert in this field.[9]

Two such studies the Secretary referred to in his paper are those of Jabour,[10] a researcher for the Department of Social Welfare and Pensions, and Louw.[11] Jabour estimated that there are 60 404 White alcoholics, and 143 800 White abusers of alcohol. Louw put the number of alcoholics at 65 000 of the White working population and calculated the cost to employers due to working hours lost on account of absenteeism caused by alcoholism as being 7 800 000 hours per annum.[12]

Van Vuuren notes that a total of 14 664 372 people of all races out of a total of 22 987 000 are estimated to be using alcoholic beverages.[13] Not only is the incidence of alcoholism amongst the White and Coloured population in South Africa high, but the Asian and African populations, who traditionally used less liquor, are producing increasing number of alcoholics.

3 Causation of Alcoholism

Alcoholism is seen to be multiply-determined. There are probably three areas in which the aetiology of alcoholism may be found, viz., the organic, the psychodynamic,

and the socio-cultural. These may operate singly or in combination.

(a) Organic Causes

The primary physical, biological or organic causes of alcoholism remain unknown, although various constitutional hypotheses have been proposed. Thus, for example, although it has helped countless people, the view of the Alcoholics Anonymous association that alcoholics are persons who are allergic to alcohol has not been conclusively proven.[14] Other theorists hypothesise an inborn difficulty in the metabolism of alcohol.[15] Although it has been found that a large number of alcoholics are sons of alcoholics, one cannot place causation at the door of inheritance or genetic factors. Causation could just as easily be linked to environment since the alcoholic could be displaying a pattern of behaviour learned from his parent as role model.[16]

Although highly plausible and very likely probable, the theory that there is an organic predisposition in certain people for alcoholism remains inconclusive and unproved.[17]

What remain undisputed however are the physical effects of alcohol on the body. These effects themselves, in combination with psycho-social aetiological factors, could lead to increased consumption and thus to alcoholism. For example, in the early stages of excessive drinking, tolerance for alcohol increases so that it takes more alcohol to produce desired psychological effects such as

diminution of stress, or anxiety.[18] This usually marks the stage in which the alcoholic needs these psychological effects in order to function effectively. This phenomenon precedes the stage of alcoholic addiction in which alcohol becomes a necessity, and the individual drinks until he is drunk. Physical effects such as loss of memory may now occur.[19] The greater the intake of alcohol, the longer the individual has been drinking, the more serious is the negative impact upon physical functioning. By the time the stage of chronic alcoholism is reached, physical and mental symptoms dominate, and drunkenness may be produced by imbibing less alcohol than the individual previously did. The body's tolerance for alcohol is now sharply diminished.[20] The chronic alcoholic cannot drink as much as he formerly could.

> His reduced intake no longer satisfies and, what is more, it makes him disorganised and helpless whereas previously he had prided himself on how much he could take without getting drunk. Alcoholics always realize that this reduction in tolerance indicates a serious physical deterioration.[21]

(b) Psychodynamic Causes

These physical effects also fall under the heading of psychodynamic or psychological causation in the sense that many, if not all, alcoholics drink or start to drink heavily in order to produce a change in subjective mood or feeling. Alcohol might be used as a tranquilliser to deaden feelings of stress or anxiety; it might be used to lubricate the wheels of social interaction by persons who want to appear more assertive in social situations than they feel themselves to be; for confidence in sexual

situations; or for facing stressful or conflictual interpersonal relationships.

Gillis states that an alcoholic is extremely sensitive about his drinking and "feel[s] intense shame and guilt. This is one of the reasons why he keeps on drinking. He has very little self-confidence. Who would have, having tried and failed so often?"[22]

The question might be asked whether there is a primary personality factor in causation. Some alcoholics who are diagnosed as passive-aggressive or passive-dependent personality types seem to drink in order to express anger which remains bottled up when not drunk. Ben-Arie, for example, reports that the passive-aggressive or passive-dependent personality type is the most common personality disorder seen in alcoholics. "Alcoholics often have severe dependency needs, feeling of hostility towards authority figures and poor sexual identities."[23]

Kessel and Walton also state that many alcoholics display behaviour traits such as passivity and dependency "together with a tendency to place excessive reliance on another person, usually of greater competence."[24] These are traits associated with the psychoanalytic diagnosis of an "oral personality" in persons theorised to be fixated at a regressive oral stage of infantile development in which oral impulses or activities associated with the mouth have not been satisfactorily resolved and persist into adulthood. Eaton and Peterson maintain that for these types of alcoholics "it is more than a figure of speech to

suggest that the liquor bottle symbolises the nursing bottle or the breast. They drink to the extent of increased helplessness, increased need to be cared for by others."[25] Other alcoholics are compulsive drinkers, whose personalities are seen to be characterised by primarily anal traits which are psychoanalytically formulated as being associated with incomplete infantile resolution of the anal stage of psychosexual development.[26]

Despite the evidence of these common personality types formed amongst alcoholics, there is nothing to suggest that there is a typical, pre-dependent alcoholic personality. The fact that so many common traits exist amongst alcoholic populations could be a result of alcohol dependence rather than a cause. For example, Glatt writes that if "alcoholics seem to resemble each other so much it is largely due to the effects of their long-continued drinking on themselves, and on their relatives' and friends' reactions to its producing in turn secondary counter-reactions in the alcoholic."[27]

The search for a common "alcoholic personality" is very much bedevilled by the "chicken and the egg" argument of which comes first, the alcoholism or the personality. It might be conceded that there is a "predisposing psychological make-up" in the sense that anxious, tense, or inadequate individuals are more likely to turn to alcohol.[28] However, it is equally true that many such individuals do not become alcoholics. Research indicates that, although not conforming to any one personality type, alcoholics do show similar character traits. For example, Fox and Lyon[29]

tested 300 alcoholic patients in their private psychiatric practice. In all cases they found the following characteristics:

- low frustration tolerance
- inability to endure anxiety or tension
- depression and withdrawal
- sense of isolation
- extremely low self-esteem
- sensitiveness
- masochistic self-punitive behaviour
- marked dependency strivings, frustration of which led to depression, hostility and rage
- marked hostility, rebellion and defiance against authority
- sexual problems
- impulsive, repetitive acting out of conflicts with little or no insight in most cases

It should be noted that these traits could be improved or changed with psychotherapeutic intervention.

(c) Socio-cultural Causes

Amongst the important psycho-social causes of alcoholism are family influences. Firstly, in terms of stresses which might lead the alcoholic to drink in the first place in order to resolve them; secondly, in terms of learned patterns of dealing with stress by using alcohol. As has previously been mentioned, alcoholism has been found to be common in children of alcoholics. This phenomenon is regarded as having to do with environmental factors such as family disorganisation and modelling rather than heredity.[30] The role of healthy family life is regarded as an important preventive feature in that many alcoholics have come from broken or distressed homes. Kessell and Walton talk of the amount of emotional deprivation and

trauma alcoholic patients have suffered. The effects of traumatic early experiences on the personality and malfunctioning behaviour patterns are often discerned and self-damaging attitudes may derive from relationships with parents who are in constant strife. "Alcoholic patients regularly describe the early death of a parent, parental quarrelling, broken homes, undue parental harshness and sometimes very gross cruelty or neglect."[31]

Three South African researchers, Theron, Laedolff, and Rip[32] have paid attention to the quality of the relationships their alcoholic subjects had with parents, and have found a frequently occurring pattern comprising an over-protective, indulgent mother and strict, harsh and rejecting father.

Occupational influences may also affect the onset of alcoholism. For example, Eaton and Peterson[33] refer to the facultative alcoholics whose occupations bring them into almost daily contact with alcohol or involve frequent social drinking. Without realising it these people drink until a physiological dependence is reached. Bartenders could be such people. Other jobs entailing similar risks are those in which business is conducted over drinks, or frequent use is made of bar facilities, such as various sales professions or other high pressure jobs.

It is socially modish in modern Western cultures to drink. The use of alcohol is an accepted part of the social structure. Loneliness, isolation and a sense of "anomie" in fast-moving, impersonal, highly industrialised

modern societies have been blamed for the prominence given to drinking in urban communities. Although it used to be true that certain ethnic groups had little or no alcoholism because of close social and family ties and traditions, feelings of belonging and social pressures to conform to the group and not to drink, rates of alcoholism which used to be low have now increased. There are still, however, lower frequencies per population of alcoholics in groups such as orthodox Jews,[34] Chinese,[35] and the Asians and Blacks in South Africa. However, with moves from country to city, the stresses of urban life, loss of social controls, and detribalisation, alcoholism is becoming more of a social problem even in ethnic groups where drinking of other than traditional wines and beers during festivals or religious customs was not accepted or condoned.

Africans in South African cities are increasingly using spirits rather than traditional beers. A survey of the liquor industry by a private company in 1974 found that South African Blacks were spending 14.5% of their total private expenditure on alcoholic liquor, and only 6% of this amount was spent on traditional low-alcohol-content "Bantu" beer; with 8,5% being spent on high-alcohol-content liquor.[36]

Gillis et al.,[37] in 1965, surveyed the incidence of psychiatric disturbance and alcoholism amongst the Coloured population in the Cape Peninsula. Amongst the socio-cultural causative factors of excessive drinking they found the availability and relative cheapness of wine and spirits; the traditional rural "tot system" whereby farmers paid workers with wine in lieu of or in addition to wages,

affecting those who migrated to the city; and the general poverty, negative social circumstances and difficulties and lack of ties to the larger political and urban community.

Glatt[38] also suggests that environmental factors in certain countries may contribute to inducing specific persons to take to heavy drinking. For example, in countries such as France, where heavy drinking is widely practised and accepted, relatively non-pathological personality types run the risk of moving into excessive drinking and eventually alcoholism. In countries where such heavy drinking is not as commonplace, it might be the more deviant, pathological or vulnerable personality types who run the gauntlet of the societal mores in regard to drinking and find themselves in the position of being alcoholic.

The prevalence of alcoholism amongst men rather than amongst women is a commonplace socio-cultural phenomenon. This could be due to the fact that modern Western society condones drinking in men and condemns it in women. Again, Glatt[39] points out that it might be assumed that the average female alcoholic is a more "vulnerable" and possibly more "deviant" type of person than the average male alcoholic because in order to arrive at the point of alcoholism she will have had to break many more social taboos and restrictions than would her male counterpart. Glatt further considers the possibility that this initial "greater emotional vulnerability of the hypothetical average female alcoholic" may handicap her prognosis and treatment.

(d) Stages of Intoxication

The progressive sequence of physical reactions to alcohol from the first stage to the point of intoxication has been set out by Roux.[40]

(i) The sub-clinical effect. In the early stages of intoxication the higher centres of the brain controlling judgement, reflection, observation and attention are blunted. Nevertheless, a feeling of good "companionship" normally accompanies this stage. (Alcohol, contrary to the notion that it acts as a stimulant, is in fact a depressant. Initial stimulating reactions such as gaiety of mood, etc., are produced paradoxically by the depressant action on the central nervous system which inhibits tension, feelings of tiredness and anxiety. Together with this apparently stimulating effect goes the loss of higher cortical functions such as judgement, ego control, and motor co-ordination. When a certain point of alcohol concentration in the blood has been reached, the individual may be so "depressed" that he falls asleep, or even in some cases, dies.)

(ii) Stimulation. When the alcoholic concentration in the blood is between one-tenth and two-tenths of 1% the drinker starts losing self-control. Some people become jovial, others depressed; some violent, others sleepy.

(iii) Confusion. By this time the alcohol content in the blood has reached three-quarters of 1%. There is reduction in the previous symptoms of stimulation. The decrease in social inhibitions characterised by

the last stage are followed by increasing difficulties in motor co-ordination. Speech becomes incoherent, and hearing dulled. At this stage the drinker can neither stand erect nor walk a straight line.

(iv) Stupor. By the time the individual has four-tenths of 1% of alcohol in his bloodstream he is unable to stand or to sit up. He is verging on a state of unconsciousness.

(v) Coma. When the alcoholic concentration in the blood is five-tenths of 1% the individual becomes completely unconscious. He is now "dead drunk". His breathing is slow and laboured; temperature is below normal and pulse rate scarcely evident. This condition borders on the fatal stage, since a dosage of between six-tenths of 1% and 1% can cause death.

(e) Stages of Alcoholism Dependence

Identifiable phases may be distinguished in the psycho-physiological dependence upon alcohol. Eaton and Peterson[41] identify four phases in the symptoms and course of alcohol addiction, viz.:

(i) The prodromal stage during which only "social drinking" occurs. Drinking is regarded as pleasant and does not interfere with social or occupational life. Despite this, increased tolerance for alcohol usually appears during this period, i.e. larger amounts of alcohol are needed to produce intoxication and the alcohol consumed is better tolerated by the gastro-intestinal tract.

(ii) The early symptomatic phase is that in which

drinking occurs daily and there is definite dependence on alcohol. Brief periods of abstinence may lead to irritability, insomnia and tremor. More frequent episodes of drunkenness occur, "morning drinking" occurs, and the individual starts patterning his life around alcohol. Defensiveness, attempts to conceal the use of alcohol appear. Family life and social and occupational life are increasingly adversely affected.

(iii) In the advanced symptomatic phase tolerance to alcohol decreases even more as dependence increases. Life revolves around alcohol, family crises escalate and jobs suffer and might be lost. Anxiety about drinking increases. It is no longer pleasurable, a tautological self-defeating cycle is set up in which drink is taken in order to escape the effects of drink. Personality and behaviour are preoccupied with alcohol. There is loss of appetite, the possibility of arrest for drunken driving, and often excessive rationalisation and projection appear. Physical effects are more evident such as blackouts or amnesic periods during drinking, chronic gastritis and cirrhosis or fatty infiltration of the liver.

(iv) The terminal phase starts when the alcoholic has reached what Alcoholics Anonymous call rock bottom. Psychologically, anxiety is severe and physically he could be suffering from Korsakov's psychosis,[42] delirium tremens, acute alcoholic hallucinosis due to damage to the nervous system, and severe pancreatitis, cirrhosis of the liver and malnutrition. He could

die from one or a combination of these physical effects or from suicide as a last resort to end anxiety, terror and awareness of his condition.

The American National Council on Alcoholism distributes a chart depicting the phases of alcoholic addiction in males which distinguishes three phases based on Jellinek's criterion of loss of control over alcohol intake being central to actual alcohol addiction.[43] The prodromal stage of this classification starts with the first blackout (partial amnesia) experienced by the alcoholic; the crucial or basic phase begins with loss of control, and the chronic phase with the first bender.

Recognising the phases in alcohol addiction is important for education, prevention and treatment.

(f) Patterns of Drinking

Type and patterns of drinking are also important in diagnosis and treatment. Jellinek,[44] a leading authority on the scientific study of alcoholism, recognised five kinds of alcoholism, only two of which he felt could be properly considered to be addictive medical diseases. These he called gamma and delta alcoholism.

The non-addictive kinds of drinking patterns he called alpha alcoholism, in which the individual drinks to rid himself of psychological or physical stress, i.e. psychological dependence; beta alcoholism in which physical damage, not necessarily accompanied by psycho-physical dependence, has occurred as a result of heavy drinking; and epsilon alcoholism, which follows the pattern of

> . . . the (future) alcoholic has originally started his drinking as a custom that is not merely passively tolerated but usually actively encouraged in Western culture and that is certainly not considered as a crime by society nor as a sin by most religions. He has usually not received any education at school, or anywhere else for that matter, as to the risks involved in drinking. He is therefore not in the position of being able to appreciate what is happening until relatively late in his drinking career, and by the time he realises that there is something seriously amiss he has become psychologically, and often physically, dependent and is unable to extricate himself without outside help. But society, which originally strongly aided and abetted his drinking, now no longer wants to know but ostracises and rejects him, and he does not know where to turn for help. By now he has become a sick man driven by his need for relief drinking and his psychological dependence (alpha alcoholism) long before physical dependence (gamma or delta alcoholism) and definite mental or physical complications (beta alcoholism) may have set in.[47]

(g) Treatment of Alcoholism

A multifaceted treatment approach dealing with the multiple causes and effects of alcoholism is the one recommended by authorities in the field. This is best done in a multidisciplinary team approach by professionals representing the medical, psychiatric, psychotherapeutic, nursing, social and community work fields. Research too, could be mentioned in this respect. In the United States "lay" people, or recovered alcoholics, are increasingly assisting in the therapeutic process by counselling other alcoholics.

The treatment process is often regarded as a two-phase one. For example, Kessel and Walton remind one that the first phase of any treatment programme entails acceptance by the alcoholic for the need for treatment.[48] (Motivation becomes a central feature. One feels that this acceptance

is linked with the emotional acceptance of the role "alcoholic", and achieving this acceptance might take longer than merely initiating treatment and indeed becomes part of an ongoing treatment process.) Nonetheless this initial awareness or acceptance that there is a problem which requires treatment precedes what Kessel and Walton see as the second phase, viz., that comprising general medical treatment of the physical effects of alcohol abuse.[49]

Dealing with the physical symptoms of alcoholism is indeed primary and must be done before attention may be paid to the psychological and social aspects of the problem. Thus, withdrawal of alcohol, detoxification, and dietary and vitamin treatment are the first steps in any treatment programme. Then, once physical symptoms have been dealt with, the psycho-social aspects and aetiology may be tackled.

Eaton and Peterson, along with many other authorities in this field, recommend that, following the initial phase of treatment, a comprehensive programme of treatment and rehabilitation should be given. This they feel should involve "group living in a therapeutic milieu, group and/or individual psychotherapy, education concerning alcohol problems, vocational counselling and vocational rehabilitation if needed, and ultimately follow-up out-patient care."[50]

Fox sees the essential aims of therapy as total sobriety and a better functioning in all areas of the alcoholics life, viz., physical, psychological, social and

spiritual.[51] Of the latter goal she states:

> An attempt is made to free him [the alcoholic] from his fixed and destructive role and to help him develop a greater awareness of self, a greater flexibility and adaptability, and a greater sense of his own potential. If therapy is successful there will be a growth away from the egocentricity of addiction to a social sense and an ability to relate and share with others.[52]

Kessel and Walton describe the short-term aims of psychotherapeutic intervention as seeking to identify patient misconceptions, and to modify behaviour. "Instead of needing to relieve the symptoms with alcohol the patient is enabled to understand and control them."[53] The more long-term aim of psychological treatment is to produce personality change so that once the patient understands what distorted attitudes produced his difficulties he can correct them.

Supportive and reconstructive work with the family of the alcoholic is an important facet of treatment, as is his work adjustment.

Abstinence is generally regarded as a sine qua non for alcoholism treatment. For example, Fox, as has been mentioned, sees total sobriety as a primary goal, and usually a necessity before personality growth can occur.[54] Glatt points out that "the cardinal rule at the present state of knowledge still remains that the alcoholic has to refrain from taking alcoholic drinks for the rest of his life."[55] Although there is some experimentation allowing certain patients a treatment regime which includes alcohol, for example, Pattison,[56] Kessel and Walton, together with

Fox and Glatt maintain that alcoholism is "best regarded as a chronic disorder with a marked tendency towards relapse. Prolonged treatment is therefore necessary. The 'cure' calls for total abstinence from alcohol."[57]

C. PSYCHODRAMA IN ALCOHOLISM TREATMENT

Apart from the general values and uses of psychodrama as a therapeutic modality, several specific advantages of using psychodrama with alcoholics have been noted and claimed. In reviewing journal articles describing work using psychodrama with alcoholic patients three categories may be distinguished, viz., those articles describing psychodrama as the primary mode of private therapy; those describing treatment programmes within institutions or hospitals in which psychodrama is one of a variety of interventions used in that setting; and, finally, those describing special usages of psychodrama, or psychodramatic techniques in focusing on specific problems common to an alcoholic patient population.

1. Primary Use of Psychodrama in Treatment

In 1944, J L Moreno inaugurated a psychodrama treatment programme for alcoholics at his Institute in New York.[58] Tierney[59] writes that this project was the first "in the history of the therapy of this addiction" that took full cognisance of the role of interpersonal and intergroup relationships in the problem of alcoholism.

Moreno's programme involved the setting up of an

actual bar on stage with liquor and bartender. This extreme realism was considered important for diagnostic purposes as well as for warming patients up to their drink-related problems.[60] Moreno believed that such direct realism was essential for the treatment of his patients and that "any kind of role playing on a fictitious level, unrelated to their actual dynamic problems will not reach them." Since his programme was a residential one, he felt his format gave opportunities not only for studying the alcoholic's behaviour and its consequences as if in situ, but also for supervision and control.

Weiner[61] describes a later four-year project during which 400 psychodrama sessions were held with a total of 300 alcoholics. Weiner herself acted as the psychodrama director, and worked conjointly with a psychiatrist functioning as group "summariser" or analyser. The group sessions were open-ended, with members joining and leaving continuously. At any one time, group membership ranged from eight to twelve persons. Sessions were held once a week for approximately two hours. (Some patients were receiving medical, Alcoholics Anonymous, or other multi-disciplinary help elsewhere at the same time.)

Weiner concluded that a properly directed programme of psychodrama, integrated with other therapies, is of inestimable value to the alcoholic; further, that the total immersion of the individual's mind, personality and body demanded by the method helps to provide necessary contact with reality and self-forgetfulness.

In his presentation of himself in scenes

> constructed of his everyday life, fantasies and past recollections, we can in psychodrama reach where the ordinary methodologies cannot venture, for psychodrama is as close to living as we creative therapists can achieve. Not only is it a therapy, but it is an experience where insights can be gained and skills developed on the spot in an almost immediate re-assessment of living and life action.[62]

Gillis[63] has stated that the essence of alcoholism is denial; denial of the need or longing for people, for closeness with another individual. In psychodrama deception is difficult, and the method cuts through intellectualisation, rationalisation and denial of problems. Weiner writes that the individual who participates in psychodrama should become "an inventor of social skill rather than a slave to defense mechanism."[64]

Most writers in the field of alcoholism treatment point to the need for the alcoholic to be emotionally involved early on in the treatment process. Weiner points to the convenience of using psychodrama in this regard in that it encourages "an almost immediate emotional involvement through action and experience which frequently has been difficult to attain in alcoholics who are withdrawn, reticent, hostile and in need of social reconnection."[65] Elsewhere she notes that because the individual's participation is not dependent upon a high degree of sophistication in terms of intellect and socio-cultural level, psychodrama cuts across the usual limitations of therapy.[66]

In addition to its value as a diagnostic tool, and a cathartic agent in producing relief from inner tension and conflicts, in producing individual spontaneity and

creativity, psychodrama is claimed to decrease rigidity of approach to interpersonal problems.

> Psychodrama offers a pragmatic, dynamic approach to changing human behaviour. It is an important means of unfreezing stereotyped roles of life (characteristic of the alcoholic), and it quickly assists in the diagnosis of the underlying behaviour of the alcoholic.[67]

Self-deprecation and a negative concept of the self is repeatedly found to underlie many of the other characteristic traits and behaviour found in alcoholics, e.g., inability to tolerate frustration, anxiety or tension, to cease from acting-out and control impulse-ridden behaviour, and to learn from experience. Narcissism, dependency, and self-punishment and hostility directed at the self are also associated with low self-esteem. Weiner[68] feels that psychodrama helps to improve or change self-concepts by providing experiences wherein the patient can identify his image and its causes and learn to role play in different more productive ways. The ability to take roles is considered to be a function and a product of the social self and can be enhanced by the role training and enactment processes of psychodrama.[69]

The flexibility and adaptiveness of the psychodrama method are also seen by Weiner as advantages with the specific treatment needs of the alcoholic

Based on her work with alcoholics, Weiner[70] sums up her belief in the value of psychodrama to alcoholism in 33 assertions:

- gives a greater depth of feeling to group therapy experience

- enables the patient to discover his spontaneous self
- activates individual's unconscious to bring forth conflicts, fantasies, memories, past life experiences and emotional phenomena
- develops the (felt) need for motivation
- provides an atmosphere where the patient can try, succeed and fail -- can learn by experience, rational thought and action
- removes subconscious inhibitions and develops problem-solving ability
- teaches patients to work out and solve their own problems
- helps set realistic goals
- develops insights and reassurance
- intensifies the patient's affectivity and reduces excessive intellectualisation
- trains for family, work and community
- provides "rock bottom", i.e. the concept of the most possible consequences drinking can lead to. (Use of surplus reality can give the individual an experience of this psychodramatically, hopefully creating a preventative aversive effect
- decreases transference reaction
- develops personal freedom
- helps educate patients about the facts of alcoholism
- provides the opportunity to develop and change roles within the family
- lets off steam and rage
- develops and explores the self-concept
- restores or eliminates old roles as needed
- intensifies reality
- develops and encourages community spirit, group identification and citizenship
- betters patient-personnel understanding
- educates staff and public
- re-educates people
- modifies isolated behaviour by reducing social deprivation and anxiety-creating conditions
- develops emerging social situations
- changes self-concept in terms of picking up others' cues and expectations as well as own
- narrows grandiose feelings and in their place develops responses to reduce conflicts

- provides an educational method with a high quality of feedback
- repairs the loss of love and affection of parents, guardians or spouses through death, separation or disinterest
- reduces the effect of social deprivation
- trains how to live
- develops the courage to be

It is important to note that Weiner's assertions are descriptive and based upon her experience. They are not subjected to rigorous testing but are drawn from and illustrated by her case material. Indeed, this review of the literature found no formal controlled study of the uses and values of psychodrama in alcoholism.

2 Psychodrama in Treatment Centres

Programmes have been developed which use psychodrama as one of a number of multidisciplinary treatment modalities in an institution or clinic.

For example, in 1961 Cabrera[71] described a programme comprising monthly psychodrama sessions for alcoholic patient groups in an American State hospital. Exit situations were dramatised; patients, for example, enacted their discharge, being received by family members, being taken home, being at home, seeing alcoholic friends, and seeking employment, or dealing with employer reactions to the fact of their hospitalisation. Cabrera evaluates these sessions as being a positive experience for the patients.

> The patients obtain a great deal of benefit from this situation, giving them a great deal of insight and motivation on [sic] their problem

and helping them to understand themselves better.[72]

The Alcoholism Division at Fort Logan Mental Health Center, Denver, Colorado, uses psychodrama as one of a spectrum of treatment modalities.[73] A classical psychodrama format is used in a specially constructed theatre which has a three-tiered stage and four-colour lighting system to intensify and enhance the therapeutic process.

The programme was first introduced in 1963-64, when all staff members participated in a year-long in-service training workshop run by a Moreno-trained psychodrama consultant. The consultant (Carl Hollander), also conducted twice-weekly sessions with patient groups in which staff members participated as auxiliary egos and co-directors. By the end of the training programme those staff members considered skilled enough went on to conduct the patient groups independently.

In describing this programme, Fairchild[74] discusses the use of psychodrama with staff as well as with patients, for example in patient planning and decision-making conferences, interpersonal sensitising, and staff training in psychodrama. With patients it was used to give insight into the connections between emotion and drinking, for "personification" of the alcohol problem, and for providing rehearsal opportunities for facing the demands of daily living. Fairchild concluded that psychodrama offered considerable depth in helping patients who were locked into destructive coping habits to find new and constructive roles in dealing with stressful, or indeed positive,

experiences; also to reinforce the use of behavioural alternatives to the use of alcohol. He saw further value in having psychodramatically trained staff present to respond to daily situations with "on the spot" psychodrama sessions.[75]

Moving further afield to Europe, two years of weekly psychodrama sessions were conducted at the Jellinek Clinic in Amsterdam, Holland.[76] Evening sessions were conducted with alcoholic outpatients and their spouses, and afternoon sessions with hospitalised male patients. The sessions were conducted with groups comprising up to 15 patients and five staff members, three of whom were social workers trained as auxiliary egos. Hein, Gras and Bareman, reporting on the project, stated that the major values of the programme were in diagnosing individual members of the group and in confirming the social aspects of alcoholism.

At the Warlingham Park Hospital in England, Forrest and Glatt[77] describe group meetings held by a social worker during which psychodramatic presentations of part of a patient's life story comprised one of a range of subjects dealt with. Knowledge about patients contributed by the psychodramatic enactments, as well as the meetings as a whole, helped the efficacy of the social worker's role in the hospital and as intermediary between patients, relatives and prospective employers. The sessions were also seen as saving valuable time.

Returning to American applications, Blume, Robins and Branston[78] describe a very full psychodrama programme

which forms an integral part of the total treatment programme at an Alcoholism Rehabilitation Centre in a State-run hospital. Voluntary, non-psychotic alcoholic patients are served by a programme comprising individual therapy, antabuse, medication, and a variety of group therapeutic methods including Alcoholics Anonymous and psychodrama. Weekly psychodrama sessions of one-and-a-half hours are held in which all patients and staff participate.

Blume et al., point to the interconnectedness which psychodrama has with all other aspects of the rehabilitation programme.

> Dynamic material brought up during the psychodrama sessions often provides material for analysis in other psychotherapy groups. Individual patients who represent therapeutic problems in their groups are often chosen as protagonists for psychodrama sessions, with the psychodrama helping the patient overcome whatever obstacle is blocking his treatment. Thus all aspects of the rehabilitation program bear a flexible interrelationship. One is likely to see in one of these psychodrama sessions, a family problem, a group psychotherapy session replayed, a drinking situation, an AA meeting analyzed, a job interview rehearsed or a patient fantasy realized. Psychodrama techniques have also found their way into the small therapy groups, staff conferences, individual counselling sessions and every phase of the unit's operation.[79]

3 Specific Psychodramatic Techniques or Usages in Alcoholism Treatment

In the article reviewed above, Blume et al.,[80] describe seven imaginative ways in which psychodramatic techniques have been applied to themes found to be recurring in her hospital. These are the following:-

(a) Psychodrama in Ward Administration

Role reversal was especially used in efforts to counsel patients who wanted to leave the hospital prematurely, i.e. prior to termination of therapy. Brief 15 minute sessions were found to be helpful in leading such patients to reverse their decisions to leave and to enter more productively in the ongoing treatment process. These sessions comprised three-way participation of the administrator, a staff member conversant with psychodrama methods, and the patient. Firstly, the original encounter between administrator and patient is re-enacted, with the staff member observing. Then, the staff member takes the role of the patient, and the patient observes the ensuing enactment in the role of staff member. It was found that the patient in the role of staff member usually gained considerable insight into his impulsive escapist intention and its underlying motivation (often of unconscious anger or feelings of rejection) and more often than not decided to stay on.

(b) Psychodrama in Staff Conferences

The techniques of role reversal and doubling were used during the two staff evaluative conferences held during each patient's stay. The first conference was held following the patient's orientation week and was mainly designed to evaluate the patient and decide on suitable treatment approaches. The second conference was held after four weeks of treatment and was designed to evaluate progress and further therapeutic directions.

In order to circumvent intellectualisation and the possibility of defence the patient and staff member in

charge of the conference may role reverse during discussions of patient behaviour which was negative or of an "acting-out" nature.

(c) Personification of Alcohol in Psychodrama Sessions

The technique of having a group member personify "Alcohol", "Booze", "The Bottle", "Whiskey" or whatever was appropriate for the relevant protagonist was used within psychodrama sessions. The graphic concrete illustrations resulting from this usage were found to be very useful, e.g., a tug-of-war between alcohol and a relative pulling on either arm of the protagonist followed by the protagonist breaking through a restraining circle of life problems including alcohol.

(d) Making a Connection between Emotion and Drinking

Scenes specifically designed to overcome denial of the emotional reasons for drinking were used, e.g., a situation in which the protagonist starts drinking after a period of sobriety. Techniques such as doubling by an auxiliary ego and using another group member as a mirror are particularly mentioned in this regard.

(e) Clarifying Identifications with Alcoholic Parents

Identification with alcoholic parents may be explored and attempted to be understood through psychodramatic enactments of childhood scenes, in which the patient plays both himself and the parent.

(f) Preparing the Alcoholic for Job Interviews

A psychodramatic form of role playing and role training is used to help patients prepare for job interviews.

Different patients take turns as protagonist using different ways of approaching the interview, such as openly presenting their problem, covering up, etc. Group discussion on the different approaches follows.

(g) Preparing Patients to face Social Situations involving Alcohol

Role rehearsal of anticipated events during which alcohol may be offered and served is used. Group members urge each protagonist to drink and his method of refusal is discussed and analysed afterwards by the group.

Sachnoff[81] used puppets as a warm-up in a women's group of alcoholics and found this to be particularly useful with women who were resistant or whose self-image was negative. The hand puppets acted as a "safe" situation for expression of feelings and ventilation of hostility.

Catanzaro[82] combined the principles of psychodrama, role playing and feedback in developing a treatment technique he called "tape-a-drama" which he used to good effect in a Florida Rehabilitation Centre for Alcoholics. Brief enactments of conflict situations are taped and played back to the group. Then the group members, excluding the "actors", discuss the problem and possible solutions. Catanzaro appreciated the ability to stop the tape recorder at significant places in order to point out nuances of verbal expression, repeated coughing or slips-of-the-tongue which were significant for understanding the dynamics of the situations.

Finally, the work of Olson and Fankhauser[83] on the

alcohol treatment programme at the Veterans' Administration Hospital in Houston, Texas, is described. These authors used psychodrama as a preventive treatment measure in identifying, dealing with and resolving what Valles, the originator of their alcoholism programme, called the BUD (Building Up to Drink).[84] The latter concept characterises the identifiable set of psychophysiological symptoms which foreshadow the alcoholic's approach to relapse. These include sudden mood changes, increased psychosomatic complaints, emotional confusion and differing levels of anxiety and if not controlled could lead to renewed drinking. These symptoms, if recognised, serve as warning signals of impending relapse. The BUD is described as follows:

> At the beginning of the BUD, the alcoholic feels somewhat moody, a little irritable, slightly bored, and rather restless. This condition progresses steadily, gaining momentum as it expands. That which began feebly and became fairly moderate now deepens and grows more intense. The alcoholic's irritability is uncomfortable to him as well as to those close to him. Generally he becomes quarrelsome, raises his voice, shouts at the slightest provocation; sometimes, on the other hand, he becomes exaggeratedly quiet and withdrawn. Soon symptoms of a physical nature make their appearance; his hands begin to tremble, beads of perspiration accumulate on his forehead and in his hands. At this point he is approaching a plateau, the danger zone.[85]

The notion of "emotional inebriation" is put forward by the team on this programme, i.e. that the loss of control and volition occur before the individual takes the first drink which initiates a cycle of relapse.[86] When in the "danger zone" portending imminent relapse, the emotional and physical stress the alcoholic experiences can be resolved either through alcohol ingestion or by a

"siphoning off" of intense feelings. The authors found that psychodrama helped to dissipate the BUD by providing constructive opportunities for emotional release,[87] They recommend a "BUD service", which views the patient's return to hospital for preventive treatment in the same light that a diabetic returns to hospital for a brief period of readjustment of diet.[88]

NOTES

on Chapter V

1 Ruth Fox, "A Multidisciplinary Approach to the Treatment of Alcoholism", International Journal of Psychiatry, V, No. 1, (1968), p. 35.

2 Neil Kessel and Henry Walton, in their book on alcoholism, state that because there are many different types of alcoholics and patterns of alcoholism, there are many different definitions of alcoholism: "Some define the alcoholic from the vantage point of the sufferer, they name as an alcoholic the person who recognises that he has to stop drinking but cannot do so. Others have focused on the observable consequences of uncontrolled drinking; they define the alcoholic as a person whose drinking caused increasing problems in his health, his domestic or social life, or with his work. Others emphasize the quantity of alcohol consumed and the pattern of the drinking habits; only the man who regularly drinks till he is helpless is an alcoholic from their point of view." Alcoholism, (London: Penguin Books, 1965), pp. 15-16.

3 "Classification of Mental Disorders", derived from the American Psychiatric Association and the International Classification of Diseases. A mimeographed hand-out prepared by the Department of Psychiatry, University of Cape Town, pp. 14-15.

4 Intoxication is defined as "a state in which the individual's co-ordination or speech is definitely impaired or his behavior is clearly altered", ibid. p. 14.

5 Withdrawal symptoms occur in alcoholics who have been drinking heavily for many years; and who stop drinking or reduce the amount of alcohol ingested after drinking continuously for a period. Amongst the most common withdrawal states are acute tremulousness or tremors of the hands, often known as "the shakes", and usually accompanied by anxiety or panic feelings. Nightmares, disorientation, and hallucinations might occur, ranging in severity until they reach the state known as delirium tremens. In delirium tremens, besides experiencing intense anxiety, restlessness and disorientation, the individual may have vivid and often grotesque hallucinations, and display extremely paranoid behaviour. Alcoholic epilepsy could also follow withdrawal of alcohol, c.f. Kessel and Walton, op. cit., pp. 33-37; also Max Glatt, Alcoholism: A Social Disease, (London: Teach Yourself Books, Care and Welfare Series, 1975), pp. 53-54.

6 First Special Report to Congress on "Alcohol and

Health", U S Department of Health, Education and Welfare, Washington, D C, 1972: reported in an unpublished paper by Kit Wilson, "Double Standard -- Double Stigma", M A Course, University of Connecticut, 1975.

7 Kessell and Walton, op. cit., p. 164.

8 Ibid., self-destructive and masochistic personality structures are frequently found amongst alcoholics. Both Kessel and Walton, ibid., p. 165, and Glatt, op. cit., p. 126, refer to a book by Menninger which sees alcoholism as gradual or "chronic suicide".

9 H P J van Vuuren, "South African Survey", paper presented at the First International Conference on Alcoholism held in Cape Town, South Africa, 4-8 November, 1974, p. 1.

10 C Jabour, "The Personality and Treatment of the Alcoholic in South Africa", in F W Blignaut, ed., Report of the Project Alcoholism, Part I, Research and Information Section, Department of Welfare and Pensions (South Africa), Publication No. 4 of 1973, pp. 21-22.

11 Ettienne Louw, "Alcoholism and the Employer: A Positive Policy", Rehabilitation in South Africa, XVIII, No. 3, (1974), pp. 75-79.

12 Ibid., p. 76.

13 Van Vuuren, op. cit., p. 1. The figures he gives are based on those compiled by the Government Department of Statistics in 1972, and on the research done by Kellerman. The projections for the South African population were comprised as follows:-

White persons	4 002 267	(17.41%)
Coloured persons	2 170 892	(9.44%)
Asian persons	664 324	(2.89%)
Bantu (sic) (African persons)	16 149 517	(70.26%)
Total	22 987 000	

South African Statistics, (Pretoria: Department of Statistics, 1972).

Kellerman estimated that abstainers in the population comprised 25% of the White group, 38.80% of the Coloured group, 36.80% of the African peoples, and 80% of the Asian group. F J S Kellerman, Die Taak van die Maatskaplike Werker in Diens van die Departement van Volkswelsyn en Pensioene ten opsigte van die Getroude Alkoholis in 'n Rehabilitasiesentrum, unpublished M A Thesis, University of Pretoria, 1973. Both of these works are quoted by van Vuuren, op. cit., p. 1.

14 M W Robinson and W L Vaegtlin, "Investigations of an Allergic Factor in Alcohol Addiction", Quarterly Journal of Studies on Alcohol, XIII, No. 2, (1952),

communion". "Drunkenness is a profanity, an abomination, a perversion of the sacred use of wine. Hence the idea of drinking 'to become drunk' for some individualistic or selfish reason arouses a counter anxiety so strong that very few Jews ever become compulsive drinkers." R F Bales, "Culture Differences in Rates of Alcoholism", Quarterly Journal on Studies of Alcohol, 6, No. 1, (1946), p. 493. /The Talmudic injunction that wine should only be taken with meals probably also cuts down on intoxication. As religion loosens its hold on modern Jews, however, alcoholism becomes more of a problem. For example, in modern Israel, alcoholism is becoming evident as a social problem./

35 Leitch cites the findings of a study by Diethelm who in 1953 investigated socio-cultural factors in New York's Chinatown. Alcoholism was only rarely found to exist amongst the Chinese living there. "The Chinese sanction the drinking of alcoholic beverages, especially at meals, but not the state of being drunk. This is considered a disgrace to the individual and to his family and leads to ostracism by his fellows. This disapproval of drunkenness by the group seems to be a considerable deterrent to alcoholism. When Chinese lose their identification with a closely knit Chinese society, alcoholism tends to increase", op. cit., p. 23.

36 Louw, op. cit., p. 78.

37 Lynn S Gillis, J B Lewis and M Slabbert, "Psychiatric Disturbance and Alcoholism in the Coloured People of the Cape Peninsula". Summary of a Report of a Survey commissioned by the Cape Provincial Administration, (1965), p. 3. Mimeographed and distributed by the South African National Council on Alcoholism and Addictions (SANCA).

38 Glatt, op. cit., p. 44.

39 Ibid., p. 43.

40 E Roux, Alcoholism and the Alcoholic, unpublished teaching notes, mimeographed and distributed by the Department of Sociology, University of the Witwatersrand, (1963), pp. 78.

41 Eaton and Peterson, op. cit., pp. 283-284.

42 Named after the Russian psychiatrist who in 1877 described the selective memory loss for recent events seen in many alcoholic cases, i.e. The Korsakov's Amnestic Syndrome or Psychosis, c.f. Kessel and Walton, op. cit., pp. 37-38.

43 Chart depicting Phases of Alcohol Addiction, distributed by American National Council on Alcoholism, based on lectures delivered by E M Jellinek at the

European Seminar on Alcoholism, Copenhagen, 1961. (Mimeographed copies distributed by SANCA.)

44 E M Jellinek, The Disease Concept of Alcoholism, (Newhaven, Connecticut: College and University Press, in association with Hillhouse Press, New Brunswick, New Jersey, 1972), pp. 36-39.

45 Dipsomania is a periodic craving for alcohol in which an individual may have bouts of heavy drinking but be quite abstinent at other times. Anderson and Trethowan, when describing the psychiatric features of dipsomania, say that the attacks may be dreaded by the individual, who feels unable to resist the impulse to drink. "In some cases the condition appears related to obsessional illness while in others it is a symptom of the depressive phase of the manic-depressive psychosis", E W Anderson and W H Trethowan, Psychiatry, (London: Bailliere, Tindall and Cassell, 1967), p. 86.

46 Glatt, op. cit., p. 5.

47 Ibid., pp. 5-6.

48 Kessel and Walton, op. cit., p. 120.

49 Ibid., p. 121.

50 Eaton and Peterson, op. cit., p. 288. The model of treatment they describe is essentially that followed by the William Slater Hospital in which the research project was conducted.

51 Fox, A Multidisciplinary Approach, op. cit., pp. 36-37.

52 Ibid., p. 42.

53 Kessel and Walton, op. cit., p. 134.

54 Fox, A Multidisciplinary Approach, op. cit., p. 43.

55 Glatt, op. cit., p. 105.

56 Pattison challenges the assumptions that total abstinence is the criterion of successful treatment and is necessary during and after treatment. He suggests that these criteria be re-evaluated and modified in the light of research which has shown that a certain proportion of addictive alcoholics learn normal drinking; that abstinence after therapy need not be related to improvement in overall life adjustment; and that abstinence is not necessarily a prerequisite for successful therapy or rehabilitation. E Mansell Pattison, "A Critique of Abstinence Criteria in the Treatment of Alcoholism", International Journal of Social Psychiatry, XIV, No. 4, (1968), pp. 268-276.

57 Kessel and Walton, op. cit., p. 152.

58 Hannah B Weiner, "Treating the Alcoholic with Psychodrama", Journal of Group Psychotherapy and Psychodrama, XVIII, No. 1-2, (1965), p. 28.

59 Myles Tierney, "Psychodramatic Therapy for the Alcoholic", Sociometry, VIII, No. 1, (1945), p. 76.

60 J L Moreno, "Note on Indications and Contra-indications for Acting Out in Psychodrama", Journal of Group Psychotherapy and Psychodrama, XXVI, No. 1-2, (1973), p. 23.

61 Hannah B Weiner, "Psychodramatic Treatment for the Alcoholic", Chapter 20 in Ruth Fox, ed., Alcoholism: Behavioral Research, Therapeutic Approaches, (New York: Springer Publishing Co., 1967), pp. 218-233.

62 Weiner, "Treating the Alcoholic . . . ", op. cit., pp. 46-47.

63 Gillis, "Alcoholism Simplified", op. cit., p. 3.

64 Weiner, " Psychodramatic Treatment . . . ", op. cit., p. 218.

65 Hannah B Weiner, "An Overview on the Use of Psychodrama and Group Psychotherapy in the Treatment of Alcoholism in the United States and Abroad", Journal of Group Psychotherapy and Psychodrama, XIX, No. 3-4, (1966), p. 164.

66 Weiner, "Treating the Alcoholic . . . ", op. cit., p. 43.

69 See, for example, Gertrude Harrow who postulates that the "ability to take roles is essential for effective communication and the development of the 'social self' which in turn, plays an important part in personality formation and adjustment", "The Effects of Psychodrama Group Therapy on Role Behavior of Schizophrenic Patients", Journal of Group Psychotherapy and Psychodrama, III, No. 4, (1951), p. 316. Also the section on the Morenean concept of roles and the social self in Chapter I of this study.

70 Weiner, "Treating the Alcoholic . . . ", op. cit., p. 33.

71 Fernando J Cabrera, "Group Psychotherapy and Psychodrama for Alcoholic Patients in a State Hospital Rehabilitation Program", Journal of Group Psychotherapy and Psychodrama, XIV, No. 3-4, (1961), pp. 154-159.

72 Ibid., p. 157.

73 Donald M Fairchild, "The Use of Psychodrama in Treating the Alcoholic Patient", Alcoholism Review, XII, No. 4, (1973), pp. 9-10.

74 Ibid., p. 10.

75 Ibid., p. 12.

76 Hannah B Weiner summarises a Report by A Gras and B Bareman on this Dutch application presented to the Second International Congress on Psychodrama and Group Psychotherapy, Spain, 1966, in "An Overview . . ." op. cit., pp. 159-160.

77 C Forrest and M M Glatt, "Some Observations on Social Work with Alcoholic Patients in a Mental Hospital", Case Conference, II, No. 9, (1956), pp. 19-26.

78 Sheila B Blume, Joan Robins and Arthur Branston, "Psychodrama Techniques in the Treatment of Alcoholism", Journal of Group Psychotherapy and Psychodrama, XXI, No. 4, (1968), pp. 241-246.

79 Ibid., pp. 241-242.

80 Ibid., pp. 242-245.

81 Weiner reports a discussion and presentation of work with puppets by E Sachnoff at the Second International Congress on Psychodrama and Group Psychotherapy, Spain, 1966, in "An Overview . . . ", op. cit., p. 161.

82 Ronald J Catanzaro, "Tape-a-Drama in Treating Alcoholics", Quarterly Journal of Studies on Alcohol, XXVIII, No. 1, (1967), pp. 138-140.

83 Peter Olson and Jerry Fankhauser, "The BUD and its Resolution Through Psychodrama", Journal of Group Psychotherapy and Psychodrama, XXIII, No. 3-4, (1970), pp. 84-90.

84 Ibid., p. 84.

85 Ibid.

86 Ibid., pp. 84-85.

87 Ibid., p. 85. The authors present four cases describing how BUD situations were recognised and resolved through psychodrama, pp. 85-89.

88 Ibid., p. 90.

fact that role playing is both a noun, referring to a process, or technique, and a verb. Also, importantly, within Moreno's theoretical system, role playing takes on quite a different meaning to the meaning attached to it by, say, educationists or behavioural therapists. Considerable attention has already been paid to the history of the origin of the word role and the term role playing in socio-psychological literature, and to the place which the concept role occupies in the Morenean role theory of behaviour and personality development. (Chapter I, pp. 52-54.)

Because Moreno defines role as the smallest, observable unit of behaviour, all human behaviour may be analysed and assessed in terms of role. Thus, role playing would encompass the way in which the individual "is", or plays himself, his existential "is"-ness if one likes. Behaviour is seen in terms of its situational contexts and 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."[1]

Role playing therefore may be seen as a natural on-going reality process as opposed to the conscious focused method of role playing or the enactment of identified roles in given situations. It is unfortunate that both processes are described by the same term. Herein, I feel, lies the seed of some confusion.

Moreno himself uses the term role playing to refer to both personal functioning as a natural social phenomenon and to the clinical method which he suggests developed after he introduced psychodrama to America.

> 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.[2]

Thus, I think, an important issue in the clearing up of the misunderstandings which exist as to the differences between psychodrama and role playing is to distinguish between the theoretical concept of role playing as behavioral functioning, and the technical or clinical method of role playing.

Perhaps one could refer to the ongoing spontaneous enactment of roles or behaviour in life as natural role playing, and the process captured, focused, "framed", and made explicit as technical role playing. In other words, a major distinction is between the use of the term role playing as a paradigm for viewing human behaviour and functioning, and the use of the term to describe a clinical intervention technique which adheres to a specific format. That is, role playing is a way of looking at social reality, a process within it, and a way of restructuring it.[3]

Attention is now turned to the use of the term psychodrama. Playgoers have been heard to refer to a play like Peter Shaffer's "Equus" as a "psychodrama". In conversation, persons have reacted to the term psychodrama with "Oh, you mean like Hitchcock's film 'Psycho'." What seems to be happening is that the term suggests the dramatisation of "psychological" material and high emotion.

In the professional therapy context, clinicians are wont to call any form of technical role playing, and

especially the enactment of personal material accompanied by emotional expression, "psychodrama".

It is my personal preference to call this sort of enactment psychodramatic role playing, and to reserve the term psychodrama for that specialised activity which has been developed over the years by Moreno (and especially his wife Zerka Toeman Moreno) and his students, and which is fully described in Chapter I of this thesis. Many professional psychodramatists refer to this systematic method which follows the sequence of phases described in Chapter I, and includes the five elements and major techniques, as classical psychodrama.

A distinction similar to that which has been made for the two major uses of the term role playing, may be made with regard to psychodrama, i.e. to differentiate technical psychodrama from that which is psychodramatic in nature. Perhaps, here though, the distinction should be between usage of the noun psychodrama, and the adjective psychodramatic! In other words the systematic method of therapy could be called psychodrama, whereas methods, techniques or phenomena which resemble it or use its elements could be called psychodramatic. In other words, all behaviour would have psychodramatic elements in it, whereas a proper psychodrama would refer to a particular formal version of the technical type of role playing.

Moreno, as has been pointed out in Chapter I, page 1, defined psychodrama as a science which "explores the 'truth' by dramatic methods". He derived the term from the Greek word meaning "action", or "a thing done". In

yet another definition of psychodrama, he calls it "therapeutic psychodrama" and describes it in terms of its participants, e.g., protagonist, director, auxiliary egos, and group members.[4]

The person-centred emphasis is contained in the more recent definitions of psychodrama, for example Blatner: "Psychodrama refers to an enactment involving emotional problem-solving in terms of one person's conflict."[5] A sociodrama would resemble what could be called more classical role playing in that it focuses on the social roles rather than personal roles, of a protagonist or group.

This distinction of psychodramatic enactments as dealing with personal material leads one to refer back to the discussion of roles contained in Chapter I, pp. 52-57. Not only does Moreno see the individual as having a role range, encompassing social, psychological, and psychodramatic or personal and ideal roles, but each role is seen as having both private and socio-cultural, or collective components to it.

For example, the actor playing the theatrical role of Hamlet brings his private personality to the part. There is the role as created by the dramatist and the role of the actor as himself. Part of the actorial task is to balance the one with the other. The individual who fulfils the social role of policeman does so in terms of his individualistic self as well as in terms of its societal definition. The role of eater is different from culture to culture and from person to person within each culture.

There is often conflict between private and collective aspects or demands of a role. At other times the collective aspect could rigidify personal expression of a role, or the personal elements might encroach upon or even engulf the collective aspect; as, for example, in nepotism or extreme cases of psychosis where the private personality is subsumed in the role of a Napoleon or a Christ.

The extent to which roles are being explored in terms of their private or collective aspect is another way of distinguishing psychodrama from role playing, or psychodramatic from societal or sociodramatic role playing.

Another factor, which coincides with a depth-superficiality continuum, is the amount of emotional intensity expressed or dealt with in enactments. The more intense the emotion involved, the more psychodramatic the enactment is likely to be.

It is true that not only individual-centred psychodramas, but group-centred sociodramas may generate intense emotional involvement when dealing with collective role aspects which elicit social outrage, anger or hurt. Role playing may also act as a springboard for strong feelings both in the participants and audience members. Indeed, as has been described in Chapter III, page 107, one of the historical antecedents of Moreno's psychodrama was the phenomenon of the evocation of audence emotions surrounding their private roles from witnessing the role playing of collective roles. Generally speaking, however, psychodrama deals with strong emotional involvement in roles, whereas role playing would not necessarily do so. Psychodrama also

focuses more upon the private aspects of role, whereas role play emphasises the more collective aspects.

Yet another common distinction between role playing and psychodrama with respect to content is the reality dimension. Psychodrama will deal primarily with real-life situations, whereas role playing does not as a rule involve direct self-disclosure. Roles and situations are often assigned and may be close-to-reality, or "psychodramatic", but are more often the assumption of roles other than one's own.

2 Definitions and Descriptions

Looking at definitions of psychodrama and of role playing in the literature one sees differing emphases and conceptions as a starting point or frame of reference, particularly for role playing. The most significant factor which tends to emerge is the consensus that psychodrama is used for therapeutic purposes, whereas role playing may be used as therapy, or in education, and for skills training or reality practice. Whether participants play their own or another role is not the differentiating factor although, as one sees when examining descriptions of the content of role playing, this does seem to be significant.

Gordon Lippitt uses the term role playing interchangeably with "reality practice" and "role practice". It is:

> An action method including some aspects of both psychodrama and sociodrama, but closer to the latter. The individual may play himself, take a familiar role normally taken by someone else, or try a new or unfamiliar role.[6]

Rosemary Lippitt and Anne Hubbell see role playing as

"a temporary stepping out of one's own present role to assume the role of another individual, of oneself at another time, of an animal, or even of an inanimate object."[7]

Wohlking allows for both the educational and therapeutic objectives in his definition, and describes the typical process followed in what is by now traditional or "conserved" technical role playing. Thus role playing is:

> . . . an educational or therapeutic technique in which a life situation is developed -- typically involving conflict -- and then spontaneously acted out. The enactment is usually followed by a discussion or analysis to determine what happened, why, and how the problem could be better handled in the future.[8]

Klein sees role playing as a method to be used in education, and in leadership and human relations training.[9] His definition of role playing is as

> . . . a method for dealing with some . . . reasons /for behaving in certain ways/ by allowing a person to assume a role different from his usual one and to play it, or to observe someone else playing it. The individual can see himself, he can observe how he affects others, and he can learn new ways if he wishes. He can practise the new ways in order to develop new habits and skills.[10]

Klein feels the method can only have an impact on habits, attitudes and self-awareness if <u>discussion</u> follows enactment.[11] He also sounds a warning against using role playing for therapeutic purposes unless conducted by a trained, skilled therapist.[12]

Jennings[13] sees role playing as a technique developed through psychodrama and would recommend its careful adoption into remedial drama settings for giving individuals an

opportunity to play themselves and to gain insight with group support -- also for trying out new roles in a safe situation. She too warns her readers that psychodrama as a specialised in-depth form of psychotherapy should only be used under guidance of a psychiatrist or someone who has undergone "prescribed psychodrama training".

Blatner also recognises that historically, technical role playing, like sociodrama, is a derivative of psychodrama.

> Although some people use all these terms interchangeably, most professionals would consider role-playing to be more superficial and problem-oriented. Expression of deep feelings is not usually part of most role-playing operations. Rather, the goal of role-playing tends to be working out alternative and more effective approaches to a general problem. Industry, school, and professional training contexts are more likely to utilize this modality in meeting tasks such as developing interviewing skills, dealing with difficult children, handling customer relations, etc.[14]

Blatner's analysis of common present-day uses of role playing is close to Klein's who sees them in general as being to stimulate discussion, release emotions and bring problems to life, to depict a social problem for study, to train in leadership skills, in human relations skills and in more effective problem solving.[15]

Corsini has developed his own individualistic style of role playing in psychotherapy. His method is closely related to psychodrama. He feels that the term role playing has four connotations, viz., theatrical, sociological, dissimulative or deceptive for purposes of fooling or deceiving others, and educational.[16] When role playing is used for therapeutic purposes, he sees it as falling into

the educational category. He distinguishes between psychodrama wherein a person role plays himself, and role playing in therapy wherein persons act out imaginary situations for self-understanding, skills improvement, behavioural analysis, or demonstration of behaviour. He further points out that psychodrama is often used as a generic term to encompass all therapeutic role playing.

We have already referred to Moreno's definitions of psychodrama (Chapter I, page 1, and present chapter, page 239) and Blatner's definition (page 240). Blatner discusses psychodrama as "an enactment involving emotional problem-solving in terms of one person's conflict". He mentions the fact that the drama may move amongst past, present and future, and that it usually moves toward "relatively deep emotional issues".[17] Gordon Lippitt describes psychodrama as "a spontaneous drama concerning the individual and his inner conflicts in which the individual himself is both playwright and actor."[18]

3 Structured vs Spontaneous Role Playing

Wohlking and Weiner[19] provide a dichotomy between structured and spontaneous role playing which is very useful for unravelling confusion surrounding the differences and similarities between psychodrama and role playing. They also provide an interesting historical perspective which throws further light on possible sources of confusion.

The type of role playing which focuses on job-related skills and work-proficiency is referred to as "structured role playing". That type of role playing which focuses on

helping individuals achieve understanding into their own and others' behaviour, and to explore new approaches in handling problems in human relationships would be "spontaneous role playing".

The extent to which: the warm-up is pre-focused on a topic or a theme or is open-ended; the enactment is based on written case material or assigned or given roles, identities and attitudes; and the post-enactment period formalised with critiquing, observer assessment and analytic, cognitive discussion, or characterised by group member sharing of identifications, will determine the categorisation of role playing into the structured or spontaneous typologies.

The classical structured form of role playing is associated with the work of Norman R F Maier at the University of Michigan in management training and supervisory development.[20] He developed a synthesis of the case study method with psychodrama and spontaneity training to develop the technical form of role playing, which has become primarily associated with skills training and development. On the other hand, psychodrama has over the years primarily become associated with therapeutic objectives and, within the Wohlking-Weiner system, may be regarded as spontaneous role playing.

Both methods derive from Moreno's original psychodrama. (See the history of psychodrama, Chapter II, pp. 106-112.) Initially used in psychotherapy both early on in Austria and in America at The Hudson School for Girls, one notes that psychodrama was first used in business

training by Moreno in a programme run by R H Macy's department store.[21] Until after World War II relatively little use was made by industry of any form of role playing. However, after the war with an "upsurge" in supervisory training, industrial trainers began increasingly to use role playing. It was at this time that Maier made his contribution by transforming role playing (or psychodrama as it was then interchangeably called) from a method used solely by psychiatric professionals trained in psychodrama to "a technique which could be used by the average trainer in industry".[22] In other words Maier formalised the shift from psychodrama applied in therapy by trained specialists to its application to industry in the format popularly known as role playing. Weiner and Wohlking write that Maier did this by moving the objectives of role playing away from their psychotherapeutic foci to skills areas such as problem solving and communication, and by making role playing usable for large numbers of trainers by developing and publishing a series of cases with guidelines for instructors and written roles for group members. He also published the results of research based on his structured role plays and related to problem solving, attitude formation and communication.[23]

Thus, one can trace the lineage of both kinds of role playing from their early historical antecedents in play, ritual, and Greek theatre to Moreno's formalisation of their principles in psychodrama, and thence to Maier. As they have been applied in different fields the two types of role playing have separated, then merged again so that the boundaries between them become blurred. This differentiation

at different times must have led to differential perspectives of clarity and confusion. Now, with the influence of Esalen, Perl's gestalt therapy, Schutz's work, the "new group therapies", the emphasis on expressive-emotive aspects of experience and the humanistic influence or human potential revolution reverberating in every area of human relations, viz., therapy, growth, industry and education, the blurring of the boundaries must be at its zenith.

Weiner and Wohlking, writing in 1970, have the following to say about the historical fortunes of role playing and psychodrama:

> From the early 1950s until recently, role playing (as it was developed by Maier and modified and popularized by various trainers of the National Training Laboratories), and psychodrama tended to go in separate directions. Role playing was used by industry and the schools, while only a limited number of professionals working in the field of psychotherapy tended to use psychodrama. As the use of role playing slowly increased, specialists in the fields of education and management development became interested in making role playing a more dynamic and flexible training tool. At this time they turned to psychodrama . . . Though structured role playing has become primarily associated with skills development, and while psychodrama has become primarily associated with psychotherapy, the boundaries between the two have been less rigid.[24]

4 Format and Process

From the literature reviewed, I feel one may conclude that there are distinguishable formats adhered to by structured and spontaneous role playing respectively. For example, in the structured type the warm-up is usually based on a pre-planned problem focus, with roles already worked out, whereas the warm-up for spontaneous role play would be less directed and planned, although greater skill

and expertise would be called for to direct group members to feel trusting enough to reveal personal problems and feelings.[25] Scene setting is usually not as intense as in psychodrama. Depth techniques such as role reversal and doubling are not usually employed, nor is the same excessive use made of auxiliaries as in the psychodrama format. In addition, it is clear that an evaluative discussion about the roles and participant role playing generally follows the structured form of enactments, whereas in spontaneous role playing and/or psychodrama the post-enactment discussion consists of the sharing of identifications of audience members with the roles or situations enacted. However, the three broad phases of warm-up, enactment, and post-enactment discussion are shared by both kinds of role playing.

The various phases described in the literature for the structured forms of role playing are very similar, whether the application is in industry, education or therapy. For example, Weiner and Wohlking[26] describe the steps followed in a typical industrial setting.

- A warm-up period comprising for example a pre-focused discussion of a topic chosen by the instructor; or a lecture, film, or selected case
- An enactment period which might comprise role rotation, or the opportunity for different players to play the same role, interviewing, the use of an auxiliary ego, and perhaps multiple enactments happening simultaneously
- The post-enactment period would typically comprise a discussion of the participants' interaction focusing especially on the principle or topics selected or chosen prior to the enactment. Should observer sheets have been used, the observers report on their data

Shaftel[27] summarises the steps used by the Stanford

University School of Education for role playing in teacher training and for use with pupils.

- The warming up of the group, to identify the problem to be explored and to create awareness of the need to learn ways of dealing with the problem
- Selection of participants for the role play
- Prior to enactment, the teacher would prepare the audience to observe alertly
- The enactment
- Discussion and evaluation, usually dealing with how well the "actors" portrayed their roles and handled the problem posed
- Re-enactment traditionally follows for improving on the role playing and problem-solving. This re-enactment period provides the opportunity for participants to have more "chances" than real life allows and to arrive at solutions in a fail-safe, trial and error atmosphere
- Shaftel's mode of role playing resembles spontaneous role play in that the final step is a period during which participants share experience and generalise from it

The role playing typically used in the William Slater Hospital followed a format of pre-focused discussion of a pre-selected topic or situation, assignment of roles, enactment, possibly role rotation, and discussion of role playing. These enactments were as a rule brief and a range of two to eight, with a typical five scenes during one session. (See Chapter VII, pp. 277-280 for a description of the procedure followed during the empirical study, and Appendix 10, pp. 424-428 for examples of role playing situations and enactments used.)

The psychodrama sessions conducted for the study followed as closely as possible the classical format described in Chapter I, pp. 17-39. (The typical procedure used is described in Chapter VII, pp. 277-281. An example of a single psychodrama session is given in Appendix 11, pp.

429-458.

Blatner[28] gives a detailed outline of the typical format used for a psychodrama enactment. In the warm-up the director warms himself up to his task, group members discuss goals and practical arrangements, exercises are used for acquaintanceship, trust and cohesion. During the action phase the protagonist moves on stage. His conflict is redefined in terms of an enactable, concrete example. The scene is set, auxiliary egos chosen and the opening scene enacted. As the scene continues the various psychodramatic techniques might be used, e.g., role reversal, soliloquy, double, etc. The action is usually continued to the point where the protagonist experiences the fulfilment of act hunger or "a sense of having symbolically enacted those behaviours which had been suppressed".[29] Then the working through phase occurs in which the protagonist is helped to develop alternative adaptive and behavioural responses to his problem situation. Techniques which may be used during this phase may be repetitive role playing, modelling and role reversal.

As Blatner points out it is this phase of a typical psychodrama enactment which resembles structured role playing. The task specific to the working through process is usually the major task and focus of the group in role playing contexts. Thus the technical role playing most often used in this phase forms part of the overall, inclusive psychodrama.[30] The fact that these facets of psychodrama so closely resemble and coincide with the now independent technique of role playing is probably yet another reason

for confusion in the minds of some. Finally, during the closure phase supportive feedback in the form of sharing rather than intellectual analysis is encouraged and a variety of supportive or closing techniques may be used.

In this section I have attempted to uncover some of the common sources of confusion surrounding the distinctions between the psychodrama method and the technique of role playing. In doing so, it is my hope that many of the differences, similarities and points of overlap have become clarified.

It would seem that the terms role playing and psychodrama themselves have been sources of confusion. It has been shown that the term role playing may describe a natural behavioural phenomenon or what has come to be distinguished as an independent technique in therapy, industry and education. This technique is most likely to be confused with, or indeed overlap with, psychodrama when used in psychotherapeutic settings. This is particularly the case when both share the common goal of providing insight and alternative ways of coping with life situations.

At this point the reader is requested to refer back to Chapter II, pp. 72-77, and especially to Figure 6, pp. 75-77, which is my summary of the major similarities, differences, and points of relationship between psychodrama and role playing. This summary is based on all the relevant literature reviewed dating from 1937 to 1973.

C. PROPOSAL FOR A CONTINUUM

I should like to propose that the technique, or method of role playing and the method of psychodrama, which may include formal role playing, be viewed as falling on the continuum categorised below. The axis denotes role playing in its generic sense as human behaviour and the expression of roles. At the one polarity would be structured role playing; at the other, psychodrama. In the middle would be the shared area where they overlap, or merge the one into the other. The extent to which psychodramatic, or private roles and personal, projective elements, or social collective roles are expressed would also coincide with these two polarities.

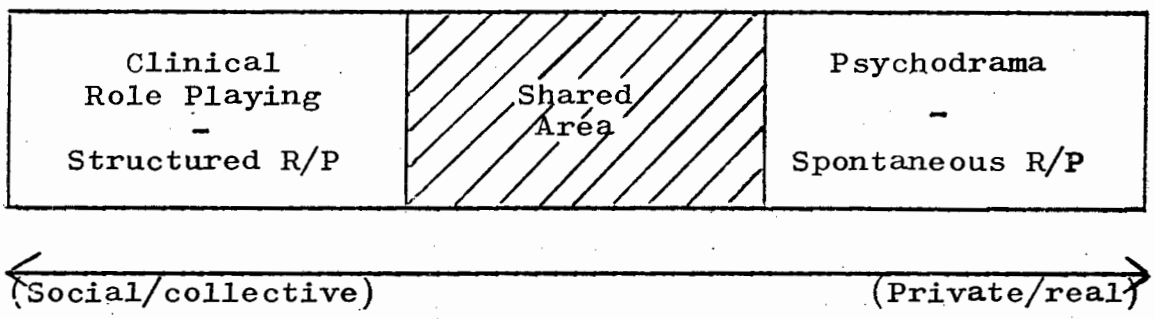

Fig. 7. Continuum of Natural Role Playing Behaviour.

Thus, for example, a form of role playing which is brief, structured in terms of assigned roles and the procedure followed, yet in which psychodramatic techniques such as role reversal or doubling are used, would move over into the shared area. I would give this form of role playing the title "psychodramatic role playing". On the other hand, psychodrama moves over into the shared area when it takes a sociodramatic form. There are also times, as has been pointed out above, when psychodrama in its purest and

most classical methodological form moves over into the shared or structured end of the continuum during part, usually the working through phase, of a session. When structured role playing uses personal roles, and emotional expression intensifies, it moves over into the shared area of spontaneous role playing.

Bearing in mind the continuum and distinctions made between role playing and psychodrama, one may now look back at Chapter IV, pp. 119-169, and see how the different authors of the literature reviewed used the terms. For many of them, the descriptions of what was actually done were an accurate reflection of the terms used in the title or the report. Thus, for example, when Polansky and Harkins write about "Psychodrama as an element in Hospital Treatment" they are in fact describing a classical form of psychodrama. Similarly, Hollander, Rabiner and Drucker, Parrish and Harrow also use the term "psychodrama" in its correct or classic form. On the other hand, under the mental health applications reviewed, what Bhattacharyya, Hicks, and Sturgess describe as "Sociodrama" in the title of the article reporting on their work resembles a creative or remedial drama format in their description.

Kulcsar used what seems to have been psychodramatic role playing in training psychotherapists. It appears to have approached very closely to the classical psychodrama mode with its adherence to the format of phases and especially the use of role reversal, soliloquy and doubling. Godlberg and Hyde, however, talk of "role playing" which seemed to be closer to sociodrama than structured role

playing in their training programme.

As "psychodrama", Shuttleworth describes a programme which seemed to employ more creative or remedial drama activities, and more sociodramatic and structured types of role playing than it did classical psychodrama.

When writing up the review of the literature, I often used a term which I felt more accurately described what was actually done in the study than the term used by the author of the report or article. For example, Florence B Moreno describes a neighbourhood programme of "psychodrama" which would today be more easily identified as psychodramatic role playing than classical psychodrama. Similarly, Treudley calls "psychodrama" what might be characterised as structured role playing and role practice. Hagan and Wright talk about "psychodramatic techniques" which may be identified as classical psychodrama, psychodramatic, and structured role playing.

It is possible that the interchangeable uses of terms to describe different processes could reflect the time or period in which authors were working and writing. The latter authors cited, for example, were writing in the 1940s when psychodrama under Moreno's influence was being used in a variety of settings and guises. The training for the use of psychodrama as a method of psychotherapy had not become as specialised as it is now.

It is also possible that some of the more modern misuses of the term psychodrama in the therapeutic field could be attributable to fashion. Jennings points out

that related to the wide misunderstanding about psychodrama, people who use drama, or music and movement in hospital settings feel obliged to call their activities "psychodrama" in order to validate them.

> It seems part of the current trend of putting the words "psycho" in front of, or "therapy" after activities done in mental hospitals. This should logically give us psychogeranium growing![31]

In my own empirical study, two of the sessions in the psychodrama programme evolved into typical sociodramas in that the entire sessions were devoted to enactments related to themes of common concern to the entire group and were not protagonist-centred as such. In addition, in some of the sessions the role playing, or role training aspect of the working through phase was employed.

Although all of the role playing sessions followed a traditionally structured format, a few enactments allowed for participants to play themselves in a situation which might be likely to occur, e.g., in scene no. 3 in session no. 8, K plays herself in a situation which <u>had</u> previously occurred. Also, in one enactment a variation of the doubling technique was used within a typically structured form of role playing. The majority of topics and roles were, however, assigned to participants in the role playing enactments and were not psychodramatic, e.g., session no. 1, scene no. 3, in which the roles and situation were designed to help patient B express anger.

In conclusion, one might extend the proposed continuum further to incorporate an even more detailed differentiation. Thus, for example, role playing in life itself

could form one extreme, whilst at the other end of the polarity theatrical role playing represents the most formalised style of structured role playing.

Newer forms of improvisational and participatory theatre and "happenings" and performance art approach the "grey" or shared area of role playing and psychodrama. Creative, educational, and remedial drama incorporate improvisational and structured role playing in their methodologies. They might also approach close to the psychodramatic end of the continuum in that expression of projective elements of personality are often explicitly encouraged.

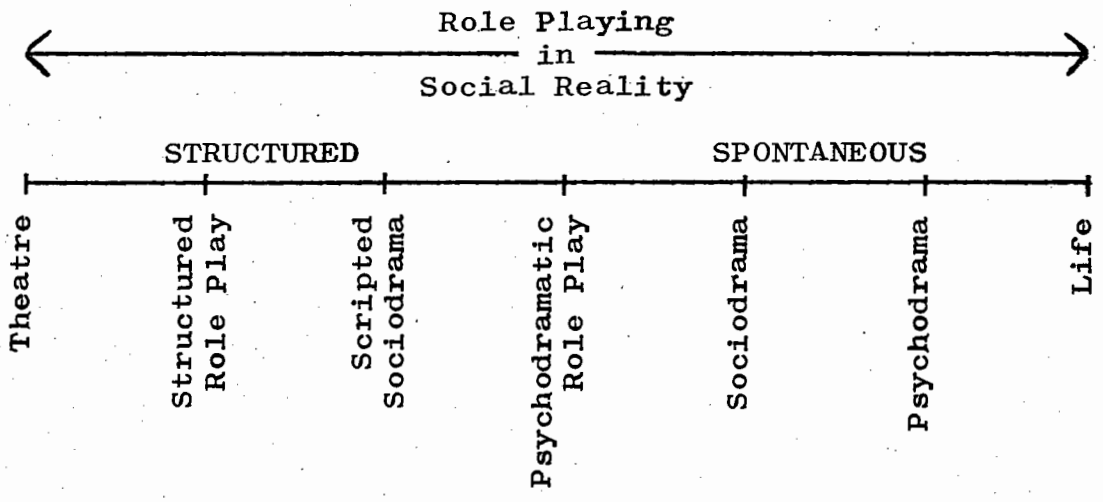

Fig. 8. Continuum from Theatre to Life.

NOTES

on Chapter VI

1 J L Moreno, Psychodrama, Vol. I, 4th ed., (Beacon, New York: Beacon House, 1972), p. IV.

2 Ibid., p. VII.

3 What is commonly referred to as role playing could more properly be labelled role training, or the rehearsal of roles for adequate future enactment. Role training, like role playing, could also be considered within the Morenean system, to take place naturally in the ongoing arena of life (e.g., childhood play, initiation rites) but also as a consciously applied technique, explicitly focusing on rehearsal and preparation.

4 Moreno, op. cit., p. VII.

5 Howard A Blatner, Acting-In: Practical Applications of Psychodramatic Methods, (New York: Springer, 1973), p. 9.

6 Gordon Lippitt, "Role Playing: Definitions, Uses, Procedures", in Role Playing: Its Application in Management Development. A Training Manual, Wallace Wohlking, ed., (New York: Cornell University, 1971), Section 8, p. 1.

7 Rosemary Lippitt and Anne Hubbell, "Role Playing for Research and Guidance Workers: Review of the Literature with Suggestions for Application", Journal of Group Psychotherapy and Psychodrama, IV, No. 2 (1956), p. 89. See Chapter II, p. 72.

8 Wallace Wohlking, "Introduction to Role Playing", in Role Playing, op. cit., Wohlking, ed., Section 1, p. 2.

9 He has written fairly extensively on the use of role playing in these contexts. See, for example, Alan F Klein, Role Playing in Leadership Training and Group Problem Solving, (New York: Association Press, 1956); also Alan F Klein, How to Use Role Playing Effectively, (New York: Association Press, 1959).

10 Klein, How to Use Role Playing Effectively, op. cit., p. 12.

11 Ibid.

12 Ibid., p. 12.

13 Sue Jennings, Remedial Drama, (London: Pitman Publishing, 1973), pp. 81-83.

14 Blatner, op. cit., p. 10.

15 Klein, op. cit., pp. 13-19.

16 Raymond J Corsini, Role Playing in Psychotherapy: A Manual, (Chicago: Aldine Publishing Co., 1966), p. xi.

17 Blatner, op. cit., p. 9.

18 Gordon Lippitt, op. cit., p. 1.

19 Wallace Wohlking and Hannah Weiner, "Structured and Spontaneous Role Playing: Contrast and Comparison", in Role Playing, op. cit., Section 1, pp. 1-11.

20 Ibid., p. 2.

21 Ibid., p. 1.

22 Ibid., p. 2.

23 Ibid.

24 Ibid.

25 Ibid., p. 3.

26 Ibid., pp. 3-10.

27 Fannie R Shaftel, "The Steps in Role-Playing". Unpublished teaching material, School of Education, Stanford University, 1971, pp. 1-2. (Mimeographed.)

28 Blatner, op. cit., pp. 11-13.

29 Ibid., p. 13.

30 Psychodrama is usually regarded as a method since it is comprised of a variety of techniques, one of which is role playing.

31 Jennings, op. cit., p. 81.

P A R T T H R E E

A COMPARATIVE STUDY OF PSYCHODRAMA AND ROLE PLAYING IN AN ALCOHOLISM TREATMENT PROGRAMME

Man is a make-believe animal -- he is never so truly himself as when he is playing a part.

HAZLITT

CHAPTER VII

SETTING, HYPOTHESES, AND METHODOLOGY

A. THE SETTING

The study took place in the William Slater Hospital, Rondebosch, Cape Town. This is a specialised treatment unit for alcoholism, and is part of the Groote Schuur Hospital, and thus a teaching hospital of the University of Cape Town. As such it provides teaching facilities for undergraduate and post-graduate students in medicine, psychiatry, nursing, occupational therapy, psychology, social work and public health.

The hospital is a "self-contained unit with administrative and consulting offices, lounges, reception area, diningrooms, kitchen, group therapy rooms, treatment rooms, nursing offices and occupational therapy rooms."[1] There is accommodation for 29 in-patients, seven beds only being reserved for females.[2]

At the top of the staffing hierarchy is the senior consultant psychiatrist, who has clinical, administrative and teaching functions. Two psychiatric registrars, or doctors undergoing psychiatric training, are attached full time to the clinic for six months as part of a practical programme involving the different units of the Department of Psychiatry of the University of Cape Town.

Similarly, in addition to permanent nursing staff, student nurses also rotate through the hospital as part of their training. The nursing staff, psychiatric and general are an integral part of the therapeutic structure. In addition to clinical duties, they are responsible for establishing meaningful relationships with patients formally and informally, and, of all the staff members, they have the most daily personal contact with patients. The community sisters are the main "communication channel for crisis intervention following discharge."[3] They visit, telephone and write to patients as part of the follow-up service.

Other staff comprise a full time internist psychologist and a part-time psychologist, a psychiatric social worker, an occupational therapist, and a physiotherapist. On the administrative side are the unit receptionist, who is responsible for appointments and the intake or admission of patients; the hospital secretary-typist; and the records clerk, who assists the community sisters in contacting outpatients and recording patient information. There are also the part-time consultant psychiatrists and medical practitioners, who are responsible for outpatient clinics, and the housekeeping, dietary and maintenance staff.

The programme consists of a three-week period of hospitalisation to initiate the diagnosis, patient motivation and therapy and is followed by weekly outpatient group meetings. The major aim is to forge a relationship between patient and hospital, which might be life-long, if

need be, so that the supportive role the hospital can play might replace the need for alcohol. The three-week in-patient cycle is regarded as the beginning of therapy, sustained and maintained by the outpatient programme.

The major philosophical cornerstone of treatment is a psychodynamic one, based on the belief that unless the individual understands why he drinks, he cannot be free from the need to drink in the future in order to cope with stressful situations. The patients' "guide" to the hospital describes an alcoholic as one who cannot cope with life, his circumstances or his problems without the use of alcohol.

> It is not simply a matter of over-indulgence in liquor, but has to do with one's personality, that is the way people are and how they (sic) manage their (sic) lives. For many, alcoholism is an escape from situations they cannot deal with, whilst in others it is a reflection of underlying conflict in the mind. For this reason, the successful treatment of alcoholism always involves coming to grips with one's self -- one's own psychological and emotional problems . . . A large part of the treatment consists of talking -- talking and thinking about one's problems, difficulties in living, early life experiences, personal relationships and current domestic situations and in comparing experiences with others, who have been through the same thing. No one should leave the William Slater Hospital without understanding why he or she drinks, for without this he is unlikely to be free of the need to drink in the future.[4]

The hospital is run on therapeutic milieu lines, i.e. in addition to activities aimed at diagnosis, treatment, and rehabilitation, all interactions, viz., peer interaction, and patient-staff interaction, become the learning material for patient awareness and therapy. The programme is a highly structured one combining medical, educational and psychological approaches to the needs of the alcoholic.

Individual therapy is given by psychiatrists, psychiatric registrars, psychologists and a psychiatric social worker. Daily group sessions are run by nursing sisters, the psychologist and the registrars. In the "orientation and discussion" groups for the full patient community, run by nursing staff, alcohol problems and patient experience in the hospital are discussed, whereas the smaller "psychotherapy groups", for which the patient community is divided in half and conducted by a psychiatric registrar and the psychologist, move into greater dynamic depth. Family and marital therapy is conducted by the social workers and at times by the other therapeutic staff.

On the medical side, pharmacological preparations and drugs such as vitamins, anti-depressants and anti-anxioloitics and prescribed by the medical staff for patients when considered to be necessary. Unless contra-indicated by the health of the patient, for example in cardiac conditions, the alcohol-aversive drug, antabuse, or disulfiram (tetraethylthiuram disulfide), is administered routinely to patients. This antabuse therapy is an important part of the hospital treatment programme, especially of the outpatient programme, and is linked to the hospital philosophy which aims at total sobriety for the individual. Antabuse produces a sensitivity to alcohol. If the patient drinks even a small amount of alcohol whilst taking antabuse, extremely unpleasant reactions ensue such as hot flushes, headaches, faintness, nausea, sweating and violent changes in blood pressure. The discomfort lasts for two to three hours, after which

the patient falls into a deep sleep.[5]

A weekly tape session is held in which patients listen to a tape-recorded lecture on the harmful effects of alcohol on the mind and body, and the purpose and value of using antabuse as a support when discharged from the hospital. After listening to the tape, patients participate in a discussion group run by the occupational therapist or a nurse, in which further information may be given, misunderstandings cleared up, and patients may share discussion of their common symptoms and experiences.

Other educational aspects of the programme are a weekly film dealing with alcohol and its psycho-social effects, or one dealing with interpersonal relationships; and a weekly visit and talk by the representative of the South African National Council on Alcoholism.[6]

Occupational therapy forms a large part of the daily treatment programme and consists of work-related projects, craft and creative activities, sport and recreation. Daily relaxation exercises are conducted, a physiotherapist runs twice-weekly physical fitness classes. Regular role playing sessions are run by the occupational therapist, assisted by students and nursing staff. The occupational therapist is also responsible for organising a weekly social club run chiefly by patients, and patient maintenance of facilities such as the tuck-shop, library, tool cupboard and the aviary. The daily programme of activities is outlined in Figure 9.

FIGURE 9

SUMMARY OF DAILY ACTIVITIES

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8.30	Physiotherapy and ward-round	Pre-role play session for staff	Occupational Therapy	Staff group ward-round	Occupational Therapy ward-round
9.00	↓	(Psychodrama and role playing)	↓	↓	↓
10.30	SANCA talk or Occupational Therapy				
11.00	Tea		Psychotherapy groups	Films and discussion	Psychotherapy groups
12.00	Lunch				
1.00	Relaxation				
2.00	Orientation groups				
3.00	Tea				
3.30	Tape on alcohol and Antabuse	Sport, recreation and hobbies		Physiotherapy	Sport, etc.
4.30	(Experimental study: Testing of new admissions)	↓	↓	(Experimental study: Exit testing)	↓

In conclusion, to summarise the hospital philosophy, the seven principles governing treatment as formulated by the senior consultant are:

1 Alcoholism is a chronic, relapsing, maladaptive behaviour pattern or illness, this concept being useful to overcome stigma, denial, non-cooperation.

2 Alcoholism causes physical disability and emotional disturbance, both of which require therapy and manifest as acute, intermittent and chronic syndromes

3 Alcoholism affects life functions, e.g., work, as well as family, social, financial and in general interpersonal relationships

4 A multidisciplinary team approach is generally more effective in modifying the established behaviour pattern, and group therapy more so than individual therapy

5 The alcoholic must be personally motivated for therapy

6 Hospitalisation permits the initiation of therapy (The three-week in-patient stay is regarded as the beginning of a much longer ongoing process.)

7 Unless socialised, i.e. he has a social support system, a temporarily abstinent patient will resume drinking [7]

B. AIMS AND HYPOTHESES

The overall aims of the experimental study was to compare the relative effectiveness of the two action methods, viz., psychodrama and role playing, as measured by the following criteria:

1 Personality test scores

2 Abstinence at follow-up

3 Degree of participation in the total hospital system

The following hypotheses were formulated prior to the commencement of the study.

Hypothesis One: It was predicted that patients who participated in the psychodrama sessions would show greater improvement on personality test scores after treatment than would patients who participated in the role playing sessions. More specifically, it was predicted that measures of anxiety, aggression and authoritarian conformity would decrease, and self-esteem and extroversion increase significantly more in psychodrama subjects than role playing subjects.

Hypothesis Two: It was predicted that more of the patients who participated in the psychodrama sessions would be abstinent at follow-up than those who participated in the role playing sessions.

Hypothesis Three: It was predicted that the patients who participated in the psychodrama sessions would show a higher degree of participation in the total hospital system than would patients who participated in the role playing sessions.

Hypothesis Four: It was predicted that positive therapeutic effects (i.e. appropriate changes in personality test scores, abstinence at follow-up, and high participation in the total hospital system) would be positively correlated with the amount of involvement within sessions. Thus, it was hypothesised that protagonists in psychodrama would show greater improvement than auxiliaries and subjects who remained audience members only; similarly for principal role players in role playing; and that this participation effect would be more marked for the psychodrama

subjects as compared to the role playing subjects.

Other findings were based on hypotheses made during the study or whilst analysing the data collected.

C. DESIGN AND METHODOLOGY

1 Pre-test or Pilot Study

A pilot study was undertaken over a period of eight weeks from 4 November to 26 December 1974. This gave the opportunity of becoming familiar with the hospital routine and procedures and of having a "dry" run with the tests and interview schedules. An initial relationship with the current hospital staff was established, and the most suitable times for administering the pre- and post-tests were decided upon. On the basis of the result of this pilot study, the division of the items in the two forms of the "General Survey"[8] test was changed to produce a more balanced set of equivalent forms. This pre-test was also helpful in providing basal information as to patient perceptions of their stay and participation in the role playing experience.

Pre- and post-admission tests using the "General Survey" which measures anxiety, aggression, extroversion, conformity and self-esteem, were administered to six cohorts of patients passing through the three-week in-patient treatment programme. Each cohort averaged four patients, giving a total of 24 in all. In addition, patients were interviewed on the day of their discharge.

The "exit interviews" covered patient reactions to the tests; feelings about their stay in hospital; in what way they felt they had changed, if at all; what aspects of the hospital programme they had found to be most/least helpful; and their comments on their role playing experience.

2 Sampling and Study Design

Patients were admitted to the hospital for a standard three-week stay. However, because there was a weekly intake system, during any three-week period, there would be continual movement through the system with overlapping sets or cohorts of patients. Thus, in any given week, the patient population would be made up of three separate cohorts, viz., those who were newly admitted and in their first week of treatment; those who were in their second week of treatment; and those who were in their third or final treatment week. The total number of patients at any one time was approximately 16.

Following at least three cohorts through this system would take nine weeks if an experimental variable is introduced. (See as an example the "role playing" column in Figure 10.) That is, were one, for example, to study the effect of a variable "a" and a variable "b" sequentially, one would introduce variable "a" in the first week, but only by the third week would there be three cohorts consisting of a patient population who will all have experienced the experimental variable. At this time the two cohorts who have experienced the "old" regime sans the experimental variable have passed through the system and one

has a "first", "second", and "third" week population all having experienced only the "new", experimental regime. Now, with the "pure" sample or cohorts, one would have five weeks with three cohorts to try out the experimental regime, or six weeks with four cohorts, seven with five, etc., and should have to wait for a further two weeks to have passed until the final "experimental" cohorts pass through the system which would by then have reverted to the "old" or pre-experimental regime. Only now may the second experimental variable be introduced to follow a comparable pattern and time as the first.

The problem with this kind of design is that it would be very difficult to control for conditions other than the experimental variables, particularly in a training hospital setting where nursing and therapeutic staff are constantly changing. Psychiatric and clinical psychology staff in training as well as the permanent nursing staff were rotated regularly; medicines would change, sometimes drug trials were used, and conditions were different during different months and seasons of the year. In other words, by the time they are admitted, the patients experiencing variable "b" might be experiencing a completely different set of treatment methods and staff members to those who experienced variable "a".

To cope with this problem and to control as far as possible for the time factor, it was decided to divide each new cohort at intake, and to assign half to role playing and half to psychodrama. Thus, in any one week both sets of subjects would be subjected to roughly the

same phenomena in the hospital system. (It was naturally impossible to control for all experiences in the hospital, nor could the participant's experience within the role playing or psychodrama sessions be equivalent.) The major aim of the study was to compare the effectiveness of the psychodrama method with the existing method of role playing used in the hospital. It was not felt ethical to deprive patients of either the role playing or psychodrama experience, and so there was no control group in the sense of having a set of patients who had experienced neither experimental variable. Furthermore, in order to reduce the total number of weeks necessary to test seven experimental cohorts, it was decided to include as the first experimental cohort C_1, subjects whose total experience was with the particular method, regardless of the presence at the same time in the group of others who had had the "old" role playing regime.

For the experimental portion of the study, conducted over the nine-week period from 13 January to 14 March 1975, patients were assigned to two samples, matched as far as possible according to the following criteria in sequence:

(i) Order of admission (number of weeks and time of admission on day of intake; the first person in the population was assigned to the role playing sample, the next to psychodrama, and so on alternately.)

(ii) Age

(iii) Sex

(iv) Marital status

Each "intake" group was given a cohort number, and each subject a code number, indicating the cohort he or

she belonged to. Thus the five experimental cohorts were numbered C_1, C_2, C_3, C_4, and C_5; the first two "impure" or interstitial cohorts, I_1 and I_2; and the final two interstitial cohorts, I_3 and I_4. Subjects were numbered consecutively throughout all nine cohorts, the first subject to be admitted being assigned the number 101 and the final subject in the series 906.

The sample design is represented diagrammatically in Figure 10, on page 273. This design was based on the expectation that the patients would continue to have only one session of role playing and one of psychodrama per week. When the hospital routine was changed during the fourth week, two sessions of role playing and psychodrama per week were held. (The fact that some patients attended more than three sessions was accounted for by computing a participation index for each patient. This also accounted for the fact that some patients missed one or two sessions during their stay due to illness such as influenza, or having to attend outpatient appointments; also for the fact that two patients had their stay extended for two weeks.)

In all, 48 patients passed through the hospital treatment programme during the controlled experimental portion of the research. Of these, 15 belonged to the "Interstitial" populations which experienced mixed regimes comprising the pre- and experimental conditions. Thus the statistical analysis of results was done on those patients belonging to the "Experimental" cohorts, a total of 31 subjects. (Two of the 48 patients could not be included

FIGURE 10

DIAGRAMMATIC REPRESENTATION OF SAMPLE DESIGN*

WEEK	ROLE PLAYING SAMPLE	PSYCHODRAMA SAMPLE
One	——— I_1	——— I_1
	——— I_2	——— I_2
	- - - - C_1	= = = = C_1
Two	——— I_2	——— I_2
	- - - - C_1	= = = = C_1
	- - - - C_2	= = = = C_2
Three	- - - - C_1	= = = = C_1
	- - - - C_2	= = = = C_2
	- - - - C_3	= = = = C_3
Four	- - - - C_2	= = = = C_2
	- - - - C_3	= = = = C_3
	- - - - C_4	= = = = C_4
Five	- - - - C_3	= = = = C_3
	- - - - C_4	= = = = C_4
	- - - - C_5	= = = = C_5
Six	- - - - C_4	= = = = C_4
	- - - - C_5	= = = = C_5
	- - - - C_6	= = = = C_6
Seven	- - - - C_5	= = = = C_5
	- - - - C_6	= = = = C_6
	- - - - C_7	= = = = C_7
Eight	- - - - C_6	= = = = C_6
	- - - - C_7	= = = = C_7
	——— I_3	——— I_1
Nine	- - - - C_7	= = = = C_7
	——— I_3	——— I_3
	——— I_4	——— I_4

*Key: ——— Subjects who had experienced pre-experimental system
- - - - Subjects in experimental role playing
= = = = Subjects in experimental psychodrama

Note: The first line of the set of three in each week represents those patients who are in their third or final week of treatment; the second line represents those patients who are in their second week; and the third line represents patients who are in their first week of treatment.

in the study; one patient admitted with cohort C_1 refused hospital treatment and left prematurely; another, admitted with cohort C_4 was asked to leave since his motivation for treatment was suspect after he had been found to have smuggled liquor into the hospital.) A total of 46 subjects was included in the study.

For what might be referred to as the "experimental" cohorts, or those sets of patients only experiencing either role playing or psychodrama under the experimental conditions of this study, the sample numbers totalled 15 subjects in role playing and 16 in psychodrama. (There were seven "interstitial" subjects in the role playing sample, one of whom died before follow-up, and eight "interstitial" subjects in the psychodrama sample.)

3 Tests and Interview Schedules Used

Two measures of self-esteem were used in the study, viz., the Ziller test of social self-esteem (SSE)[9] and the self-esteem scale on the Jackson Personality Inventory.[10]

In addition, four measures of personality were derived from using the General Survey.[11] The scales used were those designed to tap aggression, anxiety, authoritarian-conformity and extroversion.

"A" and "B" forms were derived from both the Jackson and the General Survey, in order to administer different questions at admission and discharge. The Ziller test did not have sufficient items to enable it to be successfully divided into two forms. Thus the same form was used on

pre- and post-test administrations. All tests and questionnaires were translated and administered in Afrikaans where necessary. (Copies of the tests used appear in appendices 1, 2, 3, 4 and 5.)

Pre- and post-admission scores on the measures derived from these three tests were obtained from all 46 patients passing through the hospital during the nine-week period of the study. Tests were administered on the Monday, or first day of admission, before patients were involved in any aspects of the treatment programme, provided they were "dried out" and not too toxic from the effects of alcohol. In a few cases where an extra day or two was needed for a patient to recover from a drinking episode, the tests were administered as soon as the patient was up and about. Post-measures were obtained on the day before discharge, or on the Friday afternoon of discharge whenever sessions were held on the Friday morning.

Patients were followed up six weeks after the date of discharge and those who presented for the follow-up interviews were once again tested. (The "A" forms, or versions of the Jackson and General Survey used at admission were used in these cases.) Twenty-eight patients, 18 of whom were part of the "pure" experimental sample, and another 10 of whom belonged to the "interstitial sample", were interviewed at discharge. However, a follow-up record of the drinking status of every subject was obtained from the community sisters.[12]

In addition to the testing at exit, patients were

asked to evaluate their experience during either the role playing or psychodrama sessions. (See Exit Interview Schedule in appendix 6.) Also at discharge patients were given the opportunity of granting (or refusing) permission for the audio and audio-visual recordings of activities, inclusive of role playing and psychodrama sessions. (The group meetings were also being recorded at the time for another research project being conducted in the hospital.) Permission was in fact granted by all the patients excepting one who gave partial permission provided that the videotape not be shown at the university where he had been a student. This patient (code No. 405) granted permission for transcripts of the tape recordings, and the test results and interviews to be used. It was stressed that any transcripts or reports made would conceal the identity of the individual. Thus in the sample protocols, names, places and dates are concealed or disguised. At the same time that the permission slips were signed, patients were asked whether the test and interview materials could all be used for this study. (For example of the permission slip see appendix 9.)

With the subjects who presented for the follow-up interviews, an interview schedule was used, in addition to the testing. One subject who had left the Cape Town area submitted his interview by post. (For interview schedule see appendix 7.) All the exit tests were administered and interviews conducted by a social worker. The majority of the follow-up tests and interviews were conducted by the researcher when this social worker was not available. The division of

subjects into the two experimental samples was done secretly by the researcher and was not disclosed to either the tester, the staff or patients until the following morning, an half-hour prior to the Tuesday role playing or psychodrama session. The sampling division was done without the researcher seeing any patient, but using the data recorded by the Intake Clerk in her "Admissions Book".

Staff members were also interviewed for their evaluative comments about role playing and psychodrama, and four nurses who had been in the hospital for almost all of the study period were asked to rate the patients' relative participation level in the total hospital system.

Basic identifying data on social characteristics of subjects was obtained from the hospital records. The Verbal Intelligence measure on the General Survey was not used since the hospital psychologist tested patients for their IQ score. The Intelligence test used was the Raven's Standard Progressive Matrices.[13]

4 Experimental Sessions: Procedures and Format

Ten sessions each of role playing and psychodrama were conducted over the seven-week study period.[14] Two-hourly sessions were held in the mornings. (The two Friday sessions ended slightly earlier due to discharge procedures.) All but one of the psychodrama sessions were held in the large occupational therapy workroom in the hospital, and the role playing sessions took place in a smaller patient lounge known as the "Blue Room". The role playing session which was televised was held in the

Occupational Therapy Room.

The psychodrama sessions were conducted by myself with the assistance of the social worker who conducted the testing acting as an auxiliary ego.[15] The hospital's occupational therapist ran the role playing sessions, assisted by a male nursing orderly who also ran three of the sessions for which the occupational therapist was not available.[16] A minimum of two (usually three or more) staff members and students were also present at both role playing and psychodrama sessions. At least one and sometimes two nurses were assigned in rotation to either the role playing or psychodrama sessions and at least one psychiatric registrar would attend the psychodrama sessions. Occupational therapy students doing their practical fieldwork placements at the hospital were assigned alternately to either psychodrama or role playing. At least one student was present at almost every session. Whenever medical students attended the hospital as part of their practical work, they too were assigned to attend sessions. Videotaping equipment and playback facilities were available for three sessions. Two psychodrama sessions and one role playing session were televised.

The occupational therapist and male orderly would meet with the staff and students assigned to their group for half-an-hour before each session to discuss the patient members assigned to the role playing sample, and to decide upon possible situations for role play. This was the procedure the occupational therapist had adopted for the usual pre-experimental role playing. It was in

keeping with the style and method of role playing used in the hospital. Because the psychodrama sessions developed along more unplanned, impromptu lines, it was not really necessary to use this time in the same way. However, the psychodrama "team" for the day also met for the half-hour beforehand to share developments with patients and in the hospital routines which could have a bearing on the sessions. This time was also used to see which patients were assigned to the session and to discuss possible warm-ups to be used.

The beginning procedure for the role playing sessions remained the same for all sessions. Introductions were made, staff members saying who they were, and patients giving their names and generally stating how long they had been in the hospital. Then the conductor or a "third-week" patient would explain the aims and process of the role playing. This might lead to a discussion, the theme of which would be used to formulate a role playing situation, or the conductor would suggest a topic for discussion and outline a situation for role playing. By far the majority of situations for role playing would be suggested by the occupational therapist or a staff member. The situation was often decided on prior to the session. On the whole staff assigned group members to roles they felt would be helpful for them far more often than group members volunteered for roles.[17] Thus participants were more likely to be chosen or at least encouraged to participate by staff than they were to be chosen sociometrically by the group. (Examples of role playing situations and the patterns of

choosing participants are given in appendix 10.)

In both the role playing and psychodrama sessions, the fact that tape recordings were being made for the comparative research project was mentioned. (The purpose of the research was openly communicated to patients both prior to the pre-testing and at the patient gathering 40 minutes prior to the Tuesday sessions when they were told to which sample the new members were assigned and to remind the others of the group to which they belonged.) No objections at all were made to the presence of the tape recorders in either group during the study.

In the role playing sessions group members were seated around the room in a rectangular arrangement, and the role playing took place in the centre of the room (or, in a few cases, whilst patients sat in their chairs).

The psychodrama sessions commenced with group members seated in a circle for the preliminaries and for certain of the discussions and warm-ups. Chairs were then moved back and arranged into a semi-circle for the action portion of the psychodrama, and cleared to the sides of the room when active types of warm-ups were used.

Each psychodrama session opened with the director introducing herself and the auxiliary ego, followed by staff and patient introductions. The director would explain the psychodrama process and goals, and the format to be followed in sessions. The nature and aims of the research project would be mentioned, as well as the presence of the tape recorder. The group was asked whether

they had any objections to the use of the tape recordings and it was explained that confidentiality would be respected in any transcripts used. Reference was also made to the permission slips which would be signed at exit. It was also stated that information obtained from both the role playing and psychodrama sessions would be shared with all the staff members and that in this respect they did not differ from the normal treatment programme. Opportunities for questions and comments from the group were given.

The director would then lead a formal or structured warm-up, or allow a discussion to develop from which a protagonist would emerge. Approximately 20-30 minutes was allowed for the warming-up portion of the session, an hour or more for the action portion, and 20-30 minutes for the final sharing discussion and closure of the session. (A sample protocol of a psychodrama session is given in appendix 11.) Altogether, eight of the ten sessions were protagonist-oriented, whilst two were sociodramatic or group-oriented. One sociodrama comprised an opportunity for socio-empathy by having staff and patients reverse roles and helped to defuse a tense situation which existed in the hospital at the time. The other sociodrama dealt with patient feelings about antabuse.

5 Follow-up Portion of Study

All 46 patients in the Interstitial and Experimental cohorts were followed up six weeks, or in the seventh week, after discharge, i.e. as far as was possible their drinking status was ascertained. Although all were invited to

return for the follow-up testing and interview, only 28 responded, i.e. just over half actually presented for the follow-up interview, or in one case, returned a postal interview schedule. Of these 28, 18 were members of the actual experimental cohorts. These follow-up interviews took place in the nine-week period between 28 February and 25 April 1975.

The six-week period was chosen on the basis of the community sisters' impression (no actual records are kept of when patients start drinking if they lapse or slip) that patients eventually recorded as "out of touch" with the hospital will have broken contact by the fourth to sixth week post-discharge, whereas those who keep good contact with the hospital for at least a month, are more likely to keep in touch, even if they do eventually "slip" or start drinking.[18]

6 Staff Interviews

Whenever possible hospital staff members who had observed or participated in the role playing and psychodrama sessions were interviewed and their evaluative comments about the sessions obtained. (Neither the occupational therapy nor medical students were interviewed.) These comments appear in Chapter IX. In addition staff nurses who were "core" members of the milieu programme in the hospital for the period of the study were asked to rate patient participation in the hospital treatment programme during their stay. The average rating gave an index of patient participation in the total system. (An index of

patient participation in the experimental sessions was derived from noting the roles played in the sessions, e.g., protagonist, auxiliary, audience member in psychodrama, or principal role player, supporting role player and audience member.)

7 Summary of Relevant Data obtained during the Study

(a) Data on social characteristics such as age, sex, occupation, standard of education, marital status, drinking history, duration of drinking problem, drinking pattern according to the Jellinek formulation and therapist formulation of diagnosis.

(b) Pre- and post-treatment measures of self-esteem, anxiety, aggression, authoritarian conformity, and extroversion for all Interstitial and Experimental subjects.

(c) Follow-up test scores of self-esteem, anxiety, aggression, authoritarian conformity and extroversion for ten Interstitial subjects and 18 Experimental subjects.

(d) Intelligence Quotients obtained from the Raven's Test for all but two subjects.

(e) Patient rankings and ratings of the relative helpfulness of varions aspects of the hospital treatment programme, including role playing and psychodrama.

(f) Patient evaluative comments about role playing and/or psychodrama.

(g) Staff evaluative comments about psychodrama.

(h) Information regarding patient abstinence at time of follow-up.

(i) Information regarding patient's work situation, domestic situation, interpersonal relationships, physical and psychological situation at time of follow-up for ten Interstitial and 18 Experimental subjects.

(j) Retrospective evaluative comments and comments about the impact of role playing or psychodrama during the six-week post-discharge period from the 28 patients who were interviewed at follow-up.

(k) Amount of patient participation in the role playing or psychodrama sessions.

(l) Amount of patient participation in the total hospital system, according to nurses' rankings.

(m) Summaries of role playing situations and sessions.

(n) Transcripts of psychodrama and sociodrama sessions.

NOTES

on Chapter VII

1 Much of the description of the hospital is derived from Annual Reports, the Patient's Guide to the William Slater Hospital, and The William Slater Hospital: A Specialized Treatment Unit for Alcoholism. These latter two are prepared by the Senior Consultant Psychiatrist, the former being given to patients and the latter circulated for the use of staff, students and visitors to the hospital.

2 Although the numbers of women coming forward for treatment are increasing over the years it is still true that, for whatever reason, among identified alcoholics, males far outnumber females throughout the world. In Britain, for example, Max Glatt estimated that there were three or four males to every one female alcoholic: Alcoholism: A Social Disease, (London: Teach Yourself Books, Care and Welfare Series, 1975), p. 43. In the experimental samples of the population studied by the candidate in the William Slater Hospital, three out of 31 subjects were women.

3 The William Slater Hospital . . ., op. cit.

4 Patient's Guide . . ., op. cit.

5 c.f. Antabuse in Alcoholism, a publication prepared and distributed by the Ayerst Laboratories, Montreal, Canada, undated. Also see, for example, Marvin A Block, "Medical Treatment of Alcoholism", The Journal of the American Medical Association, 162, No. 18, (1956), p. 1616.

6 The South African National Council on Alcoholism and Addictions (SANCA) was established in 1956. Its major functions are to co-ordinate services in the alcohol treatment field, to render preventive, educative and information services in respect of alcoholism and drug dependency, and to undertake treatment of alcoholics and drug dependents of all races.

7 Patient's Guide . . ., op. cit.

8 Herbert M Kritzer, A Paul Hare and Herbert H Blumberg, "The General Survey: A Short Measure of Five Personality Dimensions", The Journal of Psychology, Vol. 86, (1974), pp. 165-177.

9 Robert C Ziller, The Social Self, (New York: 1973). A non-verbal measure of social self-esteem is derived from the test which requires the subject to assign each person listed in a set of significant others (including the self) to one of six circles set in an horizontal sequence. The SSE score is the weighted

position of the self in a left-to-right order. (The test is based on the predilection found for left-right ordering of the status of social objects in research studies of children, Indian and American adolescents, neuropsychiatric patients and male, not female, college students.) Chapter 7, pp. 3-16.

10 Douglas N Jackson, Jackson Personality Inventory, (University of Western Ontario, 1970).

11 Kritzer et al., op. cit.

12 The community sisters used four categories to characterise the state of sobriety for patients at follow-up, viz., (a) Drinking -- if patient is drinking steadily and the return to alcohol is interfering with work and interpersonal relationships; (b) Dry -- if patient is abstinent; (c) "Nibbling" -- if patient has an occasional beer or drinks socially, or if patient is drinking consistently or sporadically in small amounts; (d) "Slipped" patients are those who have commenced drinking but keep in touch with the hospital, are again "dried out" and stop drinking.

13 Raven's Standard Progressive Matrices, (London, 1958). (Two subjects were not tested. However, the psychologist estimated their intelligence as falling in the "above average" category, i.e. 115 each.)

14 Beginning with the fourth week of the study, both a Tuesday and a Friday morning were used for experimental sessions. However, one of these extra sessions turned out to be a combined communications session, reducing the possible eleven role playing and psychodrama sessions to ten each. This had the effect of diluting the possible effect which an additional psychodrama session might have had. The sister-in-charge had forgotten about the first extra session scheduled, and had arranged for six patients to be sent to Groote Schuur Hospital for routine tests and examinations; the remaining patients were involved in having forms completed by staff members and were late in arriving at the venues; the occupational therapist was away and the male orderly who was to stand in for her felt nervous about conducting a role playing session with only three members. Due to this combination of unforeseen events very little time was left for a session to be held. It was eventually decided to hold a joint experience, with the psychodrama director and the male orderly conducting a dyadic communication exercise and a brief twelve-minute enactment. Since, in each week, every cohort or patient population was subjected to their own unique experiences, for example, different staff members, certain subjects having extended contact with staff, more individual therapy than others, seeing different films ,sometimes participating in minimal role play in group sessions, it was decided that since the research design was chosen with these

considerations of the different influences in mind, this could be regarded as yet another "different" experience and that the six patients who participated would still be included in the experimental analysis.

15 My own training and work experience is as a social worker, and in addition, at the time of this present study, I had completed the first phase of the psychodrama training course at the Moreno Institute, Beacon, New York. Subsequent to conducting the study, prior to completing the analysis of data and writing up the thesis, I completed all of the residential requirements for the training towards certification as a psychodrama director.

16 The occupational therapist had learned role playing as a therapeutic group technique in her professional training course, and had been conducting role playing sessions for approximately two years.

17 For all but five of the role playing scenes, the occupational therapist or her assistant assigned the roles. In four of the five exceptions the principal role players volunteered for their roles, and in the fifth exception the principal role player was elected by his peers.

18 After discharge, those patients living in the Cape Town area were placed in a once-weekly outpatient group to continue therapy. (See Description of Setting, Section A supra.) If a patient was absent from the group for two weeks sequentially, the community sisters would telephone or send a letter inquiring what was happening. If still the patient had not returned and had not attended four weekly group meetings consecutively, a more emphatic letter was sent. If the subject were still missing, spouse, employer or contact might be telephoned, home visits paid, or interviews arranged. If three major efforts failed to produce a response from a patient his file would be placed in the "out of touch" section. Tighter, more frequent follow-up contacts were made of those patients referred via the courts for treatment.

CHAPTER VIII

RESULTS AND ANALYSIS

A. INTRODUCTION

The experimental study consisted of an evaluation of the efficacy of psychodrama as compared with role playing.

The data are presented in this chapter around three major focii, viz., an examination of basic characteristics of the two samples to see whether they were evenly matched; an examination of the two samples in terms of the criteria for a positive therapeutic outcome used in the study; and thirdly, an examination of factors which could affect differences found, such as participation rate within experimental sessions, and IQ.

The specific hypotheses tested in this study have already been outlined in Chapter VII. They are repeated here for the convenience of the reader, and are as follows:

Hypothesis One: Patients who participate in psychodrama sessions will show greater improvement on personality test scores after treatment than will patients who participate in role playing sessions. This improvement should be present at discharge and either be sustained or increased at follow-up. In terms of each personality scale the predictions are that measures of

(i) patient self-esteem will rise

(ii) anxiety will drop
(iii) aggression will drop
(iv) authoritarian conformity will drop
(v) extroversion will increase

Hypothesis Two: More patients who participate in psychodrama will be abstinent at follow-up than will patients who participate in role playing.

Hypothesis Three: Patients who participate in psychodrama will have a higher degree of participation in the overall hospital system than will patients who participate in role playing.

Hypothesis Four: Patients who participate more intensively within both psychodrama and role playing will show greater improvement on the therapeutic outcome criteria than those who participate less intensively. In addition, high participators will show more marked improvement on the change criteria than high participators in role playing.

B. DIFFERENCES IN THE SAMPLES

The first question to be answered was whether the sampling procedure produced psychodrama and role playing samples that were evenly matched with regard to basic background variables.

As has already been described in the section of methodology in Chapter VII, the role playing and psychodrama samples were matched as far as possible in terms of order of intake, age, and sex. Patients were admitted to the

hospital in what was essentially a random order. They were alternately assigned to role playing, or psychodrama, except that in a few instances patients were shifted at intake so that each incoming cohort would be more evenly matched on the basis of sex and age.

The characteristics examined for differences are age, sex, marital status, occupation, education, Intelligence Quotient (IQ), diagnosis, and drinking pattern. (Other factors noted were the duration of problem drinking, and the number of years since the onset of drinking. Figures for these factors were based upon patient self-reports, and as such are assumed to be only approximate since they might be subject to distortions of fact and patient memory; and there was no way of verifying the figures given.)

All figures given are those for the <u>experimental</u> samples only, i.e. those patients comprising the "pure" cohorts one through five.

1 <u>Age</u>

Age was recorded in years at last birthday. Table 1 shows the age distribution for the experimental samples.

TABLE 1

DISTRIBUTION ACCORDING TO AGE

Sample	$\leq$ 29	30-39	40-49	50-59	$\geq$ 60	n
Role playing	0	6	6	3	1	16
Psychodrama	1	5	4	4	1	15
	1	11	10	7	2	31

The somewhat larger age range for the psychodrama sample was produced by having only one patient falling into the category "less than 29 years of age". The age range for the role playing sample was 30 to 63, whereas that for the psychodrama sample was 23 to 61. For role playing the mean age was 43.2, with a standard deviation of 9.1. For role playing the mean age was 42.1, with a standard deviation of 11.2. The lower mean, and higher standard deviation were accounted for by the presence of the one 23-year old in the sample.

Table 2 presents these means and standard deviations and shows that the difference between the mean ages is not statistically significant. Thus, one can conclude that the two samples were evenly matched with respect to age.

TABLE 2

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR AGE

	Age range	Mean	Std.dev.	t	Probability (p)
Role playing	30-63	43.2	9.1	.31	$>.70$ not sign. (df = 29)
Psychodrama	23-61	42.1	11.2		

2 Sex

There were two women in the role playing sample (ages 47 and 51); and three women in the psychodrama sample (ages 38, 40 and 55). The sex distribution is as follows in Table 3. There is no statistically significant difference between the two samples.

TABLE 3

DISTRIBUTION ACCORDING TO SEX

	Male	Female	n
Role playing	14	2	16
Psychodrama	12	3	15
	26	5	31

Chi-square = .0002 ($p > .99$, not significant)

3 Marital Status

As regards marital status, the two samples were evenly matched, i.e. there were no significant differences between them, with nine married persons in each sample; and the remainder of seven subjects in the role playing sample, and six in the psychodrama sample not married. Those not married were either divorced or single. In the role playing sample there were five divorced and two single subjects, and in the psychodrama sample those not married consisted of one divorced and four single subjects, and one widower. (See Table 4.)

TABLE 4

DISTRIBUTION ACCORDING TO MARITAL STATUS

	Role playing	Psychodrama	Totals
Married	9	9	18
Not married:			
Divorced/ Widower	5	2	7
Single	2	4	6
Sub-total	7	6	13
Total	16	15	31

Chi-square = 1.95 ($p > .30$, not significant)

4 Occupation

As far as occupational groupings were concerned, there were no striking differences, and the two samples are evenly matched. (See Table 5.)

TABLE 5

DISTRIBUTION ACCORDING TO OCCUPATION

Occupational classification	Role playing	Psycho-drama	Total
Professional and technical	2	3	5
Managerial and administrative	2	1	3
Clerical	1	2	3
Trade	4	5	9
Sales workers	3	1	4
Service	2	1	3
Other	2	2	4
Total	16	15	31

5 Education

In terms of educational standard attained, the two samples were very similar, the median educational standard being the same for both samples, i.e. standard eight. Table 6 shows the age distribution in the two samples. Table 7 gives the mean standard of education and standard deviation for the two samples and the results of the Mann-Whitney U-test of significance. (For this test each standard of education was given a code number and the scores were based on this code range. The numbers assigned were 0 = no information, 1 = std 2, 2 = std 6, 3 = std 7, 4 = std 8, 5 = std 9, 6 = matric, 7 = university.)

TABLE 6

PATIENTS CLASSIFIED ACCORDING TO STANDARD OF EDUCATION

	Role playing	Psychodrama	Total
Below Std 6	1	-	1
Standards 6-8	9	8	17
Standards 9+10	5	4	9
University	1	3	4
	16	15	31

TABLE 7

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR EDUCATION

	Mean	Std. dev.	Mann-Whitney U-test	Probability
Role playing (n=16)	4.2	1.7	102.5	$> .10$ not signif. (df=29)
Psychodrama (n=15)	4.7	1.6		

6 Intelligence Quotient (IQ)

As a measure of intelligence the results of the Raven's Progressive Matrices were used.[1]

Unfortunately, the hospital psychologist failed to administer the Raven's test to two of the subjects in the psychodrama sample. However, on the basis of his contact with these two patients, and other tests done, he estimated that their intelligence quotients would lie within the above average category, i.e. 115 each.

The distribution of the IQ scores for each sample is given in Table 8, and includes the two estimated scores of

115. The means, standard deviations and t-test results for each sample are given in Table 9.

TABLE 8

PATIENTS CLASSIFIED ACCORDING TO IQ

IQ range	Role playing	Psychodrama	Total
$\leq$ 99	7	0	7
100 - 109	4	5	9
110 - 119	1	5	6
120 - 129	2	3	5
$\geq$ 130	2	2	4
Total	16	15	31

TABLE 9

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR IQ

	Mean	Std. dev.	t-value	Probability
Role playing (n=16)	104.4	16.3	— 2.05*	< .05 (df=29)
Psychodrama (n=15)	115.2	10.8		

*Significant at .05 level

It is evident that the fact that the role playing sample included seven subjects with IQs of less than 100 created the significant difference between the two samples, with the role playing sample having the lower mean.

The implications of this difference will be explored later on in connection with the findings.

It was impossible to control for intelligence at intake, since the psychologist only administered the test during the patient's hospitalisation, some days or even week after the patients had been admitted.

7 Diagnosis

With regard to subject diagnosis, the two samples are similar, with the majority of diagnoses in both samples involving a form of passive behaviour, i.e. either passive-aggressive or passive-dependent. The passive-aggressive personality type was the most frequently diagnosed in both samples.

The diagnostic formulations used were those made by the patients' individual therapists, usually toward the end of the patients' period of hospitalisation. These were recorded in the hospital files. The distributions within the diagnostic categories used are shown in Table 10.

TABLE 10

PATIENTS CLASSIFIED ACCORDING TO DIAGNOSIS OF PERSONALITY TYPE

Diagnostic formulation	Role playing	Psycho-drama	Total
Passive-aggressive	8	7	15
Passive-dependent	3	5	8
Inadequate/immature	3	1	4
Reactive depression	1	0	1
Hypomanic	0	1	1
Hysterical	0	1	1
Anxiety neurosis	1	0	1
	16	15	31

8 Drinking patterns

The hospital therapists also made an assessment of the type of drinking pattern each patient had followed

prior to admission. These assessments were made according to Jellinek's categories which are described in Chapter V. Table 11 gives the distribution of drinking patterns for the two samples.

The two samples show no significant differences between them. (The majority of subjects in both samples conformed to the delta pattern of daily drinking and chronic inability to abstain from alcohol.)

TABLE 11

PATIENTS CLASSIFIED ACCORDING TO DRINKING PATTERN

Drinking pattern	Role playing	Psychodrama	Total
Delta	11	10	21
Gamma	2	2	4
Delta/gamma	2	0	2
Gamma/delta	1	3	4
	16	15	31

Chi-square = 3.23 ($p > .30$, not significant)

9 Duration of problem drinking, and years since onset of drinking

Data were available in the files pertaining to the number of years each patient had been drinking, and the length of time the drinking had been a problem. These figures were obtained from patient self-reports, and could not therefore be authenticated.

Bearing this caution in mind, the figures were examined and found to be similar for both samples. Table 12 gives

the distributions of subjects who had had an acute drinking problem for the years specified, and Table 13 presents the means, standard durations and results of the test of statistical significance used to compare the differences in the means. Table 14 gives the distributions for the number of years since the onset of drinking, and Table 15 presents the means, standard deviations, and results of the test of significance for the difference for the two samples in terms of the duration of drinking.

TABLE 12

DURATION OF ACUTE DRINKING PROBLEM

No. of years	Role playing	Psychodrama	Total
1 - 4	8	9	17
5 - 9	3	4	7
10 +	5	2	7
	16	15	31

TABLE 13

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR DURATION OF ACUTE DRINKING

	Mean	Std. dev.	t	Probability
Role playing (n=16)	7.1	5.5	1.60	> .10 not sign. (df = 29)
Psychodrama (n=15)	4.5	2.7		

TABLE 14

YEARS SINCE ONSET OF DRINKING

No. of years	Role playing	Psychodrama	Total
1 - 9	3	2	5
10 - 19	7	6	13
20 - 29	4	7	11
30 +	2	-	2
	16	15	31

TABLE 15

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR DURATION OF DRINKING HISTORY

	Mean	Std. dev.	t-value
Role playing (n=16)	17.8	7.9	0.00
Psychodrama (n=15)	17.8	6.9	

Neither of the differences was significant. In fact, the mean number of years since onset of drinking was exactly the same for the role playing as the psychodrama sample.

10 Language and religion

The cultural groupings of the subjects were to some extent reflected by their home language and religious affiliation. No striking differences were evident between the two samples. (See Tables 16 and 17.)

TABLE 16

PATIENTS CLASSIFIED ACCORDING TO LANGUAGE GROUPINGS

Language	Role playing	Psychodrama*	Total
Afrikaans	8	6	14
English	8	6	14
Other	-	2	2
	16	14	30

*No information for one of the psychodrama subjects

TABLE 17

PATIENTS CLASSIFIED ACCORDING TO RELIGIOUS AFFILIATION

Affiliation	Role playing	Psychodrama	Total
Ch. of England	7	5	12
Dutch Ref./Ned. Geref.Kerk	4	5	9
Roman Catholic	3	1	4
Other	1	2	3
None	1	2	3
	16	15	31

Chi-square = 1.85 ($p > .40$, not significant)

11 Police contact, committed or voluntary patient, employment at time of admission

Other than the fact of whether a patient had entered treatment as a voluntary patient, or had been committed through the courts in terms of Section 30, Abuse of Dependence-producing Substances and Rehabilitation Centres Act of 1971[2] the figures regarding police contact, and employment were also gained for the most part from patient self-reports. Although the nature of police contact

varied from subject to subject, the most frequent types of encounter had been arrests for drunken driving, or minor offences committed whilst the patient concerned was intoxicated.

Table 18 presents the data for the two samples as obtained from the hospital files. No major differences between the two samples were found.

TABLE 18

PATIENTS CLASSIFIED ACCORDING TO POLICE CONTACT, VOLUNTARISM OF HOSPITALISATION, AND EMPLOYMENT PRIOR TO TREATMENT

	Police contact			Committed*		Employment		
	Yes	No	No info.	Voluntary	Commit.	Yes	No	Other**
Role playing	5	10	1	16	0	7	7	2
Psychodrama	7	8	0	13	2	11	4	0
	12	18	1	29	2	18	11	2
		31			31		31	

*i.t.o. Section 30: Act No. 41 of 1971
**One housewife, one retired company director

12 Personality tests

The two samples were compared in respect of the personality tests administered to subjects at admission.[3] These pre-test scores consisted of two measures of self-esteem, and measures of anxiety, aggression, authoritarian conformity, and extroversion. (See section on methodology, Chapter VII.)

It was important to check that no differences existed in the pre-testing which could have manifested themselves

in the post- or follow-up testing, and be interpreted mistakenly as indicative of changes attributable to the experimental variables.

Table 19 presents the mean scores and t-values on each t-test done for the two samples. No significant differences were found to exist between the two samples when they were compared statistically in respect of each personality test item.

TABLE 19

MEAN PERSONALITY TEST SCORES AND TESTS OF SIGNIFICANCE FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

Test scales	Role playing	Psycho-drama	t-value	Prob-ability
Ziller self-est.	18.4	19.7	0.40	$> .60$
Jackson "	18.8	20.1	0.82	$> .40$
Anxiety	19.8	18.3	0.92	$> .30$
Aggression	12.5	13.4	0.56	$> .50$
Auth. Conf.	23.3	24.5	0.39	$> .60$
Extroversion	15.8	16.5	0.51	$> .60$

Conclusion

Except for a tendency in the psychodrama sample for subjects to have higher IQs than the role playing sample, there were no other statistically significant differences between the two samples.

Thus, one may conclude that the sampling procedure produced evenly matched samples with respect to background variables with the exception of the level of intelligence.

Any differences therefore, which may be found between samples are not attributable to differences in age, sex, marital status, occupation, educational standard, diagnostic category, drinking pattern, duration of drinking problem, and the number of years since onset of drinking.

C. COMPARATIVE EFFICACY OF PSYCHODRAMA OVER ROLE PLAYING

The major aim of the study was to see whether psychodrama was more effective as a therapeutic modality than the type of role playing already in use in the hospital.

In order to answer this question, one needed to look firstly at the effectiveness of role playing, secondly at the effectiveness of psychodrama in terms of the criteria used, and then one could see whether the changes under psychodrama were significantly greater in the anticipated directions than were those under role playing. However, since there was no control-group in the sense of having a sample that was subjected neither to role playing nor to psychodrama, one cannot in fact distinguish whether any effects which might appear in the role playing sample are due to role playing, or to the effect of the total hospital system, or any part thereof. The only way one may identify whether these effects are due to the role playing itself would be to demonstrate that these effects vary with the patient's participation within the role playing sessions. In other words, only those changes correlated with participation within role playing may be judged to be due to the effect of the role playing modality alone. The

same is true for psychodrama.

1 Personality Test Scores

The data were analysed by means of t-tests and one-way analyses of variance (ANOVA), to see whether the changes from pre- to post-, and from pre- to follow-up testing were statistically significant.

The full samples were used for the t-test treatment of differences between pre- and post-testing. However, only those subjects who presented for follow-up could be included in the treatment of differences for follow-up, i.e. t-tests of the differences from pre- to follow-up and the analysis of variance for the overall trend of differences from pre- through post- to follow-up testing.

The expectations were that measures of self-esteem would rise from pre- to post-testing, anxiety, aggression, and authoritarian conformity measures would drop, and extroversion increase. These changes were expected to increase, or at least be sustained at follow-up.

(a) Role playing Sample

Table 20 presents the results of the analysis of variance for the scores for pre-, post- and follow-up testing for the role playing sample. Table 21 gives the results of t-tests for dependent means which examined the differences from pre- to post-testing, and Table 22 shows the results of t-test analyses for the differences from pre- to follow-up testing.

The total sample for role playing consisted of 16 subjects. However, only half, or eight subjects, presented themselves for the follow-up interviews and tests.

Therefore, the t-tests of differences for pre- to post-testing were based on a sample of 16 subjects, whereas those for the differences from pre- to follow-up, and the ANOVA, were based on a small sample of eight subjects.

TABLE 20

ANALYSIS OF VARIANCE FOR PRE-, POST-, AND FOLLOW-UP TEST SCORES FOR ROLE PLAYING SAMPLE

(n = 8)

Test item	Means of test scores			F value	Probability (df=2; 14)
	Pre-	Post-	Follow-up		
Ziller self-est.	18.0	26.3	25.0	3.50	> .05
Jackson "	20.5	20.6	20.9	3.31	> .05
Anxiety	19.9	18.6	15.3	1.80	> .05
Aggression	12.9	13.3	12.9	3.73	> .05
Auth. conform.	25.0	20.3	23.3	*4.13	< .05
Extroversion	16.0	16.6	17.0	0.27	> .05

*Significant at .05 level

TABLE 21

ROLE PLAYING SAMPLE: DIFFERENCES BETWEEN PRE- AND POST-TESTING

(n = 16)

Test item	M_D (Mean differences)	t-value (dep. means)	Probability (df=n-1=15)
Ziller self-est.	5.8	2.73*	< .02
Jackson "	2.2	1.46	> ,10
Anxiety	— 1.3	— 1.38	> .10
Aggression	0.1	0.10	> .10
Auth. conform.	— 4.1	— 4.60**	< .001
Extroversion	0.6	0.75	> .10

*Significant at the .05 level
**Significant at the .01 level

TABLE 22

ROLE PLAYING SAMPLE: DIFFERENCES BETWEEN PRE- AND FOLLOW-UP TESTING

(n = 8)

Test item	M_D (Mean differences)	t-value (dep. means)	Probability (df=n-1=7)
Ziller	7.0	1.64	$> .10$
Jackson	0.4	0.30	$> .10$
Anxiety	— 4.6	— 1.59	$> .10$
Aggression	0.0	0.00	$> .90$
Auth. conform.	— 1.6	— 1.54	$> .10$
Extroversion	1.0	0.62	$> .50$

(i) Changes in self-esteem. The Ziller and the Jackson tests provided two measures of self-esteem.

Looking at Table 20, one sees an apparent rise on the Ziller test from pre- to post-testing, with a slight decline at follow-up. However, the overall trend is not significant. On the Jackson test there is no change in self-esteem on the three test administrations. The F-value is not significant.

However, looking at Table 21, one sees that the increase from pre- to post-testing on the Ziller sub-test is statistically significant at the .05 level -- although the increase from pre- to follow-up is not significant. (See Table 22.)

As regards the Jackson sub-test of self-esteem, the results of the t-tests as presented in Tables 21 and 22 confirm the finding on the ANOVA in that there are no significant changes in self-esteem between the pre- and post-, and pre- and follow-up testing.

(ii) Changes in anxiety. For the role playing sample, anxiety shows the expected decreases. However, the differences are not statistically significant. Neither the ANOVA nor the t-tests indicate any significant decrease from pre- to post- through to follow-up testing.

(iii) Changes in aggression. The anticipated decrease in aggression was not found. The scores remained essentially the same at pre-, post-, and follow-up, and the differences were not statistically significant on the ANOVA and t-tests.

(iv) Changes in authoritarian conformity. The results show the anticipated decrease from pre- to post-testing. However, there is an upward swing again at follow-up.

The overall trend was significant at the .05 level using the ANOVA test. Since the ANOVA test shows the presence of some significant difference, but does not indicate which of the means are significantly different from each other, Tukey's HSD test (honestly significant difference test)[4] was used to identify where the difference lay.

The T_c value computed for the set of means on authoritarian conformity was 4.40. Thus, a difference between any two means would have to be greater than 4.40 to be significant at the .05 level. This T_c value indicates that the only significant difference is between the means of 25.0 for the pre- and 20.3 for the post-test. (See Table 20.)

An additional analysis of the same data was made by using a t-test for dependent means. The initial decrease from pre- to post-testing was highly significant at the .01 level. (See Table 21.) The t-test done on the pre- to follow-up measures showed no statistical significance. (See Table 22.) The results of both the Tukey and the t-test suggest that the major change was indeed from pre- to post-testing.

In sum, for the role playing sample alone, there were two significant findings, viz., an increase in the Ziller measure of self-esteem, and a decrease in the measure of authoritarian conformity for the pre- to post-test changes only. For both the Ziller and the test of authoritarian conformity the gains from pre- to post-testing are lost at follow-up.

At this stage, one cannot attribute these differences to the effect of role playing on the sample. One may only conclude this to be the case if the psychodrama sample do not also show the same significant differences.

(b) Psychodrama Sample

The total sample for psychodrama comprised 15 persons for the pre- to post-testing. However, only two-thirds or ten subjects actually presented for follow-up (a higher percentage than for the role playing sample). Thus, the ANOVA and the t-tests for dependent means for changes from pre- to follow-up testing could only be based upon the smaller sample of ten subjects. Table 23 presents the

analysis of variance (ANOVA) for the trend of differences between the pre-, post- and follow-up scores. Table 24 presents the findings of t-tests (for dependent means) for the means of the change scores for pre- and post-testing, and Table 25 presents the results for similar t-tests for dependent means for the changes from pre- to follow-up testing.

TABLE 23

ANALYSIS OF VARIANCE FOR PRE-, POST-, AND FOLLOW-UP TEST SCORES FOR PSYCHODRAMA SAMPLE

(n = 10)

Test item	Means of test scores			F value	Probability (df=2; 18)
	Pre-	Post-	Follow-up		
Ziller self-est.	20.7	24.7	27.2	3.30	$> .05$
Jackson "	21.0	22.7	24.0	3.10	$> .05$
Anxiety	18.7	17.7	14.2	2.44	$> .05$
Aggression	12.6	12.5	11.9	0.13	$> .05$
Auth. conform.	23.3	20.4	22.5	*6.29	$< .01$
Extroversion	15.1	14.4	18.7	1.57	$> .05$

*Significant at .01 level

TABLE 24

PSYCHODRAMA SAMPLE: DIFFERENCES BETWEEN PRE- AND POST-TESTING

(n = 15)

Test item	M_D (Mean differences)	t-value (dep. means)	Probability (df=n-1=14)
Ziller self-est.	7.1	2.92*	$< .02$
Jackson "	1.0	0.97	$> .10$
Anxiety	— 0.5	— 0.52	$> .10$
Aggression	— 0.5	— 0.40	$> .10$
Auth. conform.	— 3.3	— 2.36*	$< .05$
Extroversion	0.0	0.00	$> .90$

*Significant at .05 level

TABLE 25

PSYCHODRAMA SAMPLE: DIFFERENCES BETWEEN PRE- AND FOLLOW-UP TESTING

(n = 10)

Test item	M_D (Mean differences)	t-value (dep. means)	Probability (df=n-1=9)
Ziller self-est.	7.1	2.16	$> .05$
Jackson "	3.0	2.96*	$< .02$
Anxiety	— 4.5	— 1.73	$> .10$
Aggression	— 0.7	— 0.63	$> .50$
Auth. conform.	— 0.5	— 0.49	$> .60$
Extroversion	2.1	2.02	$> .05$

*Significant at .05 level

(i) Changes in self-esteem. For the psychodrama sample, both the Ziller and the Jackson tests of self-esteem show the anticipated increase from pre- to post- to follow-up testing. However, these trends are not significant when using an ANOVA test for significance. (See Table 23.)

For the larger sample of 15 cases, the increase is a statistically significant one for the Ziller test in terms of pre- to post- scores. The t-value of 2.92 was significant at the .05 level. (This is a similar finding to the increase in self-esteem as measured by the Ziller from pre- to post-testing in the role playing sample.) However, the t-test did not indicate any significant increase from pre- to post-testing on the Jackson (Table 24). The change from pre- to follow-up as measured by the Jackson test of self-esteem was statistically significant at the .05 level

for the smaller sample of ten subjects in the follow-up analysis. (See Table 25.) This significant increase was not present in the role playing sample; nor did the Ziller test of self-esteem show a significant change on the pre- to follow-up testing in either sample.

(ii) Changes in anxiety. For the psychodrama sample, anxiety shows the expected decrease over the three testing periods. However this decrease was not statistically significant on the ANOVA test. (See Table 23.) Similarly, looking at Tables 24 and 25, one sees that neither the t-test for the pre- to post-testing, or the pre- to follow-up findings show any statistically significant decreases.

(iii) Changes in aggression. The aggression scores remained approximately the same over the three testing periods. The differences were not statistically significant, either in terms of the overall trend as measured by the ANOVA (see Table 23), or the t-tests for the larger and the smaller samples, from pre- to post-, and pre- to follow-up testing (see Tables 24 and 25).

(iv) Changes in authoritarian conformity. The measures of authoritarian conformity show a drop at post-testing and a rise again at follow-up. The overall trend is significant at the .01 level as measured by the ANOVA test (see Table 23).

To determine which of the increases, or differences between means accounted for the significant result, the Tukey HSD test was again used. This procedure has already been described in connection with

self-esteem and was found in the psychodrama sample.

(c) Comparison between Psychodrama and Role Playing Samples on Change Scores for the Personality Tests

Attention is now paid to the question of whether the changes in test scores for the subjects in the psychodrama sample were greater than the changes for test scores for the role playing sample.

For statistical comparisons of the changes in the two samples, see Tables 26 and 27. These tables present the mean of the differences and the standard deviations of the scores for each sample, the mean difference and a t-value for each item for pre- to post-, and pre- to follow-up testing.

Thus, Table 26 gives the means of the difference scores for role playing, and the means of the difference scores for psychodrama on the pre- to post-testing. No statistically significant differences at all are found when the two samples are compared.

Similarly, looking at the subjects who presented for follow-up, no statistically significant differences were found between the two samples on difference scores for pre- to follow-up testing. (See Table 27.)

Only one of the differences even approaches significance. This is for the Jackson test of self-esteem. The t-value was greater than .10 and not significant.

With regard to the psychological test scores, I conclude that, although there were differences, given the

TABLE 26

MEAN DIFFERENCES BETWEEN PAIRED SCORES ON PRE- AND POST-TESTING FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

Column:	1		2		3	4	5
Test item	Role playing (n=16)		Psychodrama (n=15)		Mean diff. (M_D=RP-PD)	t-value	Probability
	Mean (of diffs.)	Std. dev.	Mean (of diffs.)	Std. dev.		(Indep. means)	(df=n_1+n_2-2 =16+15-2 =29)
Ziller self-esteem	5.80	8.4	7.1	9.4	− 1.5	− 0.43	> .60
Jackson self-esteem	2.20	6.0	1.0	4.1	1.2	0.64	> .50
Anxiety	− 1.3	3.8	− 0.5	3.9	− 0.8	− 0.56	> .50
Aggression	0.1	4.9	− 0.5	5.8	0.7	0.36	> .70
Auth. conformity	− 4.1	3.6	− 3.3	5.5	− 0.8	− 0.48	> .60
Extroversion	0.6	3.3	0.0	4.9	0.6	0.42	> .60

TABLE 27

MEAN DIFFERENCES BETWEEN PAIRED SCORES ON PRE- AND FOLLOW-UP TESTING FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

Column:	1		2		3	4	5
Test item	Role playing (n= 8)		Psychodrama (n=10)		Mean diff. (M_D=RP-PD)	t-value	Probability
	Mean (of diffs.)	Std. dev.	Mean (of diffs.)	Std. dev.		(Indep. means)	(df=n_1+n_2-2 =8+10-2 =16)
Ziller self-esteem	7.0	12.1	7.1	10.4	− 0.1	− 0.02	> .90
Jackson self-esteem	0.4	3.6	3.0	3.2	− 2.6	− 1.63	> .10
Anxiety	− 4.6	8.2	− 4.5	8.2	− 0.1	− 0.32	> .90
Aggression	0.0	4.0	− 0.7	3.5	0.7	− 0.40	> .60
Auth. conformity	− 1.6	3.0	− 0.5	3.2	− 1.1	− 0.76	> .40
Extroversion	1.0	4.5	2.1	3.3	− 1.1	− 0.59	> .50

sample sizes, these differences did not reach statistical significance.

The fact that both the role playing and psychodrama samples showed similar patterns of change on the Ziller test of self-esteem, and the measure of authoritarian conformity from pre- to post-testing might lead one to assume that these changes were due to the patients' admission into and participation in the overall hospital programme rather than being attributable to any inherent aspect of either experimental modality.

Although the change on the Jackson test of self-esteem from pre- to follow-up was significant for the psychodrama sample, this difference was not significantly greater than the difference for the role playing sample when the change scores for the two samples were compared with each other.

2 Abstinence at Follow-up

Abstinence was used as an index of successful therapeutic outcome for the present study.[5]

Although, of the role playing sample, only eight subjects actually presented for follow-up, and ten subjects out of the psychodrama sample, information regarding abstinence was in fact available for more of the subjects from community sisters dealing with follow-up for the overall hospital programme. Some patients who were drinking still had contact with the hospital, but were unable to be interviewed or tested at follow-up. Others had been drinking at some stage during the follow-up period, but were "dry"

at the time of the follow-up interview and were able to be interviewed and tested.

(a) Role Playing Sample

Of the 16 subjects in the role playing sample, nine were drinking, or had been drinking at some time before the date of the follow-up interviews and testing, five subjects were dry, or still abstinent at the time of follow-up, and two had lost complete contact with the hospital.

Three of those who were not considered to have been abstinent until the time of follow-up, were dry and fit to be interviewed and tested. All the dry subjects presented for the follow-up interviews and testing.

(b) Psychodrama Sample

Of the 15 subjects in the psychodrama sample, five were drinking, or had drunk at some stage prior to follow-up; nine were dry, or abstinent; and one was completely out of touch with the hospital.

All of the abstinent subjects presented themselves for follow-up interviews and tests. Only one of the five non-abstinent subjects could be interviewed and tested.

(c) Comparison of Role Playing and Psychodrama Samples with respect to Abstinence at Follow-up

It was hypothesised that there would be proportionately more abstinent subjects in the psychodrama sample than in the role playing sample at follow-up. A trend supporting this hypothesis was evident from looking at the

relative numbers of patients dry and drinking at follow-up.

To check whether this difference was in fact statistically significant, the Chi-square test was used to compare the different frequencies of dry and drinking subjects in the two samples. Comparisons were made only between those patients whose drinking status was known. Subjects who had lost contact with the hospital were excluded from the computations even though the community sisters presumed that those patients who were out of touch, and whose drinking status could not be ascertained, were in fact drinking.

One subject in the psychodrama sample who was quite dry when interviewed had in fact only "slipped" over a weekend. Two computations were made, one counting him as dry, the other more conservative one including him with the subjects who were drinking. (It should be noted here that all further calculations incorporating abstinence as a variable take the more conservative step, least favourable to the psychodrama sample, of classifying this subject as drinking. Some such calculations relate to abstinence and test scores, for example, and abstinence and the participation indices.)

The frequencies for abstinence, and the results of the most conservative picture incorporating the subject concerned as drinking are given in Table 28. Table 29 presents the least conservative picture, considering this subject as dry. A third analysis was based on the distribution which resulted when all the subjects who had lost

touch with the hospital were incorporated as drinking. This picture is presented in Table 30.

TABLE 28

COMPARISON OF ROLE PLAYING AND PSYCHODRAMA SAMPLES WITH RESPECT TO ABSTINENCE AT FOLLOW-UP (most conservative picture)

	Role playing	Psychodrama	Total
Dry	5	9	14
Drinking	9	5*	14
Total	14	14	28

*Patient code No. 703 regarded as drinking
Chi-square = 1.30 ($p > .10$, not significant on a one-tailed test)

TABLE 29

COMPARISON OF ROLE PLAYING AND PSYCHODRAMA SAMPLES WITH RESPECT TO ABSTINENCE AT FOLLOW-UP (less conservative picture)

	Role playing	Psychodrama	Total
Dry	5	10*	15
Drinking	9	4	13
Total	14	14	28

*Patient code No. 703 considered as abstinent
Chi-square = 2.30 ($p > .05$, not significant on a one-tailed test)

TABLE 30

COMPARISON OF ROLE PLAYING AND PSYCHODRAMA SAMPLES WITH RESPECT TO ABSTINENCE AT FOLLOW-UP (least conservative picture)

	Role playing	Psychodrama	Total
Dry	5	10*	15
Drinking	11**	5***	16
Total	16	15	31

*Still considers patient 703 as abstinent
**Adds two subjects to drinking category in role playing
***Adds one subject to drinking category in psychodrama
Chi-square = 2.57 ($p > .05$, not significant on a one-tailed test)

Although the trends are all in the predicted direction of having approximately half as many of the psychodrama subjects as role playing subjects drinking at follow-up (5:9, 4:9, 5:10); and twice as many dry; and also within the psychodrama sample twice as many dry as were drinking (9:5, 10:4, 10:5) whereas in the role playing sample twice as many were drinking as were dry (9:5, 9:5, 11:5); none of these trends is statistically significant.

(d) Comparison of Role Playing and Psychodrama Samples with respect to Abstinence and Personality Test Scores

The two samples were compared in terms of the relationship between abstinence and change scores on the personality, or psychological test scores administered at admission and discharge. That is, the dry subjects in the role playing sample were compared with the dry subjects in the psychodrama sample as regards change scores. The drinking subjects were also compared in this way and, finally, the two samples were combined with all the abstinent subjects in the role playing plus psychodrama samples being compared with all those drinking subjects in both samples in terms of change scores on the psychological test scores from pre- to post-testing. Table 31 presents the results of the t-tests performed on these three sets of data.

No significant differences were found in any of the cases, and therefore no further similar analyses were made for the smaller follow-up samples.

TABLE 31

COMPARISON OF CHANGE SCORES FROM PRE- TO POST-TESTING FOR EXPERIMENTAL SAMPLES IN TERMS OF ABSTINENCE CRITERION

Abstinence and Change Scores

	Role playing (n = 5)	Psychodrama (n = 9)	t-value
Ziller	9.8	5.3	.97
Jackson	1.4	1.3	.00
Anxiety	— 1.2	— 1.4	.11
Aggression	.8	.1	.22
Auth. conform.	— 4.6	— 3.4	— .47
Extroversion	1.4	.6	.37

Drinking and Change Scores

	Role playing (n = 9)	Psychodrama (n = 5)	t-value
Ziller	2.7	7.0	— .88
Jackson	2.9	— 1.0	1.03
Anxiety	— 1.4	1.0	—1.06
Aggression	— .8	— 1.0	.01
Auth. conform.	— 3.8	— 2.2	— .54
Extroversion	.8	— 1.8	1.02

Combined Samples Drinking vs Dry

	Dry (n = 14)	Drinking (n = 14)	t-value
Ziller	6.9	4.2	.85
Jackson	1.4	1.5	— .01
Anxiety	— 1.4	— .6	— .51
Aggression	.4	— .9	.66
Auth. conform.	— 3.9	— 3.2	— .36
Extroversion	.7	— .1	.62

Because no significant differences were found, one may conclude that for neither the role playing nor the psychodrama sample did those who stayed dry differ from those who were drinking by the time of follow-up in respect of the change scores on the psychological tests administered at admission and discharge.

3 Participation

Participation is regarded as being related to success in therapeutic outcome. The more active and involved individuals are assumed to have better chances for positive growth and change. Amount of participation is commonly used as a yardstick to measure pathology, improvement after treatment, and prognosis.[6]

In my own study, I looked at two forms of participation. The first of these was patient participation within the experimental sessions. This was linked to the fourth major hypothesis formulated as regards the outcome of the study, viz., that the greater the amount of patient participation within sessions, the more favourable would be the therapeutic outcome in terms of the personality test scores and the abstinence criterion.

Breaking this hypothesis into three operational parts, it was anticipated, for example, that in the psychodrama sample protagonists would show greater change relative to those who played auxiliary roles, and both of these in turn would show proportionately more favourable changes than subjects who remained audience members only. It was also anticipated that the same type of effect would hold

for the role playing subjects relative to their participation within sessions as principal role players, supporting players, or audience members. It was further hypothesised that this participation effect would be more marked for the psychodrama sample than for the role playing sample.

The second form of participation examined was patient participation in the hospital system at large. This involvement in the hospital treatment programme as a whole was referred to as the "gross participation rate".

(a) Participation within Experimental Sessions

(i) Participation index. An index of participation was obtained for each member of the two experimental samples.[7] This index was based on the nature and amount of participation for each subject in all the sessions he or she attended.

For the psychodrama sample, all protagonists were rated as HIGH (H), with a participation index of 4; major auxiliaries were rated as HIGH-MEDIUM (HM), and given an index of 3; minor auxiliaries rated as MEDIUM-LOW (ML), with an index of 2; and those subjects who spent all their time in the sessions as audience members only were given a LOW (L) rating, and an index of 1.

Equivalence for the role playing sample was obtained by rating as HIGH (H) those participants who were principal, or focal role players three or more times (given an index of 4); HIGH-MEDIUM (HM) were those who were principal role players at least twice

(given an index of 3); MEDIUM-LOW (ML) were those who participated only once as principal role player (given an index of 2); whilst a LOW (L) rating was given to those subjects who remained audience members only throughout the experimental sessions.

Table 32 shows the distribution of subjects in the two experimental samples in terms of their index of participation rate within role playing or psychodrama respectively.

TABLE 32

PARTICIPATION WITHIN ROLE PLAYING AND PSYCHODRAMA SESSIONS

Index of participation	4 High (H)	3 High-Med. (HM)	2 Med-Low (ML)	1 Low (L)	Total
Role playing	4	5	5	2	16
Psychodrama	6	2	5	2	15
Total	10	7	10	4	31

The two samples were compared as regards their relative participation rates within each modality respectively, and no statistically significant difference was found between them, i.e. the two samples were similar as regards the distribution of participation indices within the sessions. (See Table 33.)

The participation indices were examined for both groups in relationship to the outcome variables used in this study, viz., abstinence, and psychological test scores.

TABLE 33

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR PARTICIPATION INDICES WITHIN SESSIONS FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

	Mean	Std.dev.	t-value	Probability
Role playing (n=16)	2.7	1.0	— .28	> .70 not signif. (df=29)
Psychodrama (n=15)	2.8	1.1		

(ii) Participation within sessions and abstinence.

As regards abstinence, it was predicted that the greater the amount of participation within sessions, the greater the likelihood of staying dry. Tables 34 and 35 show the distributions of those subjects known to be drinking and dry at follow-up in the role playing and psychodrama samples respectively. Those subjects whose drinking status was unknown at follow-up were not included in the presentations and subsequent analysis of the data for abstinence. Thus the sample size for role playing becomes 14 and psychodrama also becomes 14. (The drinking status of two role playing subjects, and one psychodrama subject was unknown.) The categories "High", "High-Medium", "Medium-Low" and "Low" have been abbreviated to H, HM, ML, and L in the tables.

Table 36 gives the means of participation scores, the standard deviations, and the statistical comparison for each sample in terms of abstinence.

TABLE 34

PARTICIPATION IN ROLE PLAYING -- AND ABSTINENCE

Index of participation	4 H	3 HM	2 ML	1 L	Total
Dry	1	1	1	2	5
Drinking	3	3	3	0	9
Total	4	4	4	2	14

TABLE 35

PARTICIPATION IN PSYCHODRAMA -- AND ABSTINENCE

Index of participation	4 H	3 HM	2 ML	1 L	Total
Dry	5	2	2	0	9
Drinking	1	0	2	2	5
Total	6	2	4	2	14

TABLE 36

MEANS, STANDARD DEVIATIONS, AND TESTS OF SIGNIFICANCE FOR PARTICIPATION WITHIN SESSIONS FOR EXPERIMENTAL SAMPLES IN TERMS OF ABSTINENCE

	Role playing			Psychodrama		
	Mean	Std.dev.	t-value	Mean	Std.dev.	t-value
Dry	2.2 (n=5)	1.3	$p > .10$	3.3 (n=9)	0.9	$p < .05$
			— 1.39			2.39*
Drinking	3.0 (n=9)	0.9		2.0 (n=5)	1.2	

*Significant at the .05 level

One may see from Table 36 that the mean score for those subjects who were drinking at follow-up in the role playing sample was higher than the mean for those subjects who were dry. Conversely, in the

psychodrama sample, subjects who were dry have a higher mean participation score than those who were drinking.

The latter difference for the psychodrama sample was statistically significant at the .05 level. In other words, high participation in psychodrama was positively and significantly related to therapeutic success in terms of abstinence.

The difference between the two means in the role playing sample was not statistically significant; the probability of the t-value being greater than .10. Indeed, the trend of association for the two means was a negative one, indicating that high participators in role playing were more likely to be drinking than dry at follow-up.

(iii) Participation within sessions and personality test scores. In terms of the relationship between participation within the experimental sessions, and outcome on the psychological tests, the fourth hypothesis of the study predicted that high participators in the psychodrama and role playing sessions would show greater increases in self-esteem and extroversion, and larger decreases in anxiety, aggression, and authoritarian conformity than would low participators. It was also anticipated that these changes would be more marked for the psychodrama as compared with the role playing sample.

Because the sample sizes in each participation category were often very small, e.g., two subjects in a cell, it was decided not to analyse the data by

means of t-tests, but to correlate participation scores with the change scores on the psychological tests. Table 37 presents the correlation co-efficients or r-values which resulted when the data were treated in this way.[8]

TABLE 37

RESULTS OF CORRELATIONS BETWEEN PARTICIPATION WITHIN EXPERIMENTAL SESSIONS AND SCORES ON PERSONALITY TESTS

Test item	Correlation co-efficient (r-values) Role playing		Psychodrama	
	Pre to post (df=14)	Pre to follow-up (df=6)	Pre to post (df=13)	Pre to follow-up (df=8)
Ziller	.09	.51	— .31	— .12
Jackson	.03	.20	.08	.63*
Anxiety	.03	.23	.04	.03
Aggression	.14	.58	.31	.42
Auth. conform.	— .18	.16	— .02	.11
Extroversion	— .19	— .26	.14	.09

*Significant at the .05 level

The only statistically significant correlation was found to be within the psychodrama sample between participation score and the change scores on the Jackson test of self-esteem for the pre- to follow-up testing. This indicates that persons who participated most in the psychodrama sessions showed the greatest change in self-esteem from pre- to follow-up.

Referring back to Table 25, one may relate this finding to the one on the t-test analysis, viz., that there was a significant increase in the Jackson

self-esteem test from pre- to follow-up testing. Combining these two facts, it would appear that the significant change found by the t-test for the psychodrama group was primarily contributed to by, or reflects the changes among the high participators within the psychodrama sessions.

(b) Participation in the Total Hospital System

(i) Gross participation index. An index for patient participation in the overall hospital treatment programme was obtained from nurses' ratings. The nurses were chosen to give their ratings because patients had the most frequent daily informal and group contacts with nursing staff, upon whom the major responsibility for carrying through the therapeutic milieu aims devolved.

The four nurses who had had the most contact with all the patients were asked to rate the patients after discharge on a five-point scale, viz., LOW (L), MEDIUM-LOW (ML), MEDIUM (M), MEDIUM-HIGH (MH), and HIGH (H).

If, for example, three out of the four nurses rated a patient as LOW, then that was the index assigned to him. Similarly, if three out of the four nurses' ratings agreed with each other that a patient was MEDIUM, or HIGH, then that majority rating was the index given. If, however, two nurses rated a patient as LOW and two as MEDIUM, then the index assigned was MEDIUM-LOW. Similarly, a patient receiving two ratings of MEDIUM, and two of HIGH would have an index of MEDIUM-HIGH.

One patient was rated by two nurses as LOW; by a third as MEDIUM; and the fourth nurse rated his overall participation as HIGH. The mean rating in the range was used in this case and he was assigned a rating of MEDIUM-LOW.

For the analysis of the data, numbers from one to five were assigned to the different ratings, thereby providing a numerical index of overall participation rate in the hospital programme. Thus HIGH = 5, HIGH-MEDIUM = 4, MEDIUM = 3, MEDIUM-LOW = 2, LOW = 1.

Table 38 shows the distribution of gross participation scores for each sample. Table 39 presents the mean participation scores for each sample, and the results of the t-tests for independent means.

TABLE 38

DISTRIBUTION OF GROSS PARTICIPATION SCORES FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

	5 H	4 HM	3 M	2 ML	1 L	Total
Role playing	-	1	7	1	7	16
Psychodrama	3	3	2	4	3	15
Total	3	4	9	5	10	31

TABLE 39

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR GROSS PARTICIPATION FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

	Mean score	Standard deviation	t-value	Probability
Role playing	2.1	1.1	— 1.74*	< .05 (df=29)
Psychodrama	2.9	1.5		

*Significant at .05 level, one-tailed test

Comparing the two samples on the basis of their participation rate in the total hospital system one finds that the patients in the psychodrama sample participated significantly more than did the patients in the role playing sample. (See Table 39.)

(ii) Participation in the total hospital system and participation within sessions. Table 40 presents the correlation co-efficients for the correlations computed between gross participation and participation within sessions for both samples.

One sees that high participation in psychodrama was positively and significantly correlated with high participation in the total system ($r = .54$, significant at the .05 level). By contrast, however, high participation in role playing tended to be negatively correlated with participation in the total system ($r = -.26$, not significant).

TABLE 40

CORRELATIONS BETWEEN PARTICIPATION WITHIN SESSIONS AND GROSS PARTICIPATION FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES

	Participation within		Gross Participation		Co-efficient r =
	Mean	std.dev.	Mean	std.dev.	
Role playing (n=16)	2.7	1.0	2.1	1.1	— .26 (df=14)
Psychodrama (n=15)	2.8	1.2	2.9	1.5	.54* (df=13)

*Significant at .05 level, two-tailed test

Combining the findings in Tables 39 and 40, one sees that psychodrama subjects taken as a whole

had a higher degree of participation in the total system, and that this participation was correlated with their participation in the psychodrama sessions.

(iii) Participation in total hospital system and abstinence. Looking at the overall relationship between participation in the total hospital programme and abstinence at follow-up, patients who remained dry in both samples tended to have been more active in the total system than those who had started drinking. Table 41 shows that the means for dry subjects were 2.8 in the role playing sample and 3.00 in psychodrama, as compared with means of 1.56 and 2.4 for subjects who were drinking. (These means were computed for subjects for whom definitive information existed as to their drinking status at the time of follow-up.)

TABLE 41

MEANS, STANDARD DEVIATIONS, AND TESTS OF SIGNIFICANCE FOR GROSS PARTICIPATION RATE FOR THE TWO SAMPLES IN TERMS OF ABSTINENCE

	Role playing			Psychodrama		
	Mean	Std.dev.	t=	Mean	Std.dev.	t=
Dry	2.8 (n=5)	1.1	2.33* (df=12)	3.0 (n=9)	1.3	p > .40 0.74 (df=12) df= n_1+n_2-2
Drinking	1.6 (n=9)	0.9		2.4 (n=5)	1.7	

*Significant at .05 level, two-tailed test

Within the role playing sample, those subjects who had participated more actively in the total

hospital system were significantly more likely to stay dry than were those who had been low participators. There was no such statistically significant difference to be distinguished in the psychodrama sample. The lack of any significant difference for the psychodrama sample on total participation may well have resulted from the fact that participation in psychodrama tends to elevate the people who would otherwise have a low participation rate in the hospital. (See Table 41.) The high participators in both samples are, on the whole, the dry subjects. The drinking subjects have the lower participation scores. Although the mean score of those drinking in the psychodrama sample was higher than that for those in the role playing sample, the difference between the two means for the non-abstinent subjects was not statistically significant. (See Table 42.)

TABLE 42

MEANS, STANDARD DEVIATIONS, AND TEST OF SIGNIFICANCE FOR GROSS PARTICIPATION RATE OF SUBJECTS WHO WERE DRINKING AT FOLLOW-UP

	Mean	Standard deviation	t-value	Probability
Role playing (n=9)	1.6	0.9	0.49	$>.60$ Not signif. (df=12)
Psychodrama (n=5)	2.4	1.7		

4 Correlation Matrices for Participation Indices, Background Variables, and Patient Evaluation of Sessions; and a Comparison with respect to Abstinence

The two types of participation scores and six other variables were correlated with each other in order to explore any possible relationships which might have affected the results in terms of showing differences between the two samples.

The correlation matrices for each sample showing the resultant correlation co-efficients are presented in Tables 43 and 44. Table 45 gives the significance levels, and Table 46 presents the mean scores and standard deviations for the two samples for the eight factors investigated.

TABLE 43

CORRELATION MATRIX FOR ROLE PLAYING SAMPLE

Variable	1	2	3	4	5	6	7	8
1 Participation in sessions								
2 Gross participation	−.26							
3 Age	−.51*	.42						
4 Education	−.04	.17	.42					
5 IQ	−.26	−.12	.30	.40				
6 Duration of drinking	−.20	−.06	.26	−.22	.12			
7 Acute problem drinking	−.49	.30	.47	−.09	.17	.41		
8 Patient evaln of sessions	−.21	.41	.28	.14	−.12	.07	.26	

*Significant at .05 level

TABLE 44

CORRELATION MATRIX FOR PSYCHODRAMA SAMPLE

Variable	1	2	3	4	5	6	7	8
1 Participation in sessions								
2 Gross participation	.54*							
3 Age	-.03	-.24						
4 Education	.11	-.22	.26					
5 IQ	.40	.51*	.33	.34				
6 Duration of drinking	-.26	-.31	.48	.56*	.10			
7 Acute problem drinking	-.10	.08	.33	.45	.23	.22		
8 Patient evaln of sessions	.55*	.45	.03	-.02	.12	.04	.00	

*Significant at .05 level

TABLE 45

SIGNIFICANCE LEVELS FOR CORRELATION CO-EFFICIENTS AS PRESENTED IN THE MATRIX[9]

	Sample size n	df= n - 2	Significance level (p)		
			.10	.05	.01 (2-tailed)
Role playing	16	14	.426	.497	.623
Psychodrama	15	13	.441	.514	.641

Looking at Table 43, one sees that for the role playing sample there is a negative and significant relationship between age and participation within sessions. This suggests that the younger patients participated more actively in the role playing sessions than did the older patients. This relationship does not appear in the psychodrama sample.

TABLE 46

MEANS AND STANDARD DEVIATIONS FOR THE TWO SAMPLES FOR THE EIGHT VARIABLES INVESTIGATED IN THE CORRELATIONS

Variable	Role playing (n = 16)		Psychodrama (n = 15)	
	Mean	Std.dev.	Mean	Std.dev.
1 Participation within sessions	2.7	1.0	2.8	1.1
2 Participation in total programme	2.1	1.1	2.9	1.5
3 Age	43.2	9.1	42.1	11.2
4 Education	4.2	1.7	4.7	1.6
5 IQ	104.4	16.3	115.2	10.0
6 Duration of drinking	7.1	5.5	4.5	2.7
7 Acute problem drinking	17.8	7.9	17.8	6.9
8 Patient evaluation of sessions	2.2	1.0	2.3	0.9

The significant relationship which was seen in Table 40 is again represented in Table 44, viz., that participation within sessions is positively correlated with participation in the total hospital system for the psychodrama sample only.

Participation within sessions is also positively correlated with a positive patient evaluation of the experience. (The patient evaluations for both samples were derived from patient comments made at discharge. An average-positive evaluation was coded as 3, ambivalent as 2, and negative as 1.)

The patients with higher educational standards have been drinking longer than those with lower standards of education.

Intelligence Quotient was significantly correlated with participation in the total hospital system. That is, patients with higher IQs participated more actively in the overall programme than did those patients with lower IQs.

TABLE 47

SUMMARY OF STATISTICAL COMPARISON OF SAMPLES WITH RESPECT TO ABSTINENCE FOR BACKGROUND VARIABLES AND EVALUATION

	Role playing n=5(dry);9(drinking)		Psychodrama n=9(dry);5(drinking)	
	Mean	t-value	Mean	t-value
Age				
Dry	51.0	3.08**	44.9	1.28
Drinking	38.1		36.8	
Education				
Dry	4.6	0.68	5.2	1.40
Drinking	3.9		4.0	
IQ				
Dry	112.4	1.24	118.6[/]	2.54*
Drinking	100.7		105.3	
Duration of				
Dry	21.6	1.82	19.0	0.69
Drinking	14.1		16.2	
Acuteness				
Dry	6.2	- 0.18	4.8	0.36
Drinking	6.7		4.2	
Evaluation				
Dry	2.2	0.00	2.6	1.56
Drinking	2.2		1.8	

*Significant at .05 level
**Significant at .01 level
[/]For this comparison the two IQ scores that were estimated at 115 were omitted. One was dry and one was drinking.
∴ n for PD was 8 (dry); 4 (drinking)

Table 47 above compares the two experimental samples with respect to background variables and patient evaluations of the sessions at exit. This comparison is presented in terms of the breakdown for abstinence, i.e. into dry and drinking subjects. The comparisons between the participation indices have already been presented and discussed in the sections on participation within sessions, and participation in the total hospital system.

There are only two significant findings in the analysis presented in Table 47. In the role playing sample subjects who were dry at follow-up were significantly older than subjects who were drinking. In the psychodrama sample subjects who were dry had significantly higher IQs than subjects who were drinking at follow-up.

As regards these two findings, it has already been noted early on in this chapter when comparing the two experimental samples, that there was no significant difference in the average age of the role playing and psychodrama subjects. (See Table 2.) Therefore the differences between the numbers of dry and drinking subjects, which approached but did not reach significance (see Table 30) could not be explained on the basis of differences in age between the two samples.

However, Table 9 showed a significant difference between the two samples with regard to IQ. Role playing subjects had lower IQs than did the psychodrama subjects. Therefore, it is possible that the differences between the two samples with respect to the proportions of subjects

who were dry and drinking which approached statistical significance (see Table 30) and also with respect to difference between the mean gross participation for the two samples (Table 39) which reached statistical significance, are a reflection of the differences in IQs between the two samples.

To investigate these possibilities, further analysis of the data was conducted whilst controlling for IQ.

5 Controlling for IQ

One simple way of controlling for IQ would be to drop the seven subjects with IQs of less than 100. (See Table 8.) This gives one two samples that are more evenly matched with respect to IQ but leaves one with a role playing sample of only four subjects who were dry at follow-up, and four who were drinking. (See Table 48.) The frequency distribution of subjects with IQs of 100 or over for dry and drinking subjects in the two samples is given in Table 48 below.

TABLE 48

FREQUENCY OF SUBJECTS WITH IQs OF 100 OR ABOVE, WHO WERE EITHER DRY OR DRINKING AT FOLLOW-UP

	Dry	Drinking	Total
Role playing	4	4	8
Psychodrama	9	5	14
Total	13	9	22

Chi-square = .04 ($p > .80$, not significant)

As can be seen from the results of the Chi-square

test, the difference in the proportions of dry and drinking subjects in the two samples is far from significant.

However, with such a small sample of role playing subjects it might be difficult to establish the significance of any differences even in those cases where an actual difference exists.

A better test would be provided were it possible to increase the sample size.

The Interstitial cohorts provided a potential source of more subjects. (See Chapter VII.) There were five subjects who were exposed only to role playing, all of whom had IQs of 100 or over, and for whom evidence existed as to whether they were dry or drinking at follow-up. One of these subjects was drinking, and four were dry.

By adding these additional five subjects to the role playing sample with subjects of higher IQs, an average IQ results of 114.7, which is not significantly different from the average IQ of 115.2 for the entire psychodrama sample. (See Table 49.)

TABLE 49

MEANS, STANDARD DEVIATIONS, AND t-TEST FOR IQ FOR NEW HIGH IQ ROLE PLAYING AND THE TOTAL PSYCHODRAMA SAMPLES

	Mean	Standard deviation	t-value	Probability
Role playing (n=13)	114.7	10.5	0.33	> .70 Not signif. (df=26)
Psychodrama (n=15)	115.2	10.8		

With regard to abstinence, there is no difference in the proportions of subjects who were dry and drinking between the new high IQ role playing sample and the total psychodrama sample. (See Table 50.)

TABLE 50

FREQUENCY OF SUBJECTS WHO WERE DRY AND DRINKING AT FOLLOW-UP FOR NEW HIGH IQ ROLE PLAYING AND THE TOTAL PSYCHODRAMA SAMPLES

	Dry	Drinking	Total
Role playing	8	5	13
Psychodrama	9	5	14
Total	17	10	27

Chi-square = .06 ($p > .80$, not significant)

For the new high IQ role playing sample, the correlation between participation within sessions and total participation is -.30, and not significant. This is essentially the same as the negative and not significant correlation of -.26 between these two variables for the original role playing sample. (See Table 43.)

Likewise, the correlation between IQ and total participation for the new high IQ role playing sample is -.12 and not significant. This is the same as the correlation of -.12 in the original role playing sample. (See Table 43.)

Comparing the mean scores for gross participation for the dry and drinking subjects within the new high IQ role playing sample, it is found that dry subjects participate significantly more in the total system than do those who

are drinking. (See Table 51.) There was no such significant difference between dry and drinking subjects for the scores for participation within role playing. (See Table 52.)

TABLE 51

MEANS, STANDARD DEVIATIONS, AND t-TEST FOR GROSS PARTICIPATION SCORES OF DRY AND DRINKING SUBJECTS IN THE NEW HIGH IQ ROLE PLAYING SAMPLE

	Mean	Standard deviation	t-value	Probability
Dry (n=8)	2.3	1.0	2.76	$< .05$ Significant
Drinking (n=5)	1.0	0.0		

TABLE 52

MEANS, STANDARD DEVIATIONS, AND t-TEST FOR PARTICIPATION WITHIN SESSIONS OF DRY AND DRINKING SUBJECTS IN THE NEW HIGH IQ ROLE PLAYING SAMPLE

	Mean	Standard deviation	t-value	Probability
Dry (n=8)	1.8	1.0	—2.18	$> .05$ Not signif.
Drinking (n=5)	3.0	1.2		

These findings were similar to those for the original role playing samples. (See Tables 41 and 36.)

A comparison of the gross participation scores for the new high IQ role playing sample and the psychodrama sample indicates a significantly lower rate of participation for the role playing subjects. (See Table 52.) This was the same difference as that found with the original role playing sample. (See Table 41.)

TABLE 53

MEANS, STANDARD DEVIATIONS, AND t-TEST FOR GROSS PARTICIPATION FOR NEW HIGH IQ ROLE PLAYING AND THE TOTAL PSYCHODRAMA SAMPLE

	Mean	Standard deviation	t-value	Probability
Role playing (n=13)	1.8	1.0	—2.39*	< .05
Psychodrama (n=15)	2.9	1.5		

*Significant at .05 level

The conclusion which may be reached from comparison of the new high IQ role playing sample with the total psychodrama sample is that there is no difference between the two types of subjects with regard to the proportion of subjects who are dry or drinking at follow-up. When IQ has been controlled the differences in participation within sessions and gross participation between role playing and psychodrama which were present in the original samples are still apparent and significant.

6 Diagnosis of Personality

There were too few subjects to reveal any statistically significant trends in the differences between the role playing and psychodrama samples with respect to therapist diagnosis of personality type and abstinence. However, when both samples are combined, a significant difference is found between subjects diagnosed as "passive-aggressive" and those in other diagnostic categories. (See Table 54.) More subjects diagnosed as "passive-aggressive" than "others" are drinking rather than dry.

TABLE 54

COMPARISON OF DIAGNOSTIC CATEGORY AND ABSTINENCE FOR ROLE PLAYING AND PSYCHODRAMA SAMPLES COMBINED

(Role playing + Psychodrama)

	Passive-aggressive	Other	Total
Dry	3	11	14
Drinking	10	4	14
Total	13	15	28

Chi-square = 5.17 ($p < .05$, significant at .05 level)

The diagnostic categories were examined in terms of their relationship to participation within sessions, and gross participation rate in the total hospital sample for the total sample combined. (See Tables 55 and 56.) Although subjects diagnosed as "passive-aggressive" participated less than "others" both within sessions and in the total system, in neither case was the difference a significant one.

TABLE 55

COMPARISON OF DIAGNOSTIC CATEGORIES IN TERMS OF PARTICIPATION WITHIN SESSIONS

(Role playing + Psychodrama)

Participation index	Passive-aggressive	Other	Total
High (4 + 3)	7	10	17
Low (2 + 1)	8	6	14
Total	15	16	31

Chi-square = 0.27 ($p > .50$, not significant)

TABLE 56

COMPARISON OF DIAGNOSTIC CATEGORIES IN TERMS OF GROSS PARTICIPATION IN TOTAL HOSPITAL SYSTEM

(Role playing + Psychodrama)

	Passive-aggressive	Other	Total
High, High-Medium, Medium	5	10	15
Medium-Low, Low	10	6	16
	15	16	31

Chi-square = 1.60 ($p > .20$, not significant)

7 Drinking Pattern

There was no significant relationship between drinking pattern and abstinence in either sample.

8 Follow-up Data

Patients who presented for follow-up were interviewed with regard to abstinence, their evaluation of the experimental sessions, and their psycho-social adjustment to life outside the hospital since discharge. There were no significant differences between the two samples in any of the five areas covered, viz., psychological health, physical health, domestic situation, inter-personal relationships, and employment. The majority of the subjects in both samples had made positive adjustments in these areas, with psychodrama subjects somewhat more positive than the role playing sample. However, even in the most extreme case favouring the psychodrama sample the difference between the two samples was not statistically significant.

(This was in the case of psychological health. The distribution for the psychodrama sample was 10:0 compared to 5:3 for role playing. Chi-square was 0.12, $p > .70$, not significant.)

The three-week hospitalisation period was seen as an initiation of a long-term relationship with the hospital for the patients.[10] Taking note of this philosophical cornerstone, the follow-up interviews conducted by the present study inquired about the patient's relationship to William Slater Hospital at the time, e.g., in terms of attendance at outpatient group meetings, individual therapy sessions, social club, and continuance of antabuse therapy. There were no differences between the two samples with respect to the aspects covered.

NOTES

on Chapter VIII

1 Raven's Standard Progressive Matrices, London, 1958.

2 Act No. 41 of 1971: Abuse of Dependence-producing Substances and Rehabilitation Centres Act, Government Gazette, LXXI, No. 3118, Cape Town, 26 May 1971, p. 32.

3 The terms "personality test" and "psychological test" will be used interchangeably throughout this and successive chapters to refer to the Ziller and Jackson tests of self-esteem, and to the General Survey subtests of anxiety, aggression, authoritarian conformity, and extroversion.

4 For Tukey's HSD test, see Lee Wayne, Experimental Design and Analysis, (San Francisco: W H Freeman and Co., 1975), pp. 300-301.

5 Abstinence, or whether and for how long patients stay "dry" or not after treatment has been referred to as a primary goal of and yardstick for measuring successful treatment of alcoholism. (See Chapter V.) The William Slater Hospital also uses abstinence as a major criterion for the positive therapeutic outcome of their in-patient programme. (See Chapter VII.)

6 Lynn Gillis, "Participation -- its Measurement and Relationship to Clinical Change in Psychiatric Illness", International Journal of Social Psychiatry, XIV, No. 2, (1968), p. 290. Similar assumptions as to the benefits of participation on educational development are also made. See, for example, Gordon W Allport, "The Psychology of Participation", The Psychological Review, LIII, No. 3, (1945), pp. 117-132. Dimock, reviewing research on the effectiveness of sensitivity training, concludes that it is the extent of participant involvement and learning through experience which are the factors found to be related to the positive impact of sensitivity training. Hedley G Dimock, "Sensitivity Training as a Method of Increasing On-the-job Effectiveness", Sociological Inquiry, XLI, No. 2, (1971), pp. 227-231.

7 Quantitative involvement rather than qualitative involvement was looked at. It was felt that developing a rating scale for personal intensity of involvement would be outside the scope of this study.

8 Pearson product-moment correlation co-efficients.

9 These significance levels for the correct degrees of freedom for both sample sizes are drawn from N M Downie and R W Heath, Basic Statistical Methods, (New

York: Harper and Row, 1974), p. 314. It was thought to include them below the correlation matrices for the convenience of the reader.

10 For example, when interviewed for their evaluation of the psychodrama and/or role playing sessions, staff members answered a "warm-up" question about their perception of the goals for the three-week in-patient programme. The goals were seen variously as an "orientation period for longer-term therapy. A period of assessment where the team can get its hookers into the person and his problem and see what to do next"; as an initial period for patients to gain a basic understanding of their personality "and to work with it (sic) later in outpatient treatment". "The real growth needs to be supported afterwards, in community contacts ... . Unless patients make good contact with William Slater Hospital in the three weeks there will be no follow-up."

CHAPTER IX

PATIENT AND STAFF EVALUATIONS OF ROLE PLAYING AND PSYCHODRAMA

A. INTRODUCTION

This chapter is based on material gathered from patients during interviews given at exit and follow-up, and from interviews given to 12 staff members prior to the conclusion of the study. (See appendices 6, 7, and 8 for copies of interview schedules used.)

The patients and staff were asked to evaluate psychodrama and role playing, and to compare them with other aspects of the hospital programme. The patient responses were coded according to content. Data presented in this chapter cover both content and frequency distributions of the various types of comment.

Illustrative examples of patient and staff comments are given in appendices 12 and 13.

B. PATIENT AND STAFF PERCEPTIONS OF THE RELATIVE HELPFULNESS OF ASPECTS OF THE TOTAL HOSPITAL PROGRAMME

At exit patients were asked to rate the different activities in which they had participated during their hospitalisation on a five-point scale ranging from "not at all helpful", "minimally helpful" through "moderately

helpful", "helpful" to "extremely helpful". In addition, as a check for and a balance to the tendency for a positive response set in some of the patients, they were asked to rank-order three activities in terms of their perceived helpfulness as "first", "second", or "third" most helpful.

At follow-up, those patients who presented themselves for the interviews were asked to state which one aspect they felt had had the most impact on their lives in the period between discharge and follow-up. (See Table 58.)

During their interviews, staff members were asked to rank-order what they considered to be the "first", "second", and "third" most helpful aspect of the programme to patients. (See Table 59.)

Table 57 shows the totals of rankings of "first", "second", or "third" most helpful aspect made by the role playing and psychodrama subjects, i.e. the figures given indicate the total number of times an aspect was ranked, irrespective of whether it appears as "first", "second", or "third".

Regardless of their level of participation within role playing or psychodrama, at exit the majority of patients in both samples rated and rank-ordered individual therapy as the most helpful aspect of the programme. Educative aspects were the next most highly valued, followed by group therapy and informal contacts with staff.

Neither psychodrama nor role playing were given a high rating compared with most aspects of the programme.

However, three psychodrama subjects included psychodrama in their rankings, whereas no role playing subjects included role playing in theirs.

TABLE 57

ASPECTS FOUND MOST HELPFUL BY PATIENTS AT DISCHARGE
(TOTALS OF RATINGS IN FIRST THREE RANKS)

	Role playing (n=16)	Psychodrama (n=15)	Total ratings
Individual therapy	13	12	25
Educative aspects	8	11	19
Group therapy	9	4	13
Staff informally	5	8	13
Physical factors (rest, food, medication)	5	5	10
Peers informally	4	2	6
Occupational therapy	4	0	4
Psychodrama	0	3	3
Role playing	0	0	0
Total	48	45	93

A summary of subject responses made at follow-up is given in Table 58. This table indicates the frequency with which the different aspects are judged to have made the most impact on the patients' lives outside the hospital since their discharge.

At follow-up, the patients give similar rankings of the various aspects of the therapeutic programme to those rankings made at exit. (As at exit, role playing receives no rating at all.)

TABLE 58

ASPECT JUDGED BY PATIENTS AT FOLLOW-UP TO HAVE HAD THE MOST IMPACT ON THEM SINCE DISCHARGE

	Role playing (n=8)	Psychodrama (n=10)	Total
Individual therapy	1	2	3
Educative aspects	1	2	3
Group therapy	2	0	2
Staff informally	0	2	2
Psychodrama	0	2	2
Role playing	0	0	0
Totality of programme	4	1	5
Don't know	0	1	1
Total	8	10	18

The largest number of rankings was given to the total experience of the hospitalisation. Four role playing subjects, as compared with one psychodrama subject felt that they could not distinguish between the different aspects and felt that it was the hospital programme in its entirety which had been important.

Twelve staff members were interviewed and asked to rank-order the aspects of the therapeutic milieu in terms of their helpfulness to patients. A summary of the staff perceptions is given in Table 59. As with the patient perceptions at exit, the "first", "second", and "third" ranks were combined to give a total number of ranks for each aspect.

Comparing the total numbers of staff rankings for each aspect with the total numbers of patient rankings at

exit, one sees a similar pattern for the most highly valued aspects. In other words, on the whole the patients and staff shared similar conceptions of the helpfulness of individual therapy, educative aspects, and group therapy. Some staff members also rated the totality of the programme as important, as did some of the patients at follow-up.

TABLE 59

ASPECTS JUDGED IN TERMS OF HELPFULNESS TO PATIENTS BY STAFF MEMBERS

	Total number of ranks
Individual therapy	6
Educative aspects	5
Group therapy	6
Staff informally	1
Physical factors (rest, food, medication)	1
Peers informally	2
Occupational therapy	1
Psychodrama	2
Role playing	1
Totality of programme	4
Total	29 (n=12)

C. PATIENT PARTICIPATION AND EVALUATION

At exit, following the ratings and rankings of aspects of the total hospital programme, subjects were invited to comment on their experience during the role playing or psychodrama sessions. These evaluative comments were

characterised as negative, positive or mixed. Each subject received a score or "code" according to the average evaluative dimension of the comments made. Thus, an average picture of negative comments received a score of 1; an average ambivalent evaluation received a 2; and a positive average was coded or scored as 3. This procedure made it possible for the evaluative comments to be included in the correlation matrices presented in Tables 43 and 44 in Chapter VIII.

The only significant correlation with evaluation for the experimental sessions was with patient participation within the psychodrama sessions (T = .55, significant at the .05 level).

There was no corresponding relationship in the role playing sample. In fact the correlation was negative and not significant (r = − .21).

There were no significant relationships between patient evaluation of sessions and abstinence at follow-up, nor did the two samples differ from each other in respect of the evaluations.

D. PATIENT COMMENTS ON EXPERIMENTAL SESSIONS

1 Exit Interviews

The same data used for the correlations between patient evaluation and other variables were examined in terms of content.

The question asked at exit was a general "open-ended" one. The interviewer could use probing questions at her discretion. Thus the comments made were not only responses to the general question but were also stimulated by the specific probes. The comments were sorted into ten categories, nine of which described specific aspects of patient experience whilst the tenth covered general evaluative statements.

In each case, as has already been described, it was noted whether a comment was positive, negative, mixed or ambivalent in its underlying evaluative dimension. Where a subject made a number of comments in one category which differed in their respective emphases or conflicted with each other, e.g., one statement positive and one negative, this was recorded as being a mixed statement. (Since each category had these three dimensions, there were in fact thirty possible categories or classes into which comments could be sorted.)

Since subjects could, and indeed did, make more than one comment per category, in the interest of having some comparable standard for the frequency tables, only one comment per person in each category was counted.

The categories used in the analysis of patient comments are as follows:

Specific categories

1 Catharsis, relief from tension, self-expression

2 Insight, self-understanding

3 Self-confidence

TABLE 61

PROPORTIONS OF SUBJECTS IN ROLE PLAYING AND PSYCHODRAMA SAMPLES COMMENTING IN GENERAL AND SPECIFIC CATEGORIES

	General	Specific
Role playing	$^{12}/_{16}$	$^{8}/_{16}$
Psychodrama	$^{13}/_{15}$	$^{10}/_{15}$

TABLE 62

SUBJECTS COMMENTING IN GENERAL AND SPECIFIC CATEGORIES AT EXIT BY SAMPLE

	General		Specific	
	Yes	No	Yes	No
Role playing (n=16)	12	4	8	8
Psychodrama (n=15)	13	2	10	5

In the role playing sample 12 of the 16 subjects (75%) make at least one general evaluative comment, whilst half, or eight of the 16 subjects (50%), make specific comments. In the psychodrama sample 13 of the 15 subjects (87%) make general comments, and ten of 15 (66.6%) make specific comments. Fewer comments altogether are made by the role playing sample. The psychodrama sample made twice as many specific comments as the role playing sample.

General comments were spread around the three evaluative dimensions more than were the specific comments. Specific comments were mainly positive in nature.

The highest number of responses is in the general category, with mixed comments being the most frequent,

followed by positive and then negative comments in that order. There is no basis for differentiation between the role playing or psychodrama samples with regard to general comments.

Where the specific categories are concerned, psychodrama subjects comment on the positive values of aspects which are inherent in or associated with the psychodrama method, viz., catharsis, sociometric status, and sharing, whereas role playing subjects found the rehearsal aspect of role playing to be important. The remaining specific categories were held in common by the two samples.

TABLE 63

DISTRIBUTION OF COMMENTS AT DISCHARGE
(one comment per subject per category)

	Positive		Mixed		Negative		Total
	RP	PD	RP	PD	RP	PD	
Catharsis	-	2	-	-	-	-	2
Insight	2	2	-	-	-	-	4
Confidence	2	4	-	-	-	-	6
Rehearsal	2	-	-	-	-	-	2
Sociometric	-	2	-	-	-	-	2
Interpersonal	-	-	-	-	-	-	-
Sharing	-	3	-	-	-	-	3
Reality	1	3	-	1	2	2	9
General	4	4	5	7	3	2	25
Total	11	20	5	8	5	4	53
	31		13		9		53

2 Follow-up Interviews

At follow-up, subjects who presented for the interview and testing were asked whether their participation in either the role playing or psychodrama sessions had made any difference to them in the six weeks following discharge. In addition, a number of specific questions or probes were also used. (See appendix 7.) These latter questions were not responded to equally by all the interviewees.

Table 64 shows the total number of comments made within the general and specific categories. Table 65 describes the proportion of subjects commenting in the two kinds of categories, and Table 66 looks at the differences between the two samples. Table 67 presents the distribution of comments made in the two samples in terms of the evaluative dimensions of the aspects.[3]

TABLE 64

TOTAL NUMBERS OF COMMENTS MADE AT FOLLOW-UP

	General	Specific	Total
Role playing (n=8)	7	7	14
Psychodrama (n=10)	6	18	24
Total	13	25	38

TABLE 65

PROPORTION OF SUBJECTS COMMENTING IN GENERAL AND SPECIFIC CATEGORIES AT FOLLOW-UP

	General	Specific
Role playing	7/8	6/8
Psychodrama	6/10	9/10

TABLE 66

SUBJECTS COMMENTING IN GENERAL AND SPECIFIC CATEGORIES AT FOLLOW-UP BY SAMPLE

	General		Specific	
	Yes	No	Yes	No
Role playing (n=8)	7	1	6	2
Psychodrama (n=10)	6	4	9	1

TABLE 67

DISTRIBUTION OF COMMENTS AT FOLLOW-UP
(one comment per subject per category)

	Positive		Mixed		Negative		Total
	RP	PD	RP	PD	RP	PD	
Catharsis	-	3	-	-	-	1	4
Insight	2	3	-	-	-	-	5
Confidence	1	2	-	-	-	-	3
Rehearsal	-	1	-	-	-	-	1
Sociometric	-	-	-	-	-	-	-
Interpersonal	-	2	-	1	-	-	3
Sharing	-	3	-	-	-	-	3
Reality	-	1	-	-	4	1	6
General	1	3	3	1	3	2	13
Total	4	18	3	2	7	4	38
	22		5		11		38

The pattern of the frequency of responses, with more comments made by the psychodrama subjects, and the pattern of positive, mixed, and negative comments within the general and specific categories is the same as that found at exit.

The responses to the question of whether participation in the role playing or psychodrama sessions had made any difference to respondents over the six weeks since discharge are given in Table 68.

TABLE 68

AFFIRMATIVE AND NEGATIVE RESPONSES TO THE QUESTION ON IMPACT OF EXPERIMENTAL SESSIONS

	Role playing (n=8)	Psychodrama (n=10)	Total
Yes	1	4	5
No/D K	7	6	13
Total	8	10	18

Chi-square = .59 ($p > .30$, not significant)

Most people in both samples had not felt that their participation in the sessions made any impact on their lives since discharge. A higher proportion of psychodrama subjects than role playing subjects answered in the affirmative to the question. The difference was however not statistically significant.

3 Summary of Content of Patient Comments

Patients who had participated in psychodrama commented at exit and follow-up on the specific values associated

with psychodrama, such as catharsis, improvement in sociometric status, and sharing, or identification with protagonist problems and enactments. Mainly role playing rather than psychodrama subjects tended to comment on the role practice aspect, which was specific to the sessions, and both role playing and psychodrama subjects commented on aspects such as gains in insight, self-confidence and the reality, or truthfulness of their experience in the sessions. Only at exit did subjects comment at all on behavioural change.

Participants in both types of sessions made general evaluative comments regarding their experience as protagonists or principal role players, auxiliary egos or supporting players, and audience members. Appendix 12 gives illustrative examples of patient comments in the various categories.

On the whole, the majority of general evaluative comments made by both samples were positive. In the psychodrama sample for example, subjects felt that protagonists had been helped, and felt that the enactment mode of exploring real, personal problems was valuable. Role playing subjects felt that the technique was helpful in bringing out a side of the patients not revealed in other activities in the hospital.

Mixed or ambivalent comments in both samples referred primarily to the subjects' feelings that the respective method was not helpful for him, but observed it as helping others.

was valuable in other contexts.

The opinion was expressed that psychodrama could aid the therapeutic milieu approach used in the William Slater Hospital since it brought the group members closer together, having shared a warmth and intimacy not possible in other types of groups.

Both protagonists and audience members were seen to have benefited from the sessions. (Auxiliary ego participation was not mentioned.)

Staff members were on the whole very positive in their appraisal of the effects of psychodrama on the participants. Protagonists especially appeared more open, spontaneous, relaxed and active in the hospital programme after their sessions.[4] They were also observed to be more receptive to individual and group therapy.[5] The opinion was expressed that having experienced a deep emotional exploration of material in psychodrama, protagonists found it easier to move into previously defended sensitive areas in other therapies. Audience members who had observed their explorations and its helpfulness were also more willing to disclose areas and to open themselves up to the process of therapeutic work. Protagonists were also seen to be more accepted by their peers and by staff members after their sessions, and in turn appeared to accept themselves more.

A number of staff members made the observation that immediately after the sessions the protagonists tended to withdraw into themselves (probably preoccupied with the

material "stirred up" by the session) and to isolate themselves from the rest of the group members for a while. Another feature noted was the "exhaustion" following the session, and the fact that protagonists would have a good night's sleep, often their first for a long time, after the session. (These factors hold implications for an in-patient programme in that staff could know what to expect and how to handle "recovery" after the session.)

It was felt that the hospital would benefit from having a psychodrama therapist on the staff to integrate the method with the other approaches used. A combined system of role playing and psychodrama was seen as holding the most promise, since not all patients were felt to be suitable, or "ready" for psychodrama. Two psychodrama sessions a week were recommended, and role playing was seen as serving a function in being the ideal introduction to psychodrama. It was felt that staff members could gain from learning psychodramatic techniques such as role reversal, doubling, and auxiliary chair, so as to be able to use these in constructively channeling spontaneous expressions of emotion which might arise in different parts of the hospital programme.

Whereas some staff members felt that psychodrama could be used with any type of patient, others recommended a screening or pre-selection process for psychodrama. Several factors were mentioned as contra-indicators for psychodrama, such as personality factors, low IQ, and high anxiety level. On the other hand, the opinion was expressed by several staff members that the IQ, or personality

type of patients would not affect suitability for psychodrama, but that the willingness of a patient to express feelings and to work on himself and his problems was the important issue. (Paradoxically, some of these same staff members had seen psychodrama as contributing to motivation and self-disclosure.)

Patients who function on a concrete rather than an abstract reasoning level, or who have a precisely defined, limited problem, or who have poor ego strengths were seen as being more suitable for role playing than for psychodrama.

Three staff members had the idea that people classed as the "extrovert" personality type would adapt more readily to psychodrama. (I personally feel that this is a fallacious assumption based upon a myth that psychodrama requires "acting skill" and that introverts would be too shy to move into exploration. I feel that since the warm-up to reality is significant in aiding a protagonist's enactment or re-enactment of his life, any personality type is suitable. Psychodrama is not acting; as Moreno put it, it is life, the "Theatre of Truth" or reality.)

In conclusion, one might say that the patient and staff comments add to and complement the statistical treatment of the findings analysed in Chapter VIII. Moreno distinguished two kinds of "validity" in psychotherapy, viz., scientific validation and existential validation. The descriptive and frequency data given here in Chapter VIII might be said to have existential validation, which

Moreno feels makes

> . . . claims of validity only *in situ*, in the here and now without any attempt to confirm the past or to predict the future. It shall be classified as more than art, although when people talk about the art of psychotherapy, it is implied that what takes place has existential validation. Scientific and existential validation do not exclude one another, they should be construed as a continuum.[6]

NOTES

on Chapter IX

1 The responses in category 6 were made during the follow-up interviews, and referred mainly to changes in behaviour in the period between discharge and follow-up.

2 Some subjects made more than one comment in a category, and in different evaluative dimensions of the category. As has already been noted, for purposes of making the categories comparable, only one comment per category was counted. Since there were three evaluative dimensions per category, it has been noted that there were thirty possible places in which the scored comment could go.

3 A similar methodological procedure for organising the comments was adhered to for follow-up as for discharge. (See note 2 supra.)

4 This observation ties up with the statistical finding in the study that the level of gross participation of the protagonists in particular, and the psychodrama participants in general, was significantly raised. A similar finding was described by Souerwine and Conway in working with a small group of children. Although the measure of improvement in social interaction used did not show a statistically significant change after role playing, they found a trend towards a greater degree of social interaction in their experimental group than in their control group. Andrew H Souerwine and Kathryn L Conway, "The Effects of Role Playing upon the social atmosphere of a small group of sixth-grade children." American Psychologist, VIII, No. 8, (1953), p. 439.

5 Crouch, describing her work with alcoholic women felt that one of the most important functions of psychodrama was the "motivational aspect". "Psychodrama helps her to come out of herself and begin to participate and take notice of the problems and aspirations of those around her." Rosemary B Crouch, "Psychodrama and the Alcoholic Woman". Paper presented to The First South African International Conference on Alcoholism and Drug Dependence. Cape Town, 4 - 8 November 1974. She felt that the form of psychodrama she used (psychodramatic role playing) was not a complete treatment in itself, but motivated patients for further therapy. Rosemary B Crouch, Interview in The Cape Times, 6 November 1974.

6 J L Moreno, Psychodrama, Vol II, (Beacon, New York: Beacon House, 1959), p. 88

P A R T F O U R

OVERALL SUMMARY AND CONCLUSIONS

. . . this then, is the lesson we learn from Moreno: "Throw away that old script. Redo it, here, now. Act yourself as you never were, so that you may begin to be what you might have become. Make it happen. Be your own inspiration, your own playwright, your own actor, your own therapist and finally, your own creator."

ZERKA T MORENO,

"Beyond Aristotle, Breuer and Freud: Moreno's Contribution to the Concept of Catharsis", 1971.

CHAPTER X

SUMMARY AND CONCLUSIONS

A. SUMMARY

The Psychodrama Method

In this present study the classical psychodrama therapy method as developed by Dr J L Moreno was used. This method may be defined as a systematised method of role playing which uses enactment rather than solely verbal means of enabling individuals to explore the psycho-social dimensions of interpersonal problems. Moreno referred to psychodrama as the theatre of truth and reality.

The goals of psychodrama, used as group therapy, include the strengthening of the self-concept; the development of insight, self-understanding, and empathy for others; the diminution of stress or anxiety through catharsis; and the facilitation of positive interpersonal relationships and adaptive, creative behavioural patterns.

Psychodrama employs the principle of simultaneity, viz., the simultaneous involvement of cognitive, emotional and affective modes, and is adaptable and flexible as a therapeutic modality in its forms and areas of application.

Five basic elements may be distinguished in the Moreno system. These are:

(i) the protagonist, or chief actor in the psychodrama who portrays his own life situation;

(ii) the director, or trained leader of the psychodrama, the psychodramatist;

(iii) auxiliary egos, or trained therapeutic assistants, who aid the director and protagonist by playing the roles of absent others in the protagonist's drama;

(iv) the audience who are spectators of the drama;

(v) the stage which is the locus of the enactment and, in the classical tradition, is a three-levelled circular platform, but could also be an in situ locus, wherever the subject is found.

All these elements were present in the experimental psychodrama sessions conducted at the William Slater Hospital with the exception that there were no trained auxiliaries and no raised formal stage. A portion of the room, or an action area, was demarcated for the stage.

The phases of a typical psychodrama as described in the Hollander Curve were used. A tripartite process of warm-up, action and integration was followed. In the warm-up phase, discussion of a theme or the use of a structured communication exercise was employed to enable participants to feel relaxed with each other and identify their own personal areas of concern. This phase terminated in the selection of a protagonist. The action phase comprised the enactment of a series of scenes and proceeded from an exploration of the presenting problem, the translation of this into the first "actable idea" in the initial scene through one or two scenes culminating in an emotional catharsis, and then one or two scenes mostly centred in a projected or surplus reality focusing on insight and chiefly employing role training methods. The final phase

comprised sharing by group members of incidents in their own lives which were similar to those portrayed by the protagonist or the sharing of identifications or emotions which might have been "triggered off" by the protagonist's drama. Analytic feedback or advice giving to the protagonist was discouraged as being anti-therapeutic in this phase.

Psychodramatic techniques and derivatives may be extracted from the classical format and used by practitioners who adhere to a variety of theoretical positions, e.g., psychoanalytical, phenomenological, or behaviourist. However, the psychodrama method itself is based on clearly defined principles and assumptions which comprise a Morenean or psychodramatic theoretical system. Some of the important underlying concepts and principles are:

(i) the principle of spontaneity which Moreno defined as an "adequate response to a new situation, or the novel response to an old situation"[1]

(ii) creativity, or the catalyst of spontaneity

(iii) the cultural conserve, or end-product of creativity

(iv) the concept of role reversal as the capacity to perceive situations from another's point of view and as a method of socialisation

(v) tele, or the two-way reciprocal flow of empathic feeling, and

(vi) the social atom, or the minimum number of psychologically meaningful relationships necessary for an individual's inner sense of homeostasis

The concept of role and the processes involving role relationships are central to the Morenean system. Moreno employs the existential principle of the here-and-now in psychodramatic explorations. In other words the time-place-reality continuum of enactments takes place as if in the

present, although the enactments occurred in the past, or are anticipated to occur in the future.

Through the use of surplus reality, the intangible, hidden dimensions of human experience are expressed externally. The concept of an integrated rather than simply abreactive catharsis was employed in the psychodrama sessions. Blatner describes this catharsis which accompanies the psychodramatic process as an

> active taking into the conscious self all the different mixed feelings that had heretofore been rejected and suppressed. Along with the feelings of anger and yearning, there is a sense of "determination to go on", which becomes integrated into the protagonist's self-concept, and in turn adds a great deal of vitality to the sense of self.[2]

Major Derivative Forms and Techniques of Psychodrama

The major derivative forms of psychodrama are sociodrama, or a group-centred action exploration (the subject-matter of sociodrama would be problems shared by all or most of the group, or would be concerned with social or collective roles); axiodrama (where the thematic subject-matter would be concerned with ultimate values and issues surrounding life and death, or religious and spiritual matters); role playing (or the technique in which an individual assumes the role of himself at another time, of another person, an animal, or an inanimate object); and role training (in which the role playing, usually of the individual as himself, is directed towards the rehearsal for anticipated events, or the practice of interpersonal skills). Remedial drama, or drama therapy, is a derivative of the spontaneity theatre origins of psychodrama, and

employs psychodramatic principles, role playing, improvisation and creative activities such as mime, movement and music-making in therapeutic settings for therapeutic or remedial aims.

The three derivative forms used in this study were sociodrama, role playing, and role training. Psychodrama and role playing are often used incorrectly as interchangeable terms. Some of the confusion which exists as to their separate meanings and distinguishable processes stems from a lack of understanding of the precise meanings of the terms, the historical development of the two as clinical methods, and the differing emphases on goals and procedures. The structured role playing format was used by the occupational therapist and a classical psychodrama format by myself in the empirical study described in this thesis.[3,4]

Psychodrama may be contrasted with role playing in the following ways: Psychodrama deals with personal private problems, whereas role playing focuses on more general social roles. Psychodrama is a deep-emotional method, whereas role playing is more superficial and does not direct itself to catharsis of deep feelings. Psychodrama applies itself to problem-solving and personality dynamics, whereas role playing concentrates on specific behaviours and skills. Psychodrama may look at the effect of the past on present behaviour, whilst role playing rehearses for anticipated future events and is not concerned with historical aetiological factors. An intensive, supervised post-graduate training is required for the practice of psychodrama, whereas skill in using the role playing technique does not

require the same amount of in-depth training. A review of reservations, criticisms, and contra-indications concerning psychodrama leads one to conclude that the single most important factor in controlling for possible dangers and abuse is formal, prescribed psychodrama training.

The most commonly used of over 200 psychodrama techniques are self-presentation, role reversal, soliloquy, the double, mirror, future projection, the auxiliary or empty chair, sculpturing or action sociogram, the dream technique, symbolic realisation, concretisation, maximising, physicalising, the magic shop, the reformed auxiliary technique, monodrama, and psychodrama à deux.

In the experimental psychodrama sessions I used all of these except psychodrama à deux. The techniques most commonly used in the study were role reversal (for giving information about a significant other, and for giving the protagonist an experience of the point of view of the other); spontaneous doubling by audience members to support the protagonist, clarify and help him to express feelings, and to deal with audience act-hunger for testing hypotheses and identifications); and the empty chair (to represent parts of the self, antabuse and alcohol, and significant persons). Two sessions were devoted entirely to future projection explorations, and the magic shop technique was used in the beginning of the action phase of one protagonist's session.

History and Training

J L Moreno (b. 19.5.1892, d. 14.5.1974) is the "father" of psychodrama. He himself played many roles, for

example, psychiatrist, sociometrist, group therapist, psychodramatist, sociologist, philosopher, and community worker, and throughout his lifetime contributed to fields of knowledge in theology, psychiatry, philosophy, and sociology.

He started experimenting with the psychodramatic method when he worked with children in Vienna (1908-1911). This early work led him to formulate his principles of spontaneity and creativity and eventually to the establishing of his Theatre of Spontaneity (Das Stegrieftheater, 1921-1923). This, and the Impromptu Theatre he later established in New York (1929-1930), were the forerunners of present-day psychodrama. In the original Theatre of Spontaneity, Moreno employed actors to improvise news items of the day or topics of common interest. Then, as he saw how audience members identified with the enactments, and at the same time how their acting background inhibited spontaneity and encouraged behavioural clichés or conserved responses in the actors, he gradually brought audience members up on to the stage to portray their own life dramas.

Moreno's ideas and methods profoundly influenced the modern "human potential movement" in psychology. Many of his innovations are to be found as central concepts or methods in modern encounter groups, sensitivity training and action therapies such as primal therapy, or Perls' Gestalt therapy. Moreno is also regarded as the forerunner of role playing and role training applications in industry.

The training to become a psychodramatist is on a post-graduate level and follows an experiential model which focuses on personal growth and development, theoretical knowledge base of psychodrama and sociometry, and practical skills in use of the method. The practical course work requirements are 16 weeks of supervised experiential involvement spread over two years integrated with practical experience and then followed by a supervised practicum in a variety of settings. For final accreditation as a psychodrama director the candidate is required to submit a thesis, to direct in front of examiners, and to pass an oral examination. The four training levels which the candidate must pass involve different skill criteria. These are firstly auxiliary ego, then assistant director, associate director, and finally director.

Review of Psychodrama for Social Workers

In my opinion, South African social workers have the relevant knowledge and skills to use psychodramatic techniques and derivatives, and would need only a little post-graduate training in these techniques.

Psychodrama and psychodramatic techniques and derivatives may be used in conjunction with the five major social work methods. For example, the use of role reversal and empty chair in social casework for exploring interpersonal situations, and doubling and soliloquy for moving through client resistances and facilitating expression and deep exploration of feelings. Conjoint counselling and family work could also use these methods. Spontaneity

methods, role playing, and the remedial drama approach can be used to facilitate group work with children and with institutionalised schizophrenics. Role reversal, soliloquy, empty chair and doubling may also facilitate the interactive processes in groups, and provide empathy and self-understanding. Role training could be used for developing behavioural skills.

Role playing and sociodrama are seen as being the most appropriate psychodramatic derivatives to use in community work. They could stimulate discussion and awareness of needs and possible action steps, and may also help to defuse situations of conflict or intergroup tension. These techniques provide a vehicle for the expression of shared emotions and a means of facilitating community cohesion.

In social welfare agency administration dramatic techniques could highlight and vivify the objectives of policy and planning, and facilitate training programmes and interpersonal communication. Social work research could make use of psychodrama as a laboratory-medium for observing the re-enactment of situations with the minimum of the experimental limitations and interferences real-life situations are prone to.

The psychodrama method is seen as being a valuable adjunct to social work training and education. It is flexible, close-to-life, and bridges the gap between the classroom presentation of knowledge and principles and the field work instruction gained from practical student placements. It could vivify the process of student supervision, giving

students objective and immediate feedback on errors, and supervisors an opportunity to observe student strengths and weaknesses in action, without intermediary variables such as written case recordings.

Special fields in which psychodrama and its derivatives have been used are the mental health field with hospitalised patients and in child guidance work and adolescent treatment centres. It has also been used with good results in the field of mental retardation, in crime and corrections, and with low-income and disadvantaged persons. Other applications have been with unmarried mothers, with mothers in a well-baby clinic, and in the home to facilitate parent-child communication and the socialisation process of children.

Alcoholism and Psychodrama

The present study provides an example of a psychodrama application in the specialised field of alcoholism treatment and compares its efficacy with that of role playing.

In alcoholism the psycho-physical addiction to alcohol disrupts the individual's interpersonal relationships in terms of marital, family, social and occupational life and harms his psychological and physical functioning.

The causes of alcoholism are multi-faceted and interrelated. Organic factors such as genetic make-up and metabolism appear to play a role in the aetiology of alcoholism, although their precise contribution is as yet inconclusive. Psychodynamic traits such as low self-esteem,

anxiety, dependancy, aggression and hostility, problems in relating to authority, and an inability to tolerate stress or frustration are some of the reasons why people use alcohol excessively, and are found to be commonly present in people with alcohol problems. Childhood histories of familial strife and discord, and alcoholic role models are some of the familial factors which account for alcoholism. Other socio-cultural factors which play a part in causation are inherent in the larger social system such as normative class and ethnic uses of alcohol. Certain occupational groupings also bring the persons into daily contact with alcohol and might lead to dependence, e.g., bartenders, salesmen, and persons employed in the entertainment industry.

Four stages in the progression of psycho-physiological dependence on alcohol have been distinguished. These are the prodromal stage in which social drinking for its pleasant effects is seen. In the later phase of this first stage an increased tolerance for alcohol occurs. The early symptomatic stage is the next phase in which definite symptoms of dependence on alcohol appear. In the advanced symptomatic stage definite psycho-physiological addiction has been established and the alcoholic is completely preoccupied with alcohol. Physical effects such as blackouts, cirrhosis of the liver, and polyneuritis appear. When the terminal stage is reached acute physical and psychological symptoms predominate -- and this may end in death or psychosis.

Jellinek identified five drinking patterns, two of

which are considered addictive illnesses, i.e. gamma alcoholism or loss of control drinking, and delta alcoholism, or chronic inability to abstain.

The multi-disciplinary team approach is the one most commonly used in the treatment of alcoholism. Psychodrama as one facet in alcoholism treatment was first used by Moreno and involved in situ realistic enactment of drinking patterns for diagnostic purposes and as a warm-up to drink-related problems. Weiner conducted a large-scale psychodrama treatment project for alcoholics. She concluded that the method, if integrated with other therapies, is of immense value to the alcoholic person, and that the simultaneous involvement of mind, body and personality produced by the method was its major asset.

Weiner saw numerous other values of the psychodrama method in alcoholism treatment, for example its ability to slice through the typical defence mechanism of denial, rationalisation and intellectualisation of problems; its cathartic value in producing relief from intra-psychic anxiety and tension, and its diagnostic value in uncovering repressed memories and fantasies. In addition she was impressed with the ability of the method to activate spontaneity and creativity, insight and problem-solving ability, and in enhancing self-esteem.

Psychodrama has been used in alcoholism in-patient hospital programmes in working with staff and patients. Blume et al suggests seven usages for psychodramatic techniques in a hospital setting, viz., in ward administration;

staff conferences; in patient sessions, by having group members personify "alcohol", "booze", "the bottle"; in helping the patient see the connection with alcohol and emotion; in clarifying identifications with alcoholic parents; and in preparing patients about to be discharged to face job interviews and social situations involving alcohol.

In one of the experimental sessions in the present study the technique of personifying alcohol and antabuse, first with empty chairs and then with auxiliaries, was used. In at least three sessions the connection between emotion and drinking was dealt with or touched upon. The experimental role playing sessions made use of the training techniques of rehearsing for job interviews and social situations likely to involve alcohol.

Setting, Hypotheses and Methodology of Study

As has been said, the experimental work reported on in this study was undertaken in the William Slater Hospital for alcoholics in Cape Town. The hospital has a three-week in-patient period to initiate diagnosis and treatment. which is continued and supported by weekly outpatient group meetings and (where necessary) individual therapy and contact by community sisters and social workers. The hospital is run on "therapeutic milieu" lines and is based on the psychodynamic assumption that the individual needs to understand why he drinks before he can stop, and that alcoholism is a function of personality make-up. Abstinence after treatment as well as insight into the reasons

for drinking is aimed at by the hospital.

The hospital programme is run by a multi-disciplinary professional team consisting of psychiatrists, psychiatric registrars, psychologists, general practitioner consultants, nursing staff, a social worker, an occupational therapist and a physiotherapist. The programme is a three-pronged one, directed towards physical, psychological, social and educational aspects.

One weekly role playing session was conducted by the occupational therapist. The major aim of the experimental study was to look at the effectiveness of psychodrama in alcoholism treatment as run by a social worker. This was done by looking at the relative efficacy of psychodrama on the treatment outcome as compared with that of the role playing regularly used in the hospital.

Four hypotheses were examined in the study, viz., that participation in psychodrama would lead to greater improvement on psychological test scores after treatment than would participation in role playing; that patients who participate in psychodrama would be proportionately more abstinent at follow-up than patients who participate in role playing; that participation in psychodrama would be correlated with higher participation in the total hospital system than would participation in role playing; and finally, that although high participation in both modalities should lead to positive improvement in personality test scores, abstinence at follow-up, and participation in the overall hospital programme at large, this

effect should be more marked for psychodrama participants than for those participating in role playing.

The actual experiment was preceded by a pilot study conducted over an eight-week period. This served to try out the testing instruments and interview procedures and provide familiarity with the hospital routine. The main experiment was conducted over a nine-week period with follow-up testing and interviewing six weeks after the respective patients' discharge. Each incoming cohort of patients was divided into two samples, role playing and psychodrama, matched according to order of admission, age, sex, and marital status. A total of 46 patients passed through the hospital, 17 of whom belonged to interstitial cohorts during the "change-over" from pre- to experimental conditions. Thus the experimental universe consisted of 31 patients, 16 in the role playing sample and 15 in the psychodrama sample.

Personality tests used at admission, discharge, and follow-up were the Ziller scale of self-esteem, the Jackson test of self-esteem and the General Survey which measured anxiety, aggression, authoritarian conformity, and extroversion. All patients were interviewed at discharge and 18 at follow-up, and 12 staff members were interviewed during the period prior to the commencement of the first follow-up testing of patients. The experimental psychodrama sessions were conducted by the candidate with the assistance of a social worker as auxiliary ego who also conducted the testing and interviewing of patients. The experimental role playing sessions were conducted by the

hospital occupational therapist, with the assistance of a male nursing orderly.

Results and Analysis

The data were presented and analysed around three foci, viz., an examination of the basic background variables of the two samples to see if they were evenly matched; an examination of the two samples as regards outcome criteria, and an examination of factors which could affect the results, such as participation rate within experimental sessions, and IQ.

With the exception of IQ, the two samples were evenly matched on the background variables, i.e. age, sex, marital status, occupation, educational standard, diagnostic category, drinking pattern, duration of drinking history and acuteness of alcohol problem. The role playing sample had a significantly lower average IQ than the psychodrama sample. The two samples were also matched in terms of initial pre-testing on the personality test scores, viz., the two measures of self-esteem, anxiety, aggression, authoritarian conformity, and extroversion.

Considering the comparative efficacy of psychodrama and role playing as regards the change scores of subjects at exit and at follow-up on the personality tests, the two samples differed only on one test. This was on the Jackson test of self-esteem from pre- to follow-up testing for the psychodrama sample. This increase in self-esteem was the only significant correlation which was found in one sample and not the other. On all the other psychological tests

there were either no statistically significant changes, or the changes occurred in both samples alike.

Comparing the two samples in terms of participation it was found that psychodrama subjects who were abstinent at follow-up had significantly higher participation scores within sessions than did those subjects who were drinking at follow-up. There was no such association in the role playing sample. High participators within the role playing sessions tended to be drinking at follow-up; a negative but not statistically significant correlation.

In the psychodrama sample again, participation within sessions was significantly correlated with change in the pre- to follow-up testing on the Jackson scale of self-esteem.

The psychodrama sample had a significantly higher mean score on gross participation in the total hospital system than did the role playing sample.

In addition, for the psychodrama sample, participation within sessions was significantly correlated with participation in the total hospital system, and with a positive evaluation of the psychodrama experience. Gross participation in the total hospital system was also correlated with IQ for the psychodrama sample.

In the role playing sample gross participation rate in the total hospital system was significantly higher for subjects who remained dry than for subjects who were drinking at follow-up. Although the same tendency was

observed in the psychodrama sample, the difference was not statistically significant. This is presumed to be due to the higher level of participation for the drinking subjects as a result of their participation in psychodrama.

In terms of abstinence the only significant relationships with any of the background variables were with age and IQ. In the role playing sample the mean age of the dry subjects was significantly greater than that of the drinking subjects, and in the psychodrama sample the mean IQ score for dry subjects was significantly higher than that for subjects who were drinking at follow-up.

Since the psychodrama and the role playing samples differed significantly on the IQ variables, it was possible that the difference between dry and drinking subjects in the psychodrama sample, as well as the previously noted correlation between IQ and gross participation in the total hospital system were influenced by the IQ differences between the two samples.

The role playing sample had seven subjects with IQs of less than 100, whereas there were no subjects at this level in the psychodrama sample. A procedure to match the two samples with regard to IQ was followed by dropping the seven low IQ subjects from the role playing sample and adding five subjects with IQs of over 100 from the interstitial cohorts who had participated solely in role playing. This procedure provided a "new" role playing sample which was equivalent to the psychodrama sample, in that there was now no significant difference in the mean IQ of the two

samples.

With the new role playing sample, the two samples were now also evenly matched in respect of the number of subjects who were drinking and dry at follow-up.

The significant relationships which were found in the original role playing sample were also seen to occur in the new role playing sample, viz., a significantly higher gross participation rate in the total hospital system for subjects who remained dry at follow-up; and a significantly higher gross participation rate in the total system for psychodrama when compared with role playing subjects.

As regards the diagnosis of personality type there were no significant relationships with abstinence, or with either of the two participation indices for both samples.

Patient and Staff Evaluation of Experimental Sessions

Patient evaluation of their participant experience in psychodrama or role playing was based on comments obtained in exit and follow-up interviews, and on relative rankings of the sessions with other aspects of the hospital programme.

In the comparisons of the major features of the hospital programme at exit individual therapy ranked first, followed by educational aspects, group therapy, informal contacts with staff, and physical features of the programme such as the rest afforded by hospitalisation, good food and medication. Psychodrama follows lower on the list, with no subjects including role playing in their ranks.

(This could be due to the fact that they saw role playing as part of occupational therapy since only role playing and not psychodrama subjects included occupational therapy in their rankings.) Part of the low total rankings of psychodrama and role playing are due to the fact that only half of the total sample participated in each format or modality. Aspects of the hospital programme which occurred more frequently, or in which there was more patient involvement were judged to have had greater impact than psychodrama or role playing.

The same set of features were judged important at follow-up as at exit, with the additional mention of the "totality of the programme". However, the small number of raters does not provide a clear rank order.

The rankings of staff members coincided with those of the patients in that they saw a similar set of activities as being of importance in their helpfulness to patients.

For the psychodrama sample, patients who evaluated psychodrama positively were high participators in the sessions. There was no such statistically significant relationship with evaluation and participation for the role playing sample.

Patient comments were coded in general and specific categories to cover the aspects of role playing and psychdrama mentioned. One general comment per person, and one comment in the specific categories per person were included in the examination of the data.

At both exit and follow-up, psychodrama subjects made more than twice as many specific comments as did the role playing subjects. There were no differences between the two samples with respect to the numbers of general comments.[4] The majority of the specific comments were positive in nature.

The psychodrama subjects tended to comment on values associated with the psychodrama method, for example catharsis (the release of pent-up feelings, or relief from distress), sociometric status (acceptance by group members), and sharing (identification with shared problems and concerns). Role playing subjects found the role training or rehearsal aspect (i.e. trying out behaviours for future anticipated situations), inherent in the role playing to be of value. Both samples tended to cite gains in self-confidence, insight or self-understanding, and positive or negative assessment of the reality dimension (assessing the method real, close-to-life, and involving or not).

At follow-up most subjects felt the sessions had made no significant impact on their lives since discharge, although more psychodrama than role playing subjects felt that it had. This latter difference was not a statistically significant one.

In the content of their overall evaluative comments the two samples were essentially the same, i.e. patients who evaluated the respective methods and aspects of the methods positively saw them as having been helpful, those who were mixed in their responses saw them as having been

of value for others but not for themselves, and those who were negative in their evaluation felt that the method had not helped them and was childish or irrelevant.

Staff descriptions of role playing and psychodrama are similar to those found in the literature. This is an indication that the styles used in both the role playing and psychodrama sessions are those typically associated with these methods.

Staff members for example, felt that role playing was more superficial, staff-directed, and dealt with more specific behavioural problems and role rehearsal than psychodrama. Within this frame of reference it was seen as fulfilling a useful and necessary function. Psychodrama was seen as being a deep-expressive method facilitating catharsis and insight and exploration of personal themes directly relating to the "crux" of patient problems.

They felt that some of the advantages of psychodrama over role playing were that it uncovered problem areas in a short space of time, and cut through the typical defence patterns found in alcoholic persons such as denial and nationalisation.

Perhaps some of the most interesting staff observations were of the effects of psychodrama on the protagonists. Staff felt that protagonists were more open, spontaneous and relaxed after sessions and took a more active part in the total hospital system. This is in line with the statistical finding that participants in psychodrama, and especially high participants, were also high

participators in the total hospital system. The second major observation was that psychodrama tended to increase the patient's receptivity to, and motivation for individual and group therapy. Protagonists seemed more willing to move into deep areas of sensitivity and concern, and other participants who had seen protagonists "work" in psychodrama were also more motivated for therapy.

An additional factor which was taken as enhancing the psychodrama participant's involvement in other forms of therapy, and in the overall hospital programme was that protagonists especially were more "visible" to staff. Staff members understood them better and this richer understanding helped their other work with patients. Not only was psychodrama seen as valuable diagnostically for the staff members in providing them with information, but also pinpointed areas of awareness for the patients.

Psychodrama was seen as facilitating the therapeutic milieu approach at the hospital by promoting cohesiveness between its group members. It was felt that staff members would benefit from learning specific psychodramatic techniques to use in the hospital as the occasion arose.

It was felt that an integrated programme involving role playing and psychodrama would be the most favourable. Role playing could serve as an introduction to psychodrama, and could also be used with patients who were not considered suitable for deep, emotional psychodramatic work.

On the whole, psychodrama was seen as having a potentially valuable role to play in the treatment of alcoholism

generally, and in this hospital setting specifically.

B. CONCLUSIONS

Psychodrama and its derivative forms may potentially be used in social work training, in conjunction with the five major social work methods, and in a variety of special fields including alcohol treatment.

As a demonstration of the relative effectiveness of role playing and psychodrama in a treatment programme for alcoholics, an empirical study was designed to compare the reactions of patients to these modalities.

Four major hypotheses were tested in the course of the study. (See Chapter VII, pp. 266-268; Chapter VIII, pp. 288-289; and the present chapter, pp. 385-386.)

Hypothesis One:

Patients who participated in psychodrama were expected to show greater improvement on personality test scores after treatment than patients who participated in role playing.

The only one of the six personality measures used which showed a statistically significant change in one experimental sample and not the other was the Jackson test of self-esteem. This was for a rise in self-esteem in the psychodrama sample from pre- to follow-up testing.

There was no equivalent increase in self-esteem as measured by the Ziller test. This raises the question as to why one test should show change and the other not when both

tests purport to measure the same thing.

It is likely that the two tests were in fact measuring different things. Self-esteem is notoriously difficult to measure by means of a questionnaire. Ziller was attempting to solve some of the difficulties involved by developing his non-verbal, projective technique. Whether he succeeded or not is still in the process of evaluation. Whereas, previous to his measure, existing tests of self-esteem were associated with a tendency for subjects to check socially desirable responses, he found an opposite tendency with his own test. He concluded that whereas "the usual measures of self-esteem invite the subject to disclose himself to others . . . /his measure/ asks the subject to disclose himself to himself".[5]

Since the Jackson test, although developed after Ziller's innovation, is based upon verbal written self-reports of the patient, it is similar to other measures Ziller was attempting to improve upon. It is therefore possible that the two were measuring different things. (The Jackson test was recommended to me as one of the better self-report tests of self-esteem which takes cognisance of the response set of subjects to appear socially acceptable. Since I did most of the follow-up testing, the factor of social desirability could, however, be operating.)

Bearing these factors in mind, it is difficult to speculate on the meaning of the significant finding for the Jackson and not the Ziller test in the psychodrama sample. Hypothesis One receives only partial support in

that one out of six measures showed change in the anticipated direction. However, this was for the trait regarded as central in the aetiological predisposition to alcohol abuse, and as being amenable to change by psychodramatic intervention.

Hypothesis Two:

It was anticipated that more of the patients who participated in psychodrama than those who participated in role playing would be abstinent at follow-up.

The two samples were matched on major background characteristics, personality tests, diagnostic categories and drinking patterns. The two samples were not evenly matched as regards IQ. However, when IQ was controlled for, the proportion of abstinent subjects was approximately the same in both samples.

Thus, there is no evidence from the present study to suggest that psychodrama in itself improves the patient's chances for remaining abstinent six weeks after discharge.

Hypothesis Three:

It was expected that patients who participated in psychodrama would show a higher degree of participation in the total hospital system than patients who participated in the role playing sessions.

This hypothesis was supported. The average participation score in the total hospital system was significantly higher for the psychodrama subjects than for the role playing subjects. This was still true, even after

controlling for IQ.

Hypothesis Four:

Positive therapeutic effects or improvements in personality test scores, abstinence at follow-up and high participation in the overall hospital programme were expected for high participators in the role playing and in the psychodrama samples. These effects were expected to be more marked for psychodrama subjects than for role playing subjects.

Personality Test Scores and Participation within Sessions

The same pattern of results as pertained for Hypothesis One was found here. The only difference between the psychodrama and the role playing samples was in the higher level of self-esteem for active participants in the psychodrama sessions at follow-up as measured by the Jackson test of self-esteem.

The significant finding noted under Hypothesis One might be said to be bolstered by the fact that a positive correlation was found between participation rate within psychodrama sessions and this rise in self-esteem. However, the reasons for the occurrence of this finding only at follow-up, and for the Jackson and not the Ziller test, of self-esteem, remains speculative and unclear.

Abstinence and Participation within Sessions

As regards abstinence, subjects who remained dry in the psychodrama sample had a statistically significantly higher level of participation within sessions than did

subjects who were drinking at the time of follow-up.

For the role playing sample, both in its original form and when controlled for IQ, the relationship between participation rate within sessions and abstinence was negative although not significant. Subjects who were dry had a lower average level of participation within sessions than subjects who were drinking.

Participation within Sessions and Gross Participation Rate in the Total Hospital System

Within the psychodrama sample there was a positive and significant correlation between participation within sessions and participation in the total hospital system.

However, within the role playing sample there was a negative although not significant correlation between participation in the total hospital system and participation within sessions.

Furthermore, those patients in psychodrama who participated highly in sessions evaluated the experience in positive terms.

For psychodrama, it was also true that participation in the total hospital system was correlated with IQ. In other words, higher IQ subjects tended to participate more actively. In contrast, within the role playing sample the correlation between subject participation in the total hospital system and IQ was negative but not significant.

These various correlations suggest that Hypothesis Three can be accepted.

The additional facts that within the psychodrama sample there is a positive correlation between participation within the sessions and participation in the total hospital system, and also a positive correlation between participation in the total system and positive evaluations of the psychodrama sessions, would not in themselves indicate that high participation in psychodrama was a cause of high participation in the total system, since the correlations only demonstrate the extent of the association and not its directionality.

However, the comments of the hospital staff members interviewed indicate that psychodrama was important in bringing patients to their attention and to the attention of staff in general, and that participation in psychodrama elevated the relevant patients' participation in group sessions, and motivated them for work in individual therapy.

This evidence from the interviews, taken together with the correlations suggest that participation in psychodrama was indeed a cause, and gross participation in the total hospital system was indeed an effect.

Hypothesis Four is, therefore, supported for two of its three sub-parts, and partially supported for its third. That is, in the psychodrama sample, and not in the role playing sample, there was a significant, positive association between participation within experimental sessions and abstinence at follow-up, and participation in the overall hospital system, and self-esteem as measured by

the Jackson test at follow-up. (Participation within sessions was not, however, associated with improvements on the other measures of personality used.)

To sum up the statistical findings, Hypothesis One received partial support only in that one out of the six measures used reflected a significant change in the anticipated direction. Hypothesis Two was unsupported. Hypothesis Three was fully supported, and Hypothesis Four was supported in the majority of its assumptions.

Patients who participated in the psychodrama sessions were more involved in the overall hospital treatment programme than were patients who had participated in the role playing sessions. Psychodrama participants also showed a rise in self-esteem as measured by the Jackson test at follow-up. These effects were particularly evident for protagonists and high participators in the sessions. In addition, high participators in the psychodrama sessions were more likely to be abstinent at follow-up than lower participants or participants in role playing. High participators in psychodrama also evaluated their experience in the sessions positively.

As regards the comments of the hospital staff, these seem to suggest that psychodrama influenced patient motivation and participation in the total therapeutic milieu, and has value for diagnosis and treatment. It was also suggested that psychodramatic techniques could productively be incorporated into other aspects of therapy used in the hospital. After witnessing sessions, the initial staff

confusion as to the distinction between role playing and psychodrama seemed to have been dispelled and staff were able to identify points of similarity and difference between the two modalities coincidental with those made in the literature. (See Appendix 13, pp. 474-476.) There was a tendency to perceive role playing as helpful for role rehearsal and practice, and as suitable for patients with specific problems, or who lacked motivation.

The low ranking, in terms of helpfulness, given to psychodrama relative to other aspects of the therapeutic programme by staff members appears inconsistent with the enthusiasm expressed for the method in their interviews. Staff members and patients both accorded individual therapy, educative aspects, and group therapy primary ranks, whereas psychodrama appeared lower down on the list of therapeutic methods used in the hospital. (See Chapter IX, pp. 349-353.) This seeming inconsistency could be explained by the fact that psychodrama, being new, could function as a "hope-builder" for staff working with difficult and generally hard-to-reach patients. Were the psychodrama programme to have been continued and integrated into the hospital system, the intense verbal enthusiasm for the method expressed might have settled into more measured evaluation.

I conclude that the findings indicate that the experimental psychodrama sessions promoted more of the therapeutic aims of the hospital programme than did role playing, and that psychodrama has more possible uses than its counterpart, role playing.

It is my recommendation that psychodrama and role playing be further explored in terms of the contributions both can make to social work training and practice.

NOTES

on Chapter X

1 In Moreno's system, the human personality is required not only to meet, or adapt to changing situations, but is seen as needing to "create", or constructively respond to them. See, for example, Leland J Bischof, Interpreting Personality Theories, 2nd ed., (New York: Harper International Edition, Harper and Row, 1970), p. 258.

2 Howard A Blatner, Acting-In: Practical Applications of Psychodramatic Methods, (New York: Springer Publishing Co., 1973), p. 72.

3 One psychodrama session developed into a sociodrama in which staff members reversed roles with patients, and patients with staff members, and proceeded to enact and explore tensions involved in scenes of hospital life in those roles. Another session was also sociodramatic in format, and was concerned with the feelings of group members about antabuse therapy.

4 The role playing and role training derivative forms which were separated for purposes of definition and description were referred to by the hospital staff, and in the study by the generic title of "role playing". Role playing and role training were used by the occupational therapist in the experimental role playing sessions.

5 There was no relationship between the number of comments made and the IQ of the subjects. Thus, the expressivity of the psychodrama subjects was not necessarily a function of their overall higher IQ scores than the role playing sample.

6 Robert C. Ziller, The Social Self, (New York: Pergamon Press, Inc., 1973), p. 16.

A P P E N D I C E S

APPENDICES

1. Form A of the General Survey, administered at admission and follow-up
2. Form B of the General Survey, administered at discharge
3. Ziller test of self-esteem, administered at admission, discharge and follow-up
4. Jackson test of self-esteem, Form A, administered at admission and follow-up
5. Jackson test of self-esteem, Form B, administered at discharge
6. Exit interview schedule
7. Follow-up interview schedule
8. Staff interview schedule
9. Permission release slip
10. Description of role playing, and summaries of four sessions
11. Protocol of psychodrama session
12. Illustrative examples of patient comments
13. Evaluative comments by staff members

NOTE:

All test forms and interview schedules were translated into Afrikaans. Only the English versions are presented in appendixes.

The A forms of the General Survey, and the Jackson tests were those used for the follow-up test administration.

APPENDIX 1

Form A of the General Survey, administered at admission and follow-up.

GENERAL SURVEY

FORM A

It is helpful to learn something about the feelings and attitudes of those filling out this survey. Your co-operation is appreciated. Thank you.

Please make a cross in the box which best represents your immediate reaction to each statement, e.g.

DISagree

Respond to the statement as a whole. If you have reservations about some part of a statement, mark the response which most clearly represents your general feeling.

1. Most people that you meet are friendly and obliging, more disposed to aid you than to refuse aid.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

2. I brood a great deal.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

3. If I encounter a group of people whom I have met previously, I begin a conversation with them.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

4. People will be honest with you as long as you are honest with them.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

5. The most important function for education is preparation for practical achievement and financial reward.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

6. I very seldom have spells of the blues.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

7. I work better when I am not being observed by others.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

8. Believe that a man will keep his promise, and he will keep it.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

9. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

10. I do not avoid large gatherings of people.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

11. Only once in a great while, if at all, does one run into a dishonest and deceitful person.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

12. I worry quite a bit over possible misfortunes.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

13. Patriotism and loyalty are the first and the most important requirements of a good citizen.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

14. I prefer to stay at home rather than attend social affairs.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

15. At times I think I am no good at all.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

16. Obedience and respect for authority are the most important virtues children should learn.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

NAME _____ DATE OF TEST _____

Please check that you have completed each question.

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11. Most people that you meet are friendly and obliging, more disposed to aid you than to refuse aid.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

12. I sometimes feel overwhelmed with anxiety.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

13. What youth needs most is strict discipline, rugged determination, and the will to work and fight for family and country.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

14. I am introverted, serious, shy, introspective.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

15. At times I think that I am no good at all.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

16. Young people sometimes get rebellious ideas, but as they grow up they ought to get over them and settle down.

Strongly DISagree	DISagree	Slightly DISagree
Slightly Agree	Agree	Strongly Agree

NAME _____ Date of Test _____

Please check that you have completed each question.

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APPENDIX 3

Ziller test of self-esteem, administered at admission, discharge, and follow-up.

Name _____ Left-handed? Yes No Date _____

Item (a)

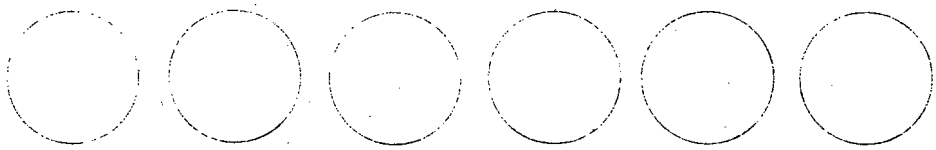
The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. DO THIS IN ANY WAY YOU LIKE, but use each person only ONCE and do NOT omit anyone.

D . . . Doctor
F . . . Father
Fr. . . Friend
N . . . Nurse
Y . . . Yourself
Uns . . someone you know who is Unsuccessful

Item (b)

The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. DO THIS IN ANY WAY YOU LIKE, but use each person only ONCE and do NOT omit anyone.

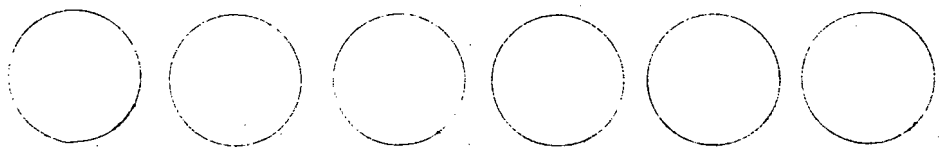
D . . . Doctor
F . . . Father
Fr. . . Friend
P . . . Politician
Y . . . Yourself
E . . . Employer



Item (c)

The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. DO THIS IN ANY WAY YOU LIKE, but use each person only ONCE and do NOT omit anyone.

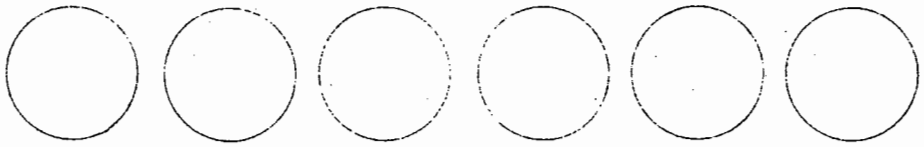
Sp. . . someone you know who is a good Sportsman
Po. . . someone you know who is Popular
Fu. . . someone you know who is Funny
Kn. . . someone who Knows a great deal
Y . . . Yourself
Unh . . someone you know who is Unhappy



Item (d)

The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. DO THIS IN ANY WAY YOU LIKE, but use each person only ONCE and do NOT omit anyone.

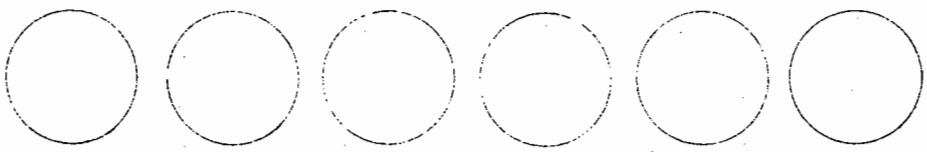
Act . . an Actor	Y . . . Yourself
Br. . . your Brother, or someone who is most like a Brother	Sa. . . a Salesman
B.Fr. . your Best Friend	Pa. . . a Politically Active person



Item (e)

The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. DO THIS IN ANY WAY YOU LIKE, but use each person only ONCE and do NOT omit anyone.

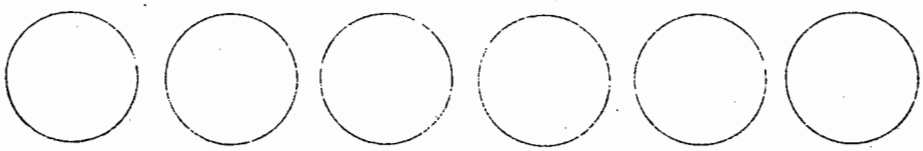
C . . . someone you know who is Cruel	Pc. . . a Policeman
J . . . a Judge	Y . . . Yourself
H . . . a Housewife	Si. . . your Sister, or someone who is most like a Sister



Item (f)

The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. DO THIS IN ANY WAY YOU LIKE, but use each person only ONCE and do NOT omit anyone.

Df. . . a Defeated Parliamentary Candidate	K . . . someone you know who is Kind
Ha. . . the Happiest person you know	Y . . . Yourself
Su. . . someone you know who is Successful	St. . . the Strongest person you know



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APPENDIX 4

Jackson test of self-esteem, Form A, administered at admission and follow-up.

JACKSON (S.E.) FORM A (English)

DIRECTIONS:

Below follow a series of statements which a person might use to describe him- or her-self. Read each statement and decide whether or not it describes you. Then indicate your answer by circling either the T or the F to the right of the statement.

If you agree with a statement or decide that it does describe you, answer TRUE (T). If you disagree with a statement or feel that it is not descriptive of you, answer FALSE (F).

Answer every statement either true or false, even if you are not completely sure of your answer.

1. I am usually quite confident when learning a new game or sport. T F

2. My behaviour would be quite awkward if I had to apply for a loan from a bank. T F

3. I am ill at ease when I am meeting new people. T F

4. I hardly ever feel self-conscious in a strange group. T F

5. I am seldom at a loss for words. T F

6. I am considered a leader in my social circle. T F

7. I am not the type of person one remembers after one meeting. T F

8. I make a better follower than a leader. T F

9. I have never been a very popular person. T F

10. It is easy for me to strike up a conversation with someone. T F

THANK YOU

NAME: ..... DATE: .....

25.1.75.

APPENDIX 5

Jackson test of self-esteem, Form B, administered at discharge.

JACKSON (S.E.) FORM E (English)

DIRECTIONS:

Below follow a series of statements which a person might use to describe him- or her-self. Read each statement and decide whether or not it describes you. Then indicate your answer by circling either the T or the F to the right of the statement.

If you agree with a statement or decide that it does describe you, answer TRUE (T). If you disagree with a statement or feel that it is not descriptive of you, answer FALSE (F).

Answer every statement either true or false, even if you are not completely sure of your answer.

1. I seem to do more listening than talking in conversation with others. T F

2. I enjoy stating my opinions in front of a group. T F

3. I prefer to go to social functions with a group of people so as not to stand out. T F

4. I usually try to add a little zest to a party. T F

5. I find it easy to introduce people. T F

6. I am able to talk intelligently to people in a wide variety of occupations. T F

7. I often wish I were more outgoing. T F

8. I like to remain unnoticed when others are around. T F

9. I have trouble expressing my opinion. T F

10. People seem to be interested in getting to know me better. T F

THANK YOU

NAME: ..... DATE: .....

25-1-75 JH

APPENDIX 6

Exit Interview Schedule

EXIT INTERVIEW SCHEDULE

PATIENT: _____ DATE: _____

INTRODUCTION:

This is our last interview and I have some questions I should like to ask you which will help us to evaluate the programme and to have some understanding of your point of view on your experience here.

QUESTION 1. (warm up question)

Have you changed at all during these weeks at William Slater?

YES
NO

If yes, in what ways? If no, have you any ideas as to why not?

Thank you.

QUESTION 2.

Now I shall read you a list of the different activities at Slater in which you have participated. I should like you to tell me or to indicate on this form how helpful they were to you. For example were they .... (interviewer please read off and indicate range on list of activities - see following page).

QUESTION 3.

In particular, please would you comment on your experience in the role playing or psychodrama group.

(Probes: Did you participate? What role did you play?
What did you gain? From watching, participating?
What effect did you feel it had on you, the others?
What are your opinions on the method?)

QUESTION 4.

What recommendations would you make for the programme?
Are there any suggestions for changes that you feel would be useful?

FOR FOLLOW-UP

1st out-patient appointment?
DATE.....
TIME.....
THERAPIST.....

Which out-patient group at night?
DAY.....
THERAPIST.....

Follow-up interview
DATE.....
.....
.....

LIST OF ACTIVITIES

ACTIVITY	Not at all helpful	Mini-mally helpful	Modera-tely helpful	Helpful	Extremely helpful
Individual therapy					
Group Psychotherapy					
Orientation group					
O.T a)Sports					
b)Games					
c) Work related activities					
Role playing/ Psychodrama					
Relaxation					
Tape on alcohol and antabuse					
Films					
S.A.N.C.A. talk and film					
Other patients informally					
Staff informally					
The food					
The rest					
Medication					
Other (specify)					

APPENDIX 7

Follow-up Interview Schedule

FOLLOW-UP INTERVIEW SCHEDULE

PATIENT(Code no.)..... DATE.....

Interviewer, please cover the belownamed areas (current situation and feelings towards). Use probes given as necessary.

1. PSYCHO-SOCIAL AND PHYSICAL ADJUSTMENT

a. Work situation.

(Probes: Adjustment to employment; the return to work;
What job currently doing; job satisfaction?
Any problems, joys, feelings?
Knowledge of the hospitalisation amongst colleagues, employees?
Any stigma reactions?)

b. Domestic situation.

(Probes: Present relationship, communication with wife/husband, children. Any problem areas? Has communication, relationship improved as result of in-patient treatment?
Attitudes of wife to treatment? Hospitalisation?
Accommodation?)

c. Interpersonal relationships/Social participation.

(Probes: Are you interacting socially; socialising, going out?
Ease of relating without alcohol? Assertion, confidence with peers? Able/Unable to refuse alcohol socially?
How do you deal with this issue?)

d. Physical situation.

(Probes: How is your current health? Any physical effects of abstinence/alcohol?
Are you on any medication? If so what?)

e. Psychological situation.

(Probe: How are you feeling within yourself? About yourself? Present mental state? - break down into "spiritual state" if necessary. Guilt etc.)

2. ABSTINENCE AND ANTABUSE THERAPY

a. Abstinence

(are you 100% abstinent? YES NO

Probes:
If so how do you feel about it.
If any lapses or relapses, duration and times, also circumstances surrounding such).

b. Craving?

Do you feel a craving for alcohol? If so, in what manner?
Are you missing the drink at all? How?
How do you deal with craving?

c. Antabuse.

Are you taking it? YES NO
(Probes: Any feelings about it, worries, difficulties.
If no; Why not? Feelings?)

3. CURRENT RELATIONSHIP TO WILLIAM SLATER HOSPITAL

a. Are you attending group meetings? YES NO

Comment:

b. Are you seeing your therapist regularly? YES NO

Comment:

c. Are you attending Social Club? YES NO

Comment:

d. What is your present perception of William Slater Hospital?

4. RETROSPECTIVE ASSESSMENT OF THE VALUE OF YOUR IN-PATIENT STAY IN WILLIAM SLATER HOSPITAL

i.e. What aspects of the in-patient programme seemed to have the most impact on you, your life, feelings and behaviour, during the past six weeks since leaving William Slater Hospital.

5. IMPACT/EFFECTS OF ROLEPLAYING/PSYCHODRAMA

(N.B. Please write down full responses to this section)

a. Did your participation in the Role Playing/Psychodrame sessions make any difference to you in these past six weeks YES NO
(If yes, how?)

.....

b. Has the role playing/psychodrama experience helped you to:-

(i) Understand yourself? (i.e. gain insight into yourself?)
(If so, please give examples) YES NO

(ii) Understand other people, their situation, their point of view? YES NO
(i.e. empathy. If so, please give examples).

5b (iii) Relate more effectively to other people? (e.g. spouse, children, friends - i.e. to be more assertive, have more confidence, energy, ... change behaviour..... if so, please give examples). YES NO

(iv) Can you attribute any changes in yourself to the role playing/psychodrama experience? (If so please give examples). YES NO

(v) Did the role playing/psychodrama experience help you to feel better about yourself, your situation? More released, relaxed. (catharsis. If so, please describe). YES NO

(vi) If you did not participate at all in the role playing/psychodrama, sessions, but remained as a spectator, did watching the role playing/psychodrama "protagonist" and others help you in any way? (e.g. through identification. If so please give examples). YES NO

(vii) If none of these categories quite applies to you, but you feel someone else gained, please say so.

6. PLEASE COULD YOU COMMENT ON YOUR FEELINGS ABOUT THE ROLE PLAYING/PSYCHODRAMA METHOD IN GENERAL.

Interviewers name

Comments

APPENDIX 8

Staff Interview Schedule

STAFF INTERVIEW SCHEDULE

1. What do you see as the goals for the three week in-patient experience?
(Probes: What do you feel, personally, in your role, you, one can hope to achieve in the three weeks? Where do you realistically feel patients should be by the end of their stay?)

2. Which of these aspects of the programme (see list) do you see as most helpful for patient's growth/therapy?

   Please could you rank order what you consider to be the FIRST; SECOND; and THIRD most important aspects in terms of their HELPFULNESS to patients.

   Individual therapy -
   Group meetings -
   O.T. (sports, games work-related activities) -
   Role playing -
   Psychodrama -
   Relaxation -
   Tape on alcohol and antabuse -
   Films -
   S.A.N.C.A. talk & film -
   Other patients informally -
   Staff informally -
   The food -
   The rest -
   Medication -
   Social Club -
   Other (specify) -

3. Please could you comment on psychodrama.

4. Could you comment on the value of psychodrama to alcoholism treatment.

5. Please could you comment on role playing.

6. Could you comment on the value of role playing to alcoholism treatment.

7. Do you see a difference between psychodrama and role playing? (If so what?)

8. Do you feel that certain patients would benefit more from psychodrama and certain from role playing? (if so, which people? Do you see any criteria for selection?)

9. What do you see as the purposes of psychodrama?

10. What do you see as the purposes of role-playing?

11. As regards psychodrama, have you noticed a difference in the "protagonists" for the psychodrama sessions? (e.g. system participation, personality, interaction, behaviour).

12. Any other comments.

Staff Member's role:.....

APPENDIX 9

Permission Release Slip

I hereby give permission for audio- and audio-visual recordings of activities in which I have participated during my stay at William Slater Hospital to be used for teaching, research and professional purposes only.

Signed: .....

Date: .....

Witnesses: .....

.....

APPENDIX 10

Description of role playing and summaries of four sessions

DESCRIPTION OF ROLE PLAYING AND SUMMARIES OF FOUR SESSIONS

A. DESCRIPTION OF AIMS AND STYLE

The occupational therapist described role playing for the purposes of this study in the following way: (Her description is based on her course training notes as well as her own experience).

> Role play is a technique of "group therapy" in which the members act scenes from life. These scenes may be related to the actor's own life situation, but are usually not those which are traumatic to him. After each scene, a discussion is held in which all group members are encouraged to participate. The most common aims of role play are:
> (1) For members to gain insight into themselves and their coping methods and into each other (i.e. including assessment by staff).
> (2) For members to improve their coping skills - through gaining insight and practice. These skills may be, for example: (a) Expression of emotion or general communication (b) self-assertion (c) self-confidence in stressful situations, such as job interviews etc.
> (3) Occasionally a member may unburder himself of pent-up feelings here - but it is felt that this aim is usually met through a fairly traumatic process, and should be led by a staff member specially trained in this technique.
> Situations may be suggested by patients themselves, but often the session is structured by the leader according to her understanding of their needs. The success of the session is difficult to judge but this may be done according to the main aims i.e. whether any members seem to have gained insight into themselves or others; whether any staff members gained insight into patients; whether a member was able to practise and gain confidence in handling a situation difficult for him - even if only participating in the discussion; whether a patient gained any relief from expressing an emotion, or sharing an experience with the group; whether a problem evolves which may be handled by other treatment modes i.e. discussion groups.
>
> Role play should always be used in conjunction with other therapy.

B. FOUR EXAMPLES OF ROLE PLAYING SESSIONS

SESSION NO. 1 DATE: 14.1.1975

Scene No. 1 Situation

> "L has a new car. B has crashed into it (parked outside L's house). L hears the crash and must express to B how he feels about it".

Theme suggested by occupational therapist.

Rationale: "Assertive training as requested by L's therapist.

Situation: also suggested by occupational therapist

Rationale: "A reaction of some sort is to be expected here".

Scene No. 2 Situation

"M is being persuaded to drink at a party by all the other group members"

Theme and Situation suggested by occupational therapist.

Rationale: "M needs practise in refusing to be persuaded in certain situations". "The drinking situation is a relevant one".

Scene No. 3 Situation

"S discusses his job with boss after leaving William Slater Hospital. Wanted to have less stress in future and 'another chance' ".

Theme and Situation suggested by occupational therapist.

Rationale: "O.T. asked if anyone had problems with bosses. He then said boss expected much of himself and employees". "(To give) a practise in how he would handle this and communicate his needs to (his) boss".

Scene No. 4 Situation

"There are two superiors at L's work who affect his work load. One is not pulling his weight and so causing other to shift extra work to L. L speaks to latter (sic. meaning employer) about this and his need for less work pressure".

Theme suggested by patient. "A problem at work causing him stress, leading to drink".

Situation suggested by occupational therapist. "Practise a scene which might lead to communication of his needs and lowered stress".

Scene 5 Situation

"A telling his sister how he and his life will have/have not changed when he returns".

Theme and Situation suggested by occupational therapist. "Make him aware of how he would have to structure his time and possibly change his I.P.R's (inter-personal relationships) in a non-drinking life". Situation suggested because "closest relationship is with his sister".

WARM UP to session used was "getting patients to explain what role-playing is".

SESSION NO. 2. DATE: 21.1.1975

Scene No. 1 Situation

"A's spanner has been borrowed once again by a fellow fitter. He is asked to confront this fitter".

Theme suggested by staff member "To get patients to express anger". Situation suggested by patient D. "To assess and improve A's insight into his ability to say 'No' ".

Scene No. 2. Situation

"M has bought 1 kg tomatoes from a barrow. When he is home, he opens the packet and finds they are rotten. Does he return them to the barrow-boy or not?"

Theme and Situation suggested by occupational therapist. Rationale for theme was "assessment of Mr. M's ability to handle anger, also to provide example of assertion to the more passive members". The situation was suggested as it was "an everyday situation".

SESSION NO. 1 DATE: 11.2.1975

(Videotaped)

Scene No. 1 Situation

"The scene was used partly as a warm-up. An introduction to H and explanation of role-play. (Then) a committee meeting. Each member given a certain attitude to express. S was chairman".

Theme suggested by occupational therapist "partly as a warm-up, also assertive training". She also suggested the situation because "all (group members) could be involved".

Scene No. 2 Situation

"M is at a party and is not drinking. His drinking friends try to persuade him to drink. It is B's birthday".

Theme and situation suggested by occupational therapist since it was one "involving assertion, also drinking problem and socializing". "M is one of many who may well be in this situation later and who need to practise (for) it now".

Scene No. 3. Situation

"B has a noisy young neighbour, R, who likes loud music. B has work to do at night, a sick mother etc. etc. and has warned R before. He now goes to him to give an ultimatum and express his feelings".

Theme of "assertion", and situation both suggested by occupational therapist since "B is quiet and pleasant, and seems to need to practise expressing negative feelings. He cannot express anger, he says".

SESSION NO. 8 DATE: 18.2.1975

Scene No. 1 Situation

"T going for a job interview to H. She applies for a job as a hotel receptionist at H's hotel, but does not get the job".

Theme of employment interview suggested by patient concerned. Male nursing orderly suggested the situation due to "previous mention by the patient about telling employer about her alcoholism"

Scene No. 2 Situation

"Party scene with various patients approaching a group of strangers who dislike alcoholics".

Theme suggested by two patients, F "who said that people reject alcoholics" and O who agreed with him, and the actual situation was proposed by the male orderly. The rationale behind his proposal was to deal with "general anxieties in social situations and fears of rejection. The scene was enacted twice with first one patient, then a pair approaching the group of strangers.

Scene No. 3 Situation

"K turning down two guests who wanted to come and stay with her for a while".

The patient herself suggested the theme and the situation enacted was suggested by the male orderly to "equip her for future situations (she'd had previous experiences in this area) and to help her to examine the situation".

APPENDIX 11

Protocol of psychodrama session (names, places and events have been disguised or concealed as far as possible in the interests of confidentiality).

SAMPLE PROTOCOL OF PSYCHODRAMA SESSION

SESSION NO. 4

Protagonist: David

Code No.: 508

Background:

David was 24 years old, the youngest patient currently in the hospital. He had been married for three years and had one child. He had started drinking at the age of sixteen; with heavy drinking becoming a problem since his marriage. He was said to become aggressive when drunk. His foreman at work referred him for treatment with the support of his wife. He had already been having blackouts, shakes, and "regmakers" for two years prior to his admission. He had recently been charged with drunken driving and had his driver's licence withdrawn for six months.

He was the eldest of six siblings. David described his mother as being "kind"; father as "strict". He had enuresis as a child until the age of fifteen. At school, he describes himself as being "stupid". He left with a standard six education, having tried and failed standard seven three times. He went to work as a boiler maker for an engineering firm when he left school and had held the same job since then. He was highly regarded by his supervisor as an efficient and hard working employee.

He had had a serious girlfriend, whose parents disapproved of him and he had therefore dropped her for his present wife, whom he said he "had" to marry when she fell pregnant. It seemed that he resented his wife because of the forced marriage and this triggered off his heavy drinking. His wife left him because of his drinking, lived with a boyfriend, but has returned to David and would like the

marriage to work. By the time of his discharge from William Slater, David was prepared from his side to give his marriage a fair chance and make an effort to improve it.

Diagnostic formulation and progress during hospitalisation:

His therapist diagnosed David as having a "passive-aggressive personality disorder associated with anxiety in social situations". He was cooperative in therapy and left the hospital in a much calmer and less depressed frame of mind than when he came in. The nursing sister felt that he had been well-motivated and involved during his stay in hospital and "grew" psychologically "due to participation in groups and in psychodrama". In his final week of treatment he "turned his attention to others and their problems". He was perceived by staff as being fairly "imaginative" and lacking a sense of responsibility. For example, he was a late riser and tried to "get out of table laying". He was friendly and cooperative with staff and with peers. He was not observed to express anger towards his peers even when he appeared to experience anger.

The occupational therapist commented that after the psychodrama session, David became very lively and was able to express his emotions in a freer manner than when he was admitted. He cut his hair after the session and plunged into activities in the occupational therapy department showing "high drive and motivation". He took on a number of tasks on his own of which he seemed justifiably proud. For example, he designed and made an attractive flower stand for the entrance hall of the hospital.

Process protocol of session:

Group composition

Ten patients were present of whom one (Mac) was soon to be discharged when found out to have smuggled alcohol into the hospital. (He was not included in our study.) Another member of the sample was absent, having had to go for a job interview. Five staff members were present, in addition to the director and the auxiliary-ego in-training. Staff comprised the senior psychiatric registrar, two nursing sisters, a medical student and an occupational therapy student.

Warm up

As this session was videotaped the warm-up exercises were chosen in order to help the participants become acclimatised to the television camera, the technicians, lights and wires. First of all they "milled" around the action space. Then they chose a partner with whom they shared a "fact" and a "feeling". All self-consciousness in front of the camera disappeared and soon the group members were involved in lively and intense conversation with each other. (After the session they all commented that they seemed to have forgotten the presence of the television camera.) They returned to sit in chairs in a circle and introduced their partners to the group.

Selection of Protagonist

Director: We have another hour-and-a-half, and as people who have been here before know, we spend the first half hour just generally getting to know each other; feeling a bit more comfortable about the situation; and finding a protagonist, that is, someone who would really like to explore the problem or a situation, or a feeling - or who would like to prepare for the future. We did this the very first time when Sandy was here. We actually played a scene which he anticipated would happen as he would go out. It was a sort of a "future" role play scene (Pause). So we take an hour with somebody, to move through their world to explore whatever is bothering them at the time. Then we take half-an-hour after that to discuss it and to share. (Pause.)

I wondered whether anybody has anything definite they would like to "work" on this morning ... or that they're unsure about working on.

Mac asks for clarification. He is a first week patient and this is the first psychodrama session he has attended.

Mac: What do you mean by, when one leaves here, this William Slater Hospital? Their future? What their future plans are, what they're going to do?

The director gives an explanation of future projection and illustrates it with an example of someone rehearsing for a return to work.

Director: (probing) Have the people who are here come to grips with possible reasons for drinking; areas that they know they have difficulty with; relationships with wife, husband, friends, difficulties in communication?

David: I'm just trying to think how would I feel when I go down the stairs and tell the foreman "Here I am. I've just been to William Slater, and er, then I start going down, and then I'll be walking to my locker, see if I've got any clean overalls, and all I'll find is paint on the locker, written "alcoholic", "alcoholic". And meanwhile my tool box is painted, or something, all over. They all know that I'm here. (Pause.) I'm just trying to feel how I would feel. I mean, I'd feel O.K. I mean, but it's not going to be easy for me to just laugh it off. I don't know what type of reaction I'm going to get.

Director: When are you going out?

David: Next week. Not this Friday, next Friday.

Hugh: (to relieve tensions): All you do when you reach your locker, just put "ex" before each "alcoholic" ! (Laughter from the group.)

It seems, from David's specific fear, that he is a potential protagonist. Director checks with the rest of the group to make sure there is no-one else who wants to be protagonist. There is nobody. David is willing to be protagonist and all the group members approve.

Director: O.K. David, let's go to work.

Action:

The chairs are moved back to form two semi-circles, clearing an area for the action space. David chooses a number of men from the group to play his workmates. The director walks with David around the perimeter of the "stage" to help him warm-up to his role as protagonist.

Director: Can you tell me a bit more about where you work and what you do?

David: Well, I'm a boiler-maker by trade.

He continues to give his occupational history, saying that this was his first job since leaving school, telling the director how he was trained on the job and how much he likes his work.

Director: Can you tell us a bit about what led to your coming into William Slater?

David: I had started drinking when I was sixteen years old; went into the bar for beers et cetera. It started from there, and gradually it just built itself up, but, I started drinking heavier when I got married, strangely enough. My wife doesn't like drinking. Her father had been, for a long time, an alcoholic and he went to M., (a rehabilitation centre for alcoholics) and she despised to drink. It's been for about two-and-a-half years very heavy.

Director: How did it affect your work?

David: It was going O.K. I mean now and then a bunch of five of us (workmates) would go at lunch time, have a few beers and then go straight back on the job again. But then it got so bad, we didn't even worry about the lunch any more, the more beers we could find, the better it was for us. Most of them are still at the plant, some left when they came out of their "time" (apprenticeship).

Setting the scene and choosing initial auxiliaries

Walking around the action space, David describes the workshop at the factory, the position of the door, and the lay-out of the building.

David: I come in the shop (workshop) and everybody would be working. Walk, first of all, I wouldn't walk straight into the middle of the shop. I'd try and hide or something, I'd walk along the wall.

At this point, all the group members are brought in as minor auxiliaries, the men playing welders and workers, the women roled as typists in the

pool next door. This process of choosing auxiliaries was done by David in a relaxed and humorous fashion, with everybody joining in the fun and laughter. The atmosphere in the group was warm and involved. The auxiliaries are placed in the scene and David describes more details of the setting.

Director: What would they be doing? (In the workshop.)

David: Well, some of them will be welding. Some of them will be making a noise with a hammer. Even if they haven't got a job, they'd make a noise, just to keep them occupied. (Laughter.)

The names of the boiler-makers, welders and workers are specified. Two of them are David's drinking partners. David chooses Dr. K to play his foreman or supervisor.

Scene I

David is interviewed in role reversal as the foreman Mr. S. Dr. K plays David.

Dr.K (as D): Well, Mr. S?

D(as Mr.S): How are you keeping?

Dr.K(asD): Very well, Mr. S.

D(as Mr.S): You look a bit better. When are you going to have your hair cut?

(In fact David cuts his hair the day following this psychodrama session).

Dr.K(as D): I don't see why I should have my hair cut.

D (as Mr.S): I'm glad to see you on your feet again. Your wife has just phoned me to tell me that you really took the treatment very nice at William Slater, and I think I'm going to give you another chance. (Aside: He says he's given you enough chances.)

Director asks David as the foreman to give his soliloquy, what he is thinking. "What is going on in your mind?"

D(as Mr.S): He's a very good worker, very good. He's been with me for eight years. He's not cheeky. Very reliable. Until a couple of months back. He was always coming to work stinking of drink in the early hours of the morning. He would promise to come in on Saturday or Sunday. He doesn't turn up and he gives me a useless excuse when he phones me. Sometimes he doesn't even

phone me, and when he does come to work on a Saturday, he's "half-dronk". I've got to send him home again. But I'll tell him, "Come in sober Sunday!"

Director: What did it make you feel when he came in like that? How did you feel?

D(as Mr.S): I feel like I want to fire the guy. But I can't lose a good man. (To Director, aside, David, as himself says, "I mean, this is the exact words I heard from the charge hand.")

Director: Uh huh.

D(as Mr.S): And, er, but I've made up my mind. I spoke to his wife, and er, the two of us have suggested that it's better if we can get him into William Slater.

Director: Uh huh. So you had a big hand in getting David into William Slater? It was in fact most of your doing? Is that right?

D (as Mr.S): That's right. Quite right.

Director: O.K. fine. Now here's David and he has just come back. Can you just do that scene again? Role reverse, change positions, physically too, and you (to David) are now yourself, David, and you (to Dr. K) are Mr. S.

David: Goodmorning, Mr. S.

Aux.Mr.S: Hello David, good to see you back.

David: Thank you Mr. S.

Aux.Mr.S: You're looking well, better than before.

David: I feel better than before, Doctor, Mr. S. (Here David initially responds to the doctor in his real role.)

Director: It's very difficult to get him out of that doctor role! I think, let's just role reverse once more. You're now Mr. S and you're David again. So now David is just arriving at work, O.K.?

Dr.K(as D): Hello Mr. S.

D(as Mr.S): Good morning David, you look very well.

Dr.K(as D): I'm feeling much better thanks.

D(as Mr.S): You look so. I'm glad to see you on your feet now.

Dr.K(as D): Ja. I'm usually horizontal. (Laughter.)

D (as Mr.S): Listen. I've decided to give you one more chance.

Dr.K(as D): I really appreciate that, Mr. S.

D(as Mr.S): Of course you know that your wife and I had all this to do, that we've done ...

Dr.K(as D): My bloody wife interfering again.

D(as Mr.S): You've got a nice wife there, David. You should appreciate her and look after her. Anyway, as I've said, I decided to give you another chance, and er ... (Pause). Do your work like I've always known you to do, and don't let the charge-hand down, and myself. Come to work your Saturdays and Sundays, and carry on like you normally used to do. Anyway, what was your wage when you left?

Dr.K(as D): (Somewhat floored): Five rand an hour. (Amidst audience laughter, David corrects him, explaining that his wage would not be as high.) O.K. One-seventy an hour.

D(as Mr.S): I'll give you one-seventy-five. I'm glad to have you back.

Dr.K(as D): O.K. I'll do my best. Thank you very much.

D (asMr.S): Go down and let Gerald take down the new terms for you.

David is spontaneous and fluid in the role of Mr. S. He has given much information, and has probably been able to express some self-recrimination and guilt and the awareness that he knows how he appears to others when drunk. He has also given information about his positive feelings for his wife. He seems thoroughly "warmed-up" by now. Before moving on to the next interaction, the director explains the technique of spontaneous doubling. "If anybody in the group at any time feels that somebody, perhaps David, is not saying what he's really feeling, you can just come up, go behind him and speak. Be his 'shadow'. If you feel that he is stuck for words, or he's blocking a feeling, not expressing a feeling, or his words don't go with what you think him to be feeling, then you can come up and 'double' for him. Be his 'twin' or 'alter ego'."

Once again the scene is repeated. This time David plays himself and Dr. K is the foreman. As himself, David is now hesitant and unsure, almost obeisant in bearing. Before, in role reversal as Mr. S. he

had displayed more confidence, spoke clearly and firmly and stood up straight. He had been open, expansive and quite fatherly.

Aux.Mr.S: Come in.

David: Good morning, Mr. S.

Aux.Mr.S: Hello David, good to see you back.

David: Thank you, Mr. S.

Aux.Mr.S: What was it like at William Slater?

David: Very good, I ... In fact, Mr. S, the truth was, it was very, very good there.

Aux.Mr.S: It's done you a power of good. I can see that. Pity you didn't have your hair cut though. (The auxiliary remembers and is using information given by David in role reversal.)

David: I'll be doing that. We never had a barber at William Slater.

Aux.Mr.S: Well David, I hope you've learned a lot by being there. Your wife and I had a lot of trouble in getting you there.

David: Yes.

Aux.Mr.S: Obviously we thought it was for the best. We know you're a good worker. We know you can do your job well, but you've really let me down in the past.

David: Well that's ... I know that Mr. S and, er, I, think, um ...

Aux.Mr.S: You know, we're going to give you another chance, but, er, I think I must make it very clear that this is probably going to be the last chance. How do you feel about that?

David: Well, Mr. S. I'm never going to look back again Mr. S. I know there's a lot of things I've got to do which I've never done. At work, at home, and what I've really done, I've really messed up my whole life, as you know, Mr. S.

Aux.Mr.S: Yes, I know. Your wife knows, selling your furniture and your curtains (using information obtained at the previous day's ward round). Getting money to drink. ----- man, can't you look after yourself?

David: (cowed): Thank you Mr. S. Anyway (brighter) I'm, I'm, thank you. Thank you for giving me another chance.

Aux.Mr.S: You'll find you won't start from scratch. What was your last wage when you were here?

David: It was one rand seventy.

Aux.Mr.S: Well, I know you're a good worker. We'll give you an extra chance. We'll start you on one rand eighty.

David: Thank you very much Mr. S.

Aux.Mr.S: O.K. Fine.

David: O.K. Will I start today or tomorrow?

Aux.Mr.S: Now!

David jumps to attention and bounds off. He turns to me and says "They'll be working". He himself has already moved into the next scene.

Scene II

This scene takes place in the workshop, David walking through to his locker. The auxiliaries are working and making their respective noises. As David comes in they maximise spontaneously, calling out comments and taunts. As he enters David turns to the director and says "I don't know when to smile. Just that, tears, you know, they start".

Aux. 1 How was Slater?

Aux. 2 "Dronkie!"

David: Go and find out for yourself.

Aux. 1 Do you think I'm a "dronkie" like you are?

David: I'll tell you, you're worse than what I am.

Aux. 1 Oh come off it man. You just couldn't hold a drink like I can hold mine.

David is visibly affected. The director asks him how he is feeling. He replies that he is tensed up, and shaking. "I go to my locker and start undressing. Should I do that here?" "No." Although this raised a laugh from the audience, David was almost in earnest, since he was finding the situation so realistic.

David: (miming putting clothes away and overall on): I close the locker.

Aux. 3: Where is your half-jack?

David: No, I don't drink. I step into my overalls, (to director), and, er, I, no, first of all, before I come to the locker, what I'm expecting (is) 'you alcoholic', 'you .....'

Director: All right. Let's see that.

The group of auxiliaries close in on David as he is walking to the locker, maximising a chorus of taunts as they enact David's worst fears and expectations. David tries to ignore the chorus, however his nonverbal body language shows that he is intensely affected. After the entry and the chorus were repeated, the director asks David what he would have liked to be able to do or say.

David: Not. I wouldn't have said nothing.

Director: That's what you'd plan to do, want to do?

David: I'd shout 'Hello boys!', but I wouldn't have said anything.

Director: What does it make you feel inside?

David: My stomach is feeling empty or something. (David indicates that he feels "tight" and "tensed up" in the middle of his chest, above his stomach. He continues to narrate what is happening as he continues dressing.) They're putting the odd head through the door, you know, giving me a peep or something. I'll turn around ...

Director: Has this happened to you before? How do you know this is going to happen?

David: Well, one Thursday I got drunk at work and the foreman sent me home for the whole weekend. That was when I was doing my apprenticeship and he sent me home and he said 'You are suspended until Monday, and I came to work on Monday.' Twice it happened and I put my overalls on, and I'm still feeling grim you see, and I'll be walking in ...

David was jeered at. Since he had reacted somatically in anticipation in the scene, the director felt we could go back to this previous experience which turned out to be approximately three-and-a-half years back, shortly before he was married. However, when she suggested David tell more about what happened, he spontaneously moved

to the night he was drunk, before going to work. Since his energy seemed to be focused on this night we moved there in the next scene.

Scene III

Director: Can you tell us more about that time? What happened, when you were drunk?

David: It was on a Wednesday night. It wasn't a party, it just turned out to be a party.

Director: Uh huh, and who were you with?

David: With one of the guys from my work and my girlfriend, and others.

Director: When was that?

David: It was about three-and-a-half years ago. I got hopelessly drunk the Wednesday night. I passed out; the party carried on until two o'clock in the morning. Two of them were on leave, and the rest were non-workers; and the girls, what about the girls, oh yes, my girl had to go to school. It's a long time ago, and eventually we all started to get potted up, ahem, early hours of the morning. Six o'clock I was hopelessly drunk. The record-player was going, the occasional record would break, someone would sit on it drunk, and, er, I passed out. I slept on the couch, she (girlfriend) was laying on my arms ...

Auxiliaries are chosen to play David's girlfriend, Eveline, and his friend George. George was unemployed, "a bum". Interviewing David in the role of George one finds out that they have known each other for six months and meet only occasionally. A drinking friend, George is not central to David's life. He is in and out of work and trouble. In order to gain a picture of David's girlfriend and the quality and nature of their relationship David is now interviewed in role reversal as Eveline. She is sixteen years old at the time, blonde, with light blue eyes and just a little shorter than David. She is his next-door neighbour and they have known each other for two years.

Director: Do you like him? Are you fond of him?

David: (as Eveline) Yes, very much. I wait every night on the stoep, waiting for him to come from work, or otherwise I go and fetch him on the station at D. (David has assumed a somewhat svelte, soft and childish lilt to his voice in the role. He seems to enjoy playing Eveline.) Then he'll come to me to save going to work (for food), and I'll rush into the kitchen and

give him all nice food, and then he'll go next door to his mother, and get a pot of food and a couple of sandwiches. Then we'll walk to the station earlier than usual just so that I can hold his hand and kiss him, mutually. (David slips out of role in order to grin with the last word.)

Director: Returning to the night of the party, has David ever gotten drunk with you before?

David: (as Eveline) Many times. I had to hit a guy over the head with my shoe once because David was in a fight. This other guy was a bit bigger than David, and more drunker (sic) than David, and he started fighting, arguing with David. David got up and smacked him. The next minute I saw this guy getting on top of David and on the lounge floor. I could see that my boyfriend wasn't getting the better of him so I took off my shoe and I hit him over the head.

Director: Good for you, you saved David in that situation. Is there anything you would like to tell David that you never did? Here on the psychodramatic stage you can say anything. O.K.? Is there anything that you didn't tell him? Anything that you'd like to tell him?

David: (as Eveline) Yes (immediately). David, you promised to speak to my mother, (I'm leaving school this year) - you'd speak to my mother and tell my mother you've got some money, that it's alright, we can get engaged. What are you going to do about it? (David turns to director out of role 'That was supposed to happen'.)

Director: What happened to you when David got married? Did you know that he was ...

David: (as Eveline) No. David started taking me out very little. He used to walk out the front, never used to come around the back. (Their houses were back to back on parallel streets.) He was hiding. I was scared I'd lost, he'd lost interest. What had I done wrong? He was avoiding me, and it went on like that for two months, and I tried to write letters to him. I believe he read them, but he never answered them. And, er, all the time I was hurt because he knew, because I told one of his sisters about this, and even they tried to help, to get from David why he was avoiding me, and he never said anything, and then one night I saw David coming over the bridge with a girl in his hand (sic) and, uh, I stood there and waited by the back gate for him, and he came past and he never greeted me or nothing, just carried on walking. So I said something that I shouldn't have said to his girl friend and he took no notice, and I burst into tears at the gate there and my mother came calling me inside. It's quite a long walk, and I can see all that you know (this last to director out of role as himself). And that was the end. Then I heard that he got engaged and that he <u>had</u> to get married.

David is role-reversed back and plays himself whilst the auxiliary becomes Eveline.

Director: Is there anything that you David would have liked to have told Eveline that you never did?

David: Yes. I wish she had nicer parents.

He talks about the way her father snubbed him. "I'd greet him and he'd flop his bloody nose up in the air ..." Director asks him to look directly at Eveline. He does so slipping into the present tense as though he is back three-and-a-half years in time.

David: Eveline, I'm sorry I can't get engaged to you. I don't think you know the reason why. Maybe you've sensed it already. But your dad and mom, you know as well, your dad and your mom don't care much for me because I'm an apprentice boiler-maker. Two more years I'll be out of my 'time', but I don't think they will ... they don't think I'm the right guy. They expect somebody, a lawyer, or a magistrate or something. I'll just be working hard with my hands and not with my head. I haven't got the education to support you and the family that maybe we will bring up. (He uses 'will' rather than 'might'.) This is what I've been dying to tell her (turning to director who gives non-verbal encouragement, uh huh, uh huh). Then I'll tell her. There's a thing I want to tell you. I'm really in love with another girl and, er, we're planning to get married soon. Of course she'll be screaming. I know that.

Director: Was that why you didn't go and speak to her?

David: You see, I wasn't sure if I did like this girl. (His present wife.) She was also happy-go-lucky (like me). I could take her out any time, every night if I wanted to, because her mother and father liked me. But Eveline's dad and mum, they, they didn't care much for me. They would make some excuse 'no, we're taking Eveline out to see her granny tonight' while they were actually at home all the time.

It appears that David's mate George is not significant in the exploration. Director thanks him and dismisses him from the stage. It seems that it will be important to explore the protagonist's feelings about Eveline, her parents, and his present wife. The next scene comprises an interaction between David and Eveline's parents and leads to the affective climax. We did not work with David's early relationship with his

David: Mr. Green, no. Mrs. Green, yes. (He 'fixes' his eye.) I wouldn't keep it too long. I'm fixing, and I came back to her again 'Mrs. Green', I say it. She'd say 'No, we're going out'.

David appears to be uncomfortable in a face to face encounter. The director suggests that the auxiliary step aside for a while and that David plays both roles of Mrs. Green and himself. This seems to work since David moves from one role to the other immediately, without hesitation.

David: I'll say "Mrs. Green, can I take her out tonight?"

Aux Mrs Green: (I can see he's looking at me.) Clive, what did you say? Are we going to your,er (to) granny tonight?

Aux Mr.Green: I, er, think that's right, what you asked (gamely) me.

D as Mrs.Green: Well, we'd better get ready.

David: (whipping back to himself.) Thank you very much Mrs. Green, 'Bang!' (gesture). I slam the gate and give her one quick look, and 'Bang!' I slam the back gate, and I walk in the passage. (Sings) 'For he's a jolly good fellow'. I walk down the stairs and I stamp extra hard in the passage to make a disturbance you see.

Director: Good. O.K. do it. (David does it, stamping and singing, completely involved. He returns.) Do you think there was any other way to have spoken to her?

David: No, I wouldn't have said things I shouldn't have said - but I could have done.

Director once again uses the restraining technique. It is quite clear that David has problems in handling his anger and expressing his feelings. The repetition of this scene is aimed at helping him to move towards a catharsis of abreaction, by allowing him the opportunity of expressing his anger and the hurt underlying his anger. A double seems called for to help David. As this repetition progressed, the senior registrar who was in the audience obviously thought so too, and spontaneously came up to double for David.

Director: O.K. Well, I'm going to hold your hands so that you can't do anything, but this time tell her exactly what you think. We'll see what happens. (David becomes aware of his physical urge to move away. He is now conscious of "fumbling" with his fingers.) You can't stomp out. What would you like to do? What would you like to say? (At this point the registrar rises and moves behind David to double for him. He maximises and supports David in removing the barriers to his control of perceived unacceptable feelings.)

Dr.K(doubling): I'd like to tell her to go and get stuffed. Why can't I take her daughter out? I'm feeling bloody angry, and humiliated. How can she say that to me. I'd like to kick her right in the (indistinct).

At this point a nursing sister in the audience moves up to double for the auxiliary playing Mrs. Green.

Double(Mrs Green): This guy isn't good enough for my daughter. I'm going to have to do something. I don't like this country. Look at him. He's terrible. He's going to do something to my daughter, I know he is.

Double(David): I wish she would calm down. How can she take her daughter away from me, humiliate me like that?

David seems magnetised, standing stock-still. The director asks him what he would like to say. His response breaks the tension and shows how he has valued the doubling. He says, "Is there any four-letter words I don't know?"

Double(Mrs Green) (continues): I've got to do something with this guy. I don't know what to do with him. I don't like this country, I don't like the people, the people are terrible. I'm not going to let it carry on. I'll have to talk to my husband. I'm going to get Eveline away from him. He's going to do something to her. I just know it. She's got to finish her schooling. She's got to get to university. She's not going with this guy.

In response to the director's query, David says he is feeling hurt and the tightness in his stomach would cause him to "creep" as though he had pains in his belly. "I'll breathe hot breath you know, and want to cry."

At this point the director uses a concretising technique by pressing on the spot where David feels tight, whilst the auxiliaries continue

maximising. This will help to promote David's affective climax and catharsis when he bursts out with anger.

David: Go to blazes! You're just a bunch of immigrants. You're not worthy of your country. (He can't keep this up, and it is contraindicated to push him beyond the point that he himself can go. He turns to the director.) That's all. (Encouraged to tell what he is feeling he continues.) Well, I'm hurt, and I'm cross, and I feel I can take a nail and stick it in and puncture all their tyres. That's exactly how I felt at the time. You know, I'd do something destructive to their belongings.

Perhaps it is a bit soon to consolidate role training by repetition of the same scene, without having David role reverse with Mrs. Green for empathy's sake. However, David was asked to confront Mrs. Green once again. This time he does indeed do so without acting-out or running away, and with direct expression of real, immediate feelings of hurt.

David: You should be ashamed. How can you possible hurt Eveline and myself? Don't you know, haven't you and your husband been through this? Don't you know what it feels like to hurt me, and Eveline? Mrs. Green I never expected this from you. I think you're very low. I wouldn't say more than that. (He checks himself. This last is addressed to director.)

One possibly advantageous way of integrating the drama and helping David ease the hurt of the past reality would have been to move into an ideal scene in surplus reality, perhaps one in which the Greens are kind, accepting and permissive and he indeed takes Eveline to the cinema, this would have followed a scene in which David fulfils his aggressive fantasy psychodramatically, under controlled conditions, for catharsis, by moving into surplus reality and enacts the puncturing of the Green's tyres. Scenes like this have the effect of closing the past and enabling the protagonist to move on to putting all his energy into his present relationships.

It appeared that some measure of catharsis had in fact been achieved when David described his somatic condition.

Director: What's happening to your stomach now?

David: It's relaxed now, more relaxed.

In a stronger, even more direct fashion, he again addresses Mrs. Green. After this he turns to the director in surprise and says, "I really feel like I'm living this over again". He recalls that he has had a tight feeling in his stomach ever since he can remember "all the time". Subsequent psychodramas, if held, would advisedly move in action to his childhood experiences with his parents as well as his relationship with his wife. Indeed David does eventually regress imaginatively in this session to the significant traumatic childhood episode, related below.

David continues to discuss his feelings when angry. He "gets aggressive, but I don't fight". He feels like fighting but can't talk. He shakes, and then, as in the episode when he beat a mate who had reminded him that he had his spanner he feels relaxed. He experiences tension and anger, does not express it appropriately, but it builds up and accumulates and he eventually lashes out in an effort to release tension, becoming violent and usually complicating rather than solving anything. His faulty impulse control and his fear that he will be violent further cause his suppression of feeling and compound his difficulties in a tautological fashion.

Closure

The director and David sat in two adjoining chairs in front of the group for the sharing. However, David had not completely catharted and was still discussing how he experiences his tension. His stomach tenses, his breath feels "cut in half", he fumbles with

his fingers, cannot speak and feels like crying only he can't, "it's dry".

Director: When you were a child, can you remember what situations would make you feel like this?

David: Well, there was one time that I really went mad with this (feeling). We were in this classroom. I was in Standard Three, and there was this one mate of mine. He stole another guy's protractor in school, and he put it in my suitcase. But I didn't quite 'click'. You know, I was busy playing with putty or something in the classroom. And er, (cough) when the school bell went for after school (cough), this guy Eric went up to the teacher and said 'My 'tractor's gone Miss'. So she said 'Well, nobody's left the classroom. Each people (person) open your suitcase'. Huh. I opened my suitcase and there was the 'tractor, and I had to hide it away quickly, and I knew it was him. You know that instantly. So the teacher called me out, up to the classroom (front of). 'David, did you steal Eric's 'tractor with the intention to take it home?' I said 'No, Miss', and I turned to Bobby, and I saw him, you know, he just stopped a giggle. Anyway, I went, (our classroom is just about there), where the principal was, and the principal spoke to me then and gave me three cuts. And the more I said 'Sir, it's not me', bang, he gave me cuts and I built up, built up (internal feelings of rage and injustice). I had my cuts, but the bus was, soon after school, a quarter past two, the bus was there, twenty past two, and I missed him (Bobby). He was gone, and all the time -- I missed my bus, and I walked up (to) the nearest bus stop further on. The more I came closer to getting hold of him, the more I was <u>green</u>, you know. I was tight, you know. Like I was really gunning for him. And he, I knew where he stayed. And I just put my suitcase down on the stoep, and I found a piece of iron pipe, about eighteen inches long, about two inches wide. Not a solid bar, it's a pipe. (He is reliving the incident, changing to the use of the present tense). And I saw him walking to the shop. You know, there was a corner road and I saw him going to the shop. I wait in the ditch there. I could see him coming down from the shop, but he couldn't see me, and the sweat was coming down me. I sat in the hedge there with this pipe. I looked through the hedge. I saw he's coming with a bag of bread or something from the shop. My eyes were fixed on him (again a repetition of the fixing on Mrs. Green in the previous scene). When he came around the corner, I let him have it with the head. I mean over his head. I just stood there. I just saw blood coming down, and I ran across the road, and I went to this elderly woman there, and I said - I was crying you know. I couldn't control myself. So the lady came out there and she 'phoned for the ambulance. And the brother meanwhile, got hold of me, his bigger brother, and slapped me. But I was, I, I couldn't, I couldn't think. I didn't know what was going on.

Director: Do you remember that crying? (Hand on David's shoulder.) Do you feel like crying now?

David: Yes. And he was hitting me, and I just got up, and I don't know, he slapped me down again, and the next minute all I remember is my mother being there, and she was acting also. Then a couple of women got hold of her and calmed her. I couldn't remember that happening but in the night, I, went to sleep. He was rushed to hospital. He had to have stitches. But I, my mother took, me, to, er, I woke up in bed, and couldn't speak to her, you know. I thought she was taking his part. Because she was slapping me too. And, er, I didn't want to speak to her. I didn't want to speak to my Dad. I didn't want to eat. All I wanted to know 'How is Bobby?' Because it was like, like I, I had punctured something, and the blood just shot out. I got such a fright. My sister said to me 'No, Bobby's alright'. Then it came over, over. I got over it.

Director: Did you ever dream about it?

David: No. Funny enough, no. I used to think before I used to go to bed about it, and it used to make me restless you know. I'd toss over this side, and I toss over, and all I could see is a pool of blood.

Director: Have you ever hit anybody since then?

David: Yes. One man at work. A hell of a big chap. A fisherman. Very hefty, a bit like (indicates a patient in the group), but more stouter and bigger (cough). I borrowed a spanner and I clean forgot to give it back to him. That night he worked through the night, and he needed that spanner badly. As I came into the shop (workshop) the next morning, into my locker, into my change-room, he pulled me out. He's a tall man you know. 'Yes man. Where's my f---ing spanner?' You know, and I felt I was, thought, I didn't even know he was warmed-up through the night. I said 'I clean forgot', and he gave me a slash to my face, and he says 'But I needed that'. He held me up to the locker. It was a small locker. It was not wide, it's long but it's light. And he flung me over my locker and I just saw heads smiling and laughing at me. But, I don't know why, I don't know how, the spanner got into my locker. I was supposed to have given it back, but it wasn't in my tool-box, it was in my locker. I saw it distinctly falling out, and I grabbed hold of the spanner, and I charged him and I hit him all over, where I could hit him. I just got hold of him, and the next minute I felt something grab my hand. It was my foreman. That was also a time I had the same, I, I couldn't go and speak to anybody. You know, if somebody had to just say, the wrong word, then I'd blow. I'd of burst out crying or something, or I would have done the same thing.

By relating these two incidents David seemed to have some sense of relief. It served as a verbal abreaction. A picture was presented of David's poor impulse control, his destructive fantasies, his fear of loss of control, his anger and blind rage when he feels caught out, pulled up short, wronged or ridiculed. It also gave valuable diagnostic information on which his therapist, who viewed the video-recording of the session later in the day, could base a formulation of the psychodynamic make-up of David's personality. Ideas for future exploration in therapy were suggested.

Had there been more time, the final integration might have been served by a scene in which David encounters the boy Bobby, either in the past or the present, and apologises for his behaviour. David told the director in reply to a query that he had seen Bobby since he was "grown-up" but had not actually talked to him.

To help David wind down more completely the director helped him to relax by using a brief progressive relaxation method before the group shared their identifications and associations.

Sharing and Discussion

The director shared an incident in the past in which she and her young sister were walking home from the shops and the sister fell and cut her chin on a tin. The blood poured freely and made a strong impression on the director, even though she hadn't actually hurt the sister. Dr. K. remembered being furious with a friend and wanted to "really smash him up". "I couldn't catch him and the more I couldn't catch him, the angrier I became. I was so frustrated." Director and a number of audience members related to David's feelings of rage and impotence in facing others when they feel victimised and taken advantage of.

The patient who played Mr. Green shared an experience related to the part of the action in which he had participated. He found a common point of identification with David, although their class and cultural antecedents were completely different. He was sixteen at the time and brought a girlfriend home. He felt ashamed and humiliated by his mother. "We had a quiet lunch, and after lunch mother said, 'I think you'd better take your girlfriend home. She wears the cheapest perfume that it's possible to wear!' That's all she said. But that's an incident in my life I have never forgotten."

Comments:

Although it is not clear whether David took the protractor from his friend Bobby, or whether he was 'framed', he perceives himself as victimised. Things are done to him. A link may be seen between the protractor found in his case, David feeling that he was unjustly punished for 'stealing' it; the spanner he borrowed and "forgot" to return which was found in his locker when it should have been in his tool-box; and his son, the reason for his forced marriage, whom his wife later insinuated might not be his child at all. (This last piece of information was told to David's therapist.) There is a common theme of being the victim, being wronged, punished unjustly, or caught with something that doesn't belong to him. He uses the defense mechanism of rationalisation, telling himself that he can't be blamed. Things are always somebody else's fault, never his own. His therapist told the director afterwards in discussing these points that David blamed his alcoholism on his wife, or his drinking friends, but never owned the cause in himself.

The therapist also told the director that Eveline was the girl he really wanted to marry. "He has never admitted this before, but events in psychodrama caused him to reveal this, and his resentment

towards his wife, as key factors in his drinking when I interviewed him later in the day."

An important diagnostic point which was revealed during the psychodrama was the difficulty David had in handling his aggressive impulses. He acts out, and lashes out, physically as well as by drinking. He appeared to fear his aggressive impulses and lack impulse control. It is possible that because he has been reported to be violent when drunk, that he drinks in order to express his anger, so that his conscious control need not prevent him from doing so. A paradoxical tautology is created by his dealing with his destructive fantasies, and controlling his anger by drinking, but also using the drink to be able to express his anger. No doubt these patterns might be traced to childhood experiences. Indeed after watching the playback of the videofilm of the session, David told the director how he was the "good son" by leaving school in order to bring money into the home, and how his father never encouraged him to have any pleasure. For example, David bought a guitar with his earnings but was not allowed to play it at home. He remembers having to walk on tip-toes at home, be quiet, and felt he was suppressed as a child.

Techniques used:

Future projection
Invocation of chorus
Re-enactment
Self-presentation
Doubling
Role reversal
Soliloquy
Maximising
Concretising

Post-session observations:

The occupational therapist reported that David was quite "sparkling" after the psychodrama. He was a "real star" in the eyes of other patients. As reported in the file, he participated in activities with interest and zest and initiated special projects of his own. He "slotted" into the hospital programme and was warm, friendly and cooperative to staff and patients alike.

When the director asked David's permission to use extracts of his videotaped session for teaching purposes, he "thought about it" for a day and came back with an affirmative answer. "Yes, if it will benefit people" and signed a permission release. (The film has been shown to medical students studying a psychiatry course, and to post-graduate psychiatric social work students.)

When interviewed a week or more after the session, David said "I am changed. Something seems to have happened to me, inside. I'm a different person to the one who came in. I don't think about drinking. I can't yet think about what will happen when I go out, perhaps I'll come down. In the meantime, I am chirpy - much more active than I have ever been. I like doing things, helping about the place. I've got more energy than I've ever had before. Something's happened to me".

He reported that the night after the psychodrama he slept late, "never slept so good before".

Exit interview

His comments during the exit interview were as follows:

"Psychodrama helped me to find myself."

"I felt more confident after the psychodrama."

"Other patients seemed to understand me better."

"Maybe seeing the TV showed my therapist what I was like, probably better than I could put into words. She helped me a lot. She just seemed to understand me. She gave me something to work. I suppose she's helped me understand why I behave in certain ways. My doctor pinpointed things in the TV which I couldn't."

Follow-up interview

The patient had started drinking just prior to the follow-up appointment. He admitted to having been drinking when telephoned to remind him of the interview. He did not turn up for the interview. Despite three more telephone calls, David did not come to the hospital at all. He had stopped attending groups and individual therapy sessions, had not shown up at work for a week, and his job was in jeopardy. Notes left at his home by the community sister were unanswered. In view of his progress whilst in the hospital, staff members were disappointed in the outcome of his treatment, but wondered whether after a second admission he wouldn't do "better".

Staff evaluations

A male nurse felt that David was more involved in the hospital programme after the session than he had previously been. A nursing sister who had come back from leave after David had been protagonist and had not known him too well "heard him saying that he had found so much benefit from psychodrama, and that he felt it was much easier to talk because he had gone through the whole thing, and now it was much easier to relate what had happened in the past (to him). So he found, I heard him express this on several occasions, that he found a terrific benefit from it (psychodrama)."

David's therapist also felt that he had changed after the session. She found watching the videotape very helpful and he came "alive"

to her as a case. She was able to base her therapeutic direction in planning on what she had seen and understood of his psychodynamics on the screen.

Yet another nursing sister found David "completely different after his psychodrama, for example to the staff. They were much closer to him, could understand him more. When sharing his experiences outside of psychodrama, the staff could understand more, see things in a completely different light. This is, of course, from the staff point of view".

The occupational therapist saw David as being "very vivacious for the rest of his stay, and outgoing, and so on".

One nursing sister did not notice any change in David, and yet another stated that he was "far more disturbed than we gave him credit for initially. I don't think one session of psychodrama is going to be enough, or one three-week session at William Slater, even with individual therapy. Long-term, intensive psychotherapy is needed. We initiated a whole set of problems we only started to come to grips with".

APPENDIX 12

Illustrative examples of patient comments

ILLUSTRATIVE EXAMPLES OF PATIENT COMMENTS

The illustrative comments are drawn from both the exit and follow-up interviews from both samples. Examples are given of positive, mixed and negative evaluative comments, and are identified by the code numbers of the subjects making them.

The comments are presented in the sequence of categories as follows:-

1. Catharsis, relief from tension, self-expression
2. Insight, self-understanding
3. Self-confidence
4. Role rehearsal, future projection
5. Sociometric status, group acceptance
6. Change in behaviour, interpersonal relationships
7. Sharing, identification from auxiliary or audience point of view
8. Reality, truthfulness of experience, involvement
9. General evaluation of method from protagonist, auxiliary, or audience point of view

1. CATHARSIS

As has already been described, only subjects in the psychodrama sample commented at exit and follow-up about expression of feelings and relief from psychic tension. This fact is taken to be a reflection of the nature and aims of the psychodrama method.

At exit two subjects commented positively. They continued to comment positively at follow-up, and in addition one other subject made a positive comment and another spoke with mixed feelings about the cathartic aspect of his psychodrama experience.

(a) Exit comments (psychodrama sample)

Positive:

405 The last one was fun, and a good way to let off steam. (Referral to staff-patient role reversal sociodrama.)

706 I got a lot more out of it /as protagonist/ than in the past. I was tense this morning as to what would happen when I get home. Now I feel a hell of a lot better. (Subject 706 is here referring to a session in which she rehearsed an anticipated encounter with her mother.)

(b) Follow-up comments (psychodrama sample)

Positive:

405 It has been helpful. We got out that thing about panic feelings. It helped to get out the fact that I had panic feelings. Then Dr K /therapist/ discussed it with me, told me what it was.

703 It should relieve you out of distress.

706 In psychodrama, the day I left I got rid of a lot of pent-up feelings inside. It helped me tremendously. I was able to sit down and talk to my mother.

Negative:

506 The bubble burst during that session /as protagonist/. They were a lot of cardboard boxes, and they sprang open and they released a lot of things that I care to forget. The effects on me were very emotional, and I don't want to go through that emotional experience again.

2. CHANGES IN INSIGHT, SELF-UNDERSTANDING

(a) Exit comments (role playing sample)

Positive:

501 I learned that I must be more assertive.

504 In the TV session, I had to learn to speak up. My facial expression looked grim. I should do something about it.

(b) Exit comments (psychodrama sample)

Positive:

304 I relived the incident. It gave me a better understanding of myself and the others involved.

508 Psychodrama helped me to find myself.

(c) Follow-up comments (role playing sample)

Positive:

503 Role playing didn't help in any great way, but I'm sure it made me more aware and able to question myself "Why do I do it that way and not another?" these last few weeks.

(d) Follow-up comments (psychodrama sample)

Positive:

304 I understand now if others show signs of aggressiveness or impatience. Actually the fault is by me, not them. I had thought the fault was in them. So now when I have a dispute with a person, I try and find the reason first in myself and then I look at the other person.

602 The chairs were the fulcrum around which everything revolved. It helped me to see my position in relation to my parents, and then how I was now transferring this to my own family. This frightened me. (Here he is referring to the technique used in his protagonist session which employed empty chairs to represent himself and members of his family in the construction of two "social atoms". It might also be noted that at follow-up this subject was more positive in evaluating his psychodrama experience than he had been at exit when he commented in a mixed, ambivalent fashion. It seems that the experience needed to "settle" somewhat in his daily life post discharge for him to appreciate it retrospectively.)

702 /The psychodrama experience makes it possible/ to talk about one's problems and things of the past that are carefully placed at the back of one's mind.

3. CHANGE IN SELF CONFIDENCE

(a) Exit comments (role playing sample)

Positive:

409 I just cut my mind off from the rest of the group. I felt like I was on stage. I had to handle my shyness.

704 It helped cure my shyness. I made myself act.

(b) Exit comments (psychodrama sample)

Positive:

304 I felt more confident in dealing with patients and staff after the drama.

403 It broadens the mind, takes your shyness away.

506 Psychodrama enabled me to discuss something with my therapist I wouldn't otherwise have brought up.

508 I felt more confident after the psychodrama.

(c) Follow-up comments (role playing sample)

Positive:

407 It did make me not so shy. I was able to do my role playing part in front of people in English. (this subject was Afrikaans-speaking.)

(d) Follow-up comments (psychodrama sample)

Positive:

304 It has given me a quiet confidence and dignity. I had such a terrific inferiority complex. It was terrible to dislike myself. Now I have regained that confidence. I sometimes think "You're not so bad after all."

502 My only thing is my shyness. That I overcame through psychodrama. When I was Sister S [in the role-reversal sociodrama] that helped a lot -- and the other time upstairs in the "blue room", I think I was also Sister S [in the sociodrama about antabuse treatment]. That changed me, completely different. I'm not shy to talk to people. I'll go up to anybody and speak.

4. ROLE TRAINING, REHEARSAL, FUTURE PROJECTION

Most of the role playing sessions involved role training situations. Only one of the "experimental" psychodrama sessions focused on the rehearsal for an actual anticipated event. (The first session was also a future projection, but the protagonist was a member of the "Interstitial" population.)

(a) Exit comments (role playing sample)

Positive:

503 I didn't feel uncomfortable. It is an excellent way of testing one's ability in a situation. Although there were some corny situations, often a simple situation expressed a great complexity. An interesting method.

705 Role playing helped in trying out situations.

(b) Exit comments (psychodrama sample)

Nil

(c) Follow-up comments (role playing sample)

No role playing subjects mentioned this aspect at follow-up.

(d) Follow-up comments (psychodrama sample)

Positive:

706 My own psychodrama was fantastic. I was able to sit down and, for the first time in my life, tell my mother that I'd like to depend on somebody now and again, and I was able to tell her all that went on here /in the hospital/, and she thanked me very much which I feel was a big thing. A very big thing that we were able to talk about it in an adult, and sensible manner, without either of us feeling awkward in any way with each other. We're closer.

5. SOCIOMETRIC STATUS, SOCIAL (GROUP) ACCEPTANCE

(a) Exit comments (role playing sample)

Nil

(b) Exit comments (psychodrama sample)

Positive:

304 I think I got more out of the groups after the drama. Other patients seemed to accept me better.

508 Other patients seemed to understand me better.

(c) Follow-up comments

Nil in both samples.

6. INTERPERSONAL RELATIONSHIPS, BEHAVIOURAL CHANGE AFTER TREATMENT

(a) Exit comments

Nil in both samples.

(b) Follow-up comments (role playing sample)

Nil

(c) Follow-up comments (psychodrama sample)

Positive:

304 When nervous I'm inclined to talk, very much, and I have found that it irritates people, at times, and now I have learned to kind of keep myself back a bit and let others talk.

702 I, as a complete instrument, found a means of looking at myself and hence found a means of being able to discuss things with others.

Mixed:

505 I just feel that I have changed. I look at people differently. I see them differently.

7. SHARING, IDENTIFICATION FROM AUDIENCE OR AUXILIARY POINT OF VIEW

(a) Exit comments (role playing sample)

Nil

(b) Exit comments (psychodrama sample)

Positive:

505 Although it was D's drama, watching it, I could understand what he was feeling. I had similar experiences.

506 In D's session, I was the girlfriend's father. That was a good one. I shared his emotion. I related it to my own experience.

706 B's session about his sons triggered off feelings about my husband's relationship with his son from a previous marriage.

(c) Follow-up comments (role playing sample)

Nil

(d) Follow-up comments (psychodrama sample)

Positive:

505 I found in D's psychodrama, there were similarities I could sympathise with. I felt that right through his session. I could see myself in a similar position. Maybe I could have ended up the same as he, but I didn't. I was steered on a different course.

706 Psychodrama helped me tremendously. From what I saw and what I learned. I do feel that I've learned a lot from the other people. I could see parts of myself in so many things. You learn "Good God, I'm not the only person with this problem." You don't feel "I'm a freak."

8. REALITY, TRUTHFULNESS OF, AND INVOLVEMENT IN THE EXPERIENCE

(a) Exit comments (role playing sample)

Positive:

507 They tried to make me drink. It felt real. I was also a salesman once. I would have preferred a situation from my own life.

Negative:

407 It won't be like that in real life -- things are different in real life.

501 I am not good at drama. I had two main parts which I didn't do well. I felt I was acting, although the situations were real.

(b) Exit comments (psychodrama sample)

Positive:

502 It was very real.

702 At the time I felt as if no-one else was in the room. I was stunned at myself. It made me think. Usually, I have to kick myself ten times to talk.

Mixed:

506 Quite pleased about that [session as a protagonist]. It turned out better than I thought it would. I can't imagine it happening in real life --it's pure play-acting. Those thoughts have always been back of my mind. [Theme of session.] I shall never lose them. I have to block them out, continuously.

Negative:

405 I did not gain anything from it. It was play-acting.

601 Stupid, no good. It doesn't appeal to me because it's unreal. I am a stone-hard realist. [Audience member only.]

(c) Follow-up comments (role playing sample)

No positive or mixed comments.

Negative:

504 I didn't like role playing much. I couldn't put my heart into acting a situation that has never happened to me at all -- that you had to imagine in front of an audience.

604 Role playing is a very good thing in cases, but to enact experiences of actual situations. Imaginary situations didn't assist much.

704 It's not real. One feels one is acting a part -- trying to act a part. It doesn't mean anything to you. It doesn't do anything.

(d) Follow-up comments (psychodrama sample)

Positive:

505 I feel it is definitely closer to the real thing. It all happens so fast. You don't get time to think, to make up answers. The truth comes naturally. It comes by itself.

Negative:

703 I might look stupid. Didn't think I could act. Other people are born actors, would be hard for me.

9. GENERAL EVALUATION OF METHOD FROM PROTAGONIST, AUXILIARY, OR AUDIENCE POINT OF VIEW

(a) Exit comments (role playing sample)

Positive:

303 It made a change from groups where all people do is talk about drinking.

401 One is able to see what people are like in normal life outside William Slater Hospital.

501 I saw people's other side, not the same as in groups.

507 Role playing helps one see that people's feelings are different. I wouldn't have handled situations in the same way as others did.

Mixed:

406 It was not my line, although it seemed to help others.

603 My feelings didn't seem to come out, other people's did. Possibly the situation wasn't strong enough.

604 I performed in most. Not very impressed. It may have been helpful to others, I didn't learn anything from it.

701 I felt uncomfortable in roles. I seemed to help others. Perhaps this was because they enjoyed performing. I definitely did not.

(Most of the mixed comments about both role playing -- and psychodrama -- come from subjects who felt the respective method did not help them personally although others seemed to derive benefit from it.)

Negative:

302 It was stupid. I think I took part in one, but I don't remember what it was about.

407 I needed time to prepare. I was always asked to do something straight away, without time to think about what I wanted to say.

504 There were a couple of childish things, like the parachute thing. I can't see what people can gain from role playing.

(b) Exit comments (psychodrama sample)

Positive:

304 M seemed to have been helped.

403 It helped to watch them /protagonists/, and I got something out of it.

508 I'm sure the experience will help me find my feet with my wife, her family and my work.

702 When you talk about something, it's one thing, but when you enact it's a different kettle of fish. It's wonderful, more came out in the psychodrama group than in the group upstairs.

Mixed:

402 I only took part as a spectator. I couldn't visualise myself in a more active role. An interesting method, but not for me.

405 R and D seemed to have got something out of it. I did not benefit from watching and participating.

505 It is not for me [being protagonist]. It is a good thing for a certain type of patient with a particular problem. For D and M it was a valuable experience, especially for D. The change in him was obvious.

Negative:

301 It was ridiculous. I gained nothing from it. Perhaps I am too stupid. Perhaps R was helped, not K or M.

601 It didn't help me, I felt like an idiot.

(c) Follow-up comments (role playing sample)

Positive:

604 I'm quite impressed with it. It's a good way of enacting actual facts and things that happened to us.

Mixed:

303 Role playing could be helpful for some people. It doesn't apply to me.

504 My problems are different. It didn't help me personally, it helped me to see other people's problems.

Negative:

302 I cannot remember anything about role playing.

407 I was frightened of it at first. I don't know if it's made any difference to me. It did not help me.

704 I honestly think I got nothing out of role playing at all.

(d) Follow-up comments (psychodrama sample)

Positive:

505 I was never the "star" in one of those sessions. I think I would have objected to being one, but I think it helped just being one of the audience. To listen to the patients, the way they are there, because it is completely different from the way they would discuss their problems in a group meeting.

702 In watching the drama one sees the emotions of others that would not ordinarily come to the fore.

706 Psychodrama brings so much out of people in a few minutes.

Mixed:

405 Didn't help me. Did help me to understand other people.

Negative:

601 I gained nothing from psychodrama.

703 I really didn't get the idea behind it.

APPENDIX 13

Evaluative comments by staff members

EVALUATIVE COMMENTS BY STAFF MEMBERS

In addition to being asked to rank order three aspects of the therapeutic milieu in terms of helpfulness to patients, the twelve staff members who were interviewed were asked to comment on a number of open-ended questions concerning their impressions of role playing and psychodrama. (See appendix 8 for staff interview schedule.)

The responses to these questions were organised under six sub-heads or categories. These categories are listed as follows:

	Category used for staff comments
1	General comments on role playing
2	General comments on psychodrama
3	Perceptions of differences between role playing and psychodrama
4	Perceptions of movement or change in protagonists or others attributable to participation in psychodrama
5	Comments concerning possible criteria for selecting patients for role playing and/or psychodrama
6	Comments concerning perceptions of specific values of psychodrama in alcoholism treatment

The roles of the twelve staff members interviewed and the code initials by which they are identified in the presentation of comments are listed below:

	Role in hospital	Code
1	Consultant psychiatrist	Dr J
2	Registrar (psychiatric intern)	Dr K
3	Registrar (psychiatric intern)	Dr L
4	Clinical psychologist	Mr M
5	Sister-in-charge (psychiatric)	Sister A

6	Male charge nurse (psychiatric)	Nurse B
7	Nursing sister (psychiatric)	Sister C
8	Nursing sister (psychiatric)	Sister D
9	Nursing sister (psychiatric)	Sister E
10	Nursing sister (in psychiatric training)	Sister F
11	Male nursing orderly	Mr N
12	Occupational therapist	Mrs O

1. GENERAL COMMENTS ON ROLE PLAYING

Sister C: Perhaps it would be better that one had a list of the needs that the patients have, for example, assertion. We could ask the patient to act out and work through these problems in the role play. I don't think there's enough being done. We should be more constructive.

Sister F: Role play to me is very artificial, because any situation that they're going to play out of here, I've not yet heard a report-back from a patient that it's helped them, so perhaps I can't say, but I honestly don't see how role play can help them because it's a completely artificial situation.

Mrs O: I don't know how much a person can change in three weeks so I think maybe its main function is assessment. It definitely does help patients gain confidence in practising new ways of handling things. Especially in assertion, because that is something straightforward, and a lot of patients just haven't got the confidence to act assertively. Whereas emotional expression is a little bit more difficult in role play where sometimes you are trying to force the expression of an emotion which isn't there. It's not always very true, although one tries to make it true. You try to make a situation which really is frustrating for the members.

2. GENERAL COMMENTS ON PSYCHODRAMA

Dr J: From seeing you direct a few sessions, it is a very useful technique. I think a lot depends on the therapist, even more so than other therapeutic techniques, because you are taking such an active role. I see it as another form of group therapy. If we had a psychodrama therapist here, it would be very useful, because it is a part of the training re-socialisation, going over situations with the patient which he may have experienced which caused him distress. I would use it as it is. We may have to use a bit of both worlds, and use some of the therapeutic techniques of psychodrama and combine them with those of role playing.

Dr K: The psychodrama concretises, makes more binding and consolidates

the therapeutic milieu approach that we have here. It brings the people who are actually involved with each other closer together. For the first time in their lives some of them have an actual close feeling with someone else -- a feeling of warmth, sharing, which some of them have never had, or seldom had.

It's an economical way of getting to know somebody. What you can learn in two hours [in psychodrama], might take you months [otherwise], or what you might suspect for months you can see confirmed in action. I can see it as a very potent technique for exploring and exposing certain areas in a person's personality.

Mr M: Well, you know, having done some work in groups, knowing my behaviourist theoretical orientation, I was very suspicious of psychodrama. I had read Moreno and various other people, but I was very suspicious of it, because of its affinity with psychoanalysis, psychoanalytic therapy. However, having seen it in practice, having heard patients report back to me what happened in psychodrama, even if they weren't involved as protagonist, even seeing other patients carrying out their drama, it was beneficial to them. Maybe I'm now biased more in the other direction. Even if I take a balanced view, an average of my two attitudes, I think it's a very good thing and especially for those people where a lot of their problems are in expressing themselves. They're personality disorders, they've got limited ways of coping with life, that psychodrama could open up new avenues for them.

Sister A: It is the experiencing in psychodrama which is useful. Experience is the only precedent for confidence. One can only gain confidence if you've done something. Otherwise, it's all fantasy.

Nurse B: I find [psychodrama] wonderful, and I think it's fantastic that we are learning more about it. I think if the treatment period were longer we could achieve so much with the patient. If you could take him for two sessions a week, and lead him to a true insight, and also teach him what to do with that insight -- and I feel you can achieve this with psychodrama. Whereas with group sessions, role play and the rest, you know, you bring about intellectual insight most times, I feel that with psychodrama you can get intellectual insight <u>and</u>, most important, you can get emotional insight into their problems, which we really aim to.

It made [patients'] lives so much richer. I think they were so much more involved afterwards, and also they felt we were really trying to do something about them.

I feel that staff should pick up techniques from you and, in a spontaneous way, use this in group sessions, because sometimes emotions come to the foreground, and one just doesn't know what to do with it all, how to handle it and it all just goes to waste. Whereas one could have used it therapeutically for that patient, you know, led him closer to insight if one had knowledge of how to. To use an empty chair technique, or some other technique which you use in psychodrama.

Sister C: Patients who were protagonists in the psychodrama sessions were different in their participation in the system in that they became more open, spontaneous, happier. They took more active part in the groups.

It can be of terrific value in making a patient realise, and also other patients to see certain situations and becoming aware of emotions.

Sister D: Psychodrama definitely has a use, but I would say with specific patients. I don't find that it is able to be generalised. I think that you have to select your patients fairly carefully.

The value for staff members was in experiencing and observing what was going on, and then taking it back and working with the patients.

Sister E: /Psychodrama is/ very involving from a staff point of view -- very useful, involving, although very threatening at first. The warming-up was tremendous, how we relaxed more. Amazing that patients didn't feel so exposed, looked forward to it.

Sister F: I found the psychodrama, going back in their lives, picking certain areas to replay as it were, an artificial situation . . . The people playing the other people's part might play it incorrectly, stimulate a "wrong" attitude.

Mr N: The psychodrama has been of tremendous value for people who have been the protagonist, and quite likely for other people as well, although I haven't really been aware of that.

Perhaps psychodrama prepared patients for groups, in that they were more desirous of getting into sensitive areas, talking about them and working with the hassles they had, possibly because they saw that could be valuable for those who had done so in psychodrama.

Mrs O: Psychodrama could be used very valuably here. I think that we should have a psychodramatist coming in twice a week, and that it could be used in conjunction with role playing. I think role playing should be used in groups more spontaneously, and in individual interviews- and psychodrama should be a specialised thing which is used for some patients more than others, because with some patients I think it's more important than actual talking interviews -- almost like an abreaction. I mean, to get through you have to see how he /the patient/ is. He's not always what he says he is, and he doesn't know it. Psychodrama goes to the crux, whereas in talking he doesn't always get to the crux of the problem.

3. PERCEPTIONS OF DIFFERENCES BETWEEN ROLE PLAYING AND PSYCHODRAMA

Dr J: They are variations on a theme. In the analytic type of group /therapist/ is passive, in role playing the therapist is direct "I want you to do this". Psychodrama more /akin/ to analytic type. Psychodrama involves physical movements in exchanging positions with the patient to show them what to

do, bringing in extra people to support the person in their role, because he may be inhibited, shy, he has never done this before. You show him the way, and then he plays this role, and acts the physical movements as well.

Dr K: Yes. I don't know if one is worse, or better than the other. Psychodrama is more intense, it's much more emotive than role playing.

Dr L: From what I saw of psychodrama, both sessions were wonderful. Role playing didn't impress me at all. In psychodrama you get a patient to act out a situation which he has experienced, and which is bothering him in some way. In role playing he doesn't necessarily act out something that's on his mind.

Mr M: Psychodrama can be much more diagnostic than role playing. Role playing forces a patient to do something which he has been unable to do before, where the "acting" is much more directed, the "part" is much more structured, whereas the psychodrama gives more licence for the person's personality to come out. There is less direction, hence there is more of the individual pushed into the role.

Sister A: Role playing is interesting, but inevitably more superficial than psychodrama.

Nurse B: There is a vast difference. Role play can easily move into psychodrama, but it is kept mainly on an unemotional level. Mostly, it is role practise. It is necessary, but too much emphasis is put on it. The patients don't really get involved in role play. That frustrates me. Whereas psychodrama if handled correctly is deep, emotional. It is much more beneficial. It's a pity we've stopped psychodrama /post-research/. I think the patients are losing something very valuable.

The audience in psychodrama was much more involved than in role playing. Watching -- I was part of the audience for quite a few times -- I was involved. I felt with that person and I could identify. That's the most important thing. Those people (and I) could identify with what's happening in front of them, or they can reject what's happening in front of them. So, they are part, and they are benefiting from this thing, and also afterwards, they get the opportunity to share their emotions and why they are, or not getting involved. All right, you are getting one patient and his problems, but I think in reality you are handling audience as well as this case. I think you should see it in a broader light, not just what's the effect on the protagonist, but what's the effect on the audience as well.

Sister C: I find it terribly difficult to differentiate between the two, because so often when we have been trying to construct a role play of what we could do I've come out with suggestions which probably would be more suitable to psychodrama than they would be to role play, I am told. I realise that the role playing here is at a superficial level where the patient is just put into a situation where he asserts himself, or shows his anger.

Sister D: Protagonists tended to isolate themselves from the group at first. They took a while to get back into the group, because it was a very personal experience and it took a while for the group to accept them. I think because of the intense emotional experience which psychodrama initiates, they become isolated from the group because the group hasn't experienced what they have. They've seen it, felt the feedback, emotion, experienced an emotional feeling with them -- not as intense as the protagonist's. Group realises this and handles him with kid gloves. Therefore /I think/ protagonist covers up until returns to normal self.

Sister E: The after-effects of psychodrama. It was an incredible thing. They /the protagonists/ are too exhausted after /a session/ to talk. They were switched off in groups. They sleep well at night. As D (508) put it, he had the first good night's sleep after his session.

D (508) was completely different after his psychodrama. For example with the staff, they were much closer to him -- could understand more. When sharing his experiences outside of psychodrama, the staff could understand more -- see things in a completely different light. This is of course from the staff point of view.

Mr N: I could notice a change in their general level of involvement, particularly D (508), less clearly with K (602). R (706) was also involved. I don't know whether this was a response to psychodrama, or a function of her personality.

Mrs O: D (508) was particularly affected. He was very vivacious for the rest of his stay, and outgoing and so on. Mrs S (304) was much more down to earth afterwards and more dominant, less submissive. I don't think M (405) changed much.

5. COMMENTS CONCERNING POSSIBLE CRITERIA FOR SELECTING PATIENTS FOR EITHER ROLE PLAYING OR PSYCHODRAMA

Dr J: I can't think of any objective criteria, every patient different.

Dr K: It's a matter of desiring to work, gaining insight, and to do something about it. It's not a matter of intelligence. Mrs S (304), for example, had a genuine desire to work, M (405) had low intelligence, D (508) was keen to participate and let himself go and express the emotions. He was not clever.

Dr L: The patients who would benefit from psychoanalysis are the ones who would benefit from psychodrama, and the ones who are more suitable for behaviour therapy would not benefit from psychodrama.

Mr M: The more extroverted people would probably like to take part in psychodrama, because this is the type of thing that extroverts use in order to express themselves. But I think

that extroverts, by the very fact that they have chosen this would least benefit from psychodrama. But, if you could motivate introverts into psychodrama, I think the effect would be much more pronounced. The person who would benefit more from role playing than psychodrama is the fellow that has a very specific problem that really hangs him up and he needs this to get cleared out.

Sister A: Role play could be a "feeder", or orientation to psychodrama. Somebody you feel might be threatened by psychodrama, who might not have the ego strength to cope with psychodrama could cope with role playing.

For selected patients, for example those who might benefit from individual therapy, psychodrama would be valuable in working through. Particularly, for example, patients where divorce is on the horizon, or difficulties in handling children in a family which has not yet gone to pieces but shows strong signs of doing so. Selected patients can do psychodrama in conjunction with family work and conjoint interviewing to back up what you're doing. One can use psychodrama, I feel, with patients who function on a fairly concrete as well as abstract level. IQ is not important, provided the person showed a willingness to express feelings and be aware of feelings.

Nurse B: Not all patients are ready for psychodrama. I think there should be a screening. You should decide who would benefit more from role playing. I think, in the first instance, you should take into account the IQ of the patient. I don't think psychodrama is going to help very much with a person with a very low IQ. Secondly, you need to take the background of the patient into consideration -- see what happened to that person and if there are areas which should be explored.

Sister D: A person with a very high anxiety level at the beginning of treatment wouldn't respond too well to psychodrama. Whilst working through anxiety it would probably tend to increase anxiety in certain cases. I think they would probably respond better to role playing. Patients who have been in psychiatric treatment before and have progressed somewhere in treatment, or who have a high IQ, and have some insight into themselves would benefit more from psychodrama. They have progressed beyond the role play situation.

Role play can be very beneficially used to introduce people to psychodrama at a later level. Psychodrama for me, as a staff member was pretty threatening at the beginning, and for a patient who hasn't any background in psychiatry I think it could be threatening, and I think that role play can be very successfully used for probably all patients and some will graduate to psychodrama, and some will benefit from a more concrete level.

Sister E: Certain patients, depending on age, personality, intelligence might find it easier to grasp role playing rather than psychodrama.

Sister F: The person who benefited would benefit from either role

playing or psychodrama. I think the person who is going to adapt themselves to this kind of acting would benefit from either -- an extroverted rather than an introverted person, a person who can adapt to situations far more quickly. The quiet, withdrawn person will not, never participate.

Mr N: For certain kinds of people, and certain kinds of problems role play and psychodrama can be more valuable than anything else. For the more anxious and inadequate type of patient of lesser intelligence, and perhaps lesser motivation, role play is more valuable. They can take things on a nice, easy, concrete level, e.g., "I've got a hassle with expressing my anger towards my wife -- don't know how to do it, here I can practise it." I think for psychodrama you need possibly, the more intelligent, less anxious, less inadequate, and possibly motivated patients -- motivated you know more than just to stop drinking, but motivated to get to find out what emotional problems they have -- more insightful. That kind of patient is most likely to benefit from psychodrama.

Mrs O: Some patients could do with just role playing, and some patients could do with just psychodrama. I think perhaps the ones who, it's difficult to say, have a glimmering of an insight, they know they've got a big problem but they don't know why it is, they need psychodrama more. The patient can go to areas of unawareness and explore feelings, etc., whereas role playing deals with specific problems or situations.

6. COMMENTS CONCERNING PERCEPTIONS OF SPECIFIC VALUES OF PSYCHODRAMA IN ALCOHOLISM TREATMENT

Dr J: I'm not sure. I can see it having value with any form of patient. You can get a schizophrenic group which would be most revealing and quite an experience to try and do; diagnostic and therapeutic. They can relive hallucinations without being condoned or repressed. I see the psychodrama director as being of value in any psychotherapeutic atmosphere. I do not see any limitations to it. The same as group therapy, it must be under a therapist who knows what they are doing.

Dr K: It's one of the best ways of getting through the denial and the defences of the alcoholic, because it's quite sneaky. You know, the person who is the protagonist does not realise what he is exposing, or letting on. It is more revealing than in one-to-one interviewing. In verbal therapy people can deny more easily.

Dr L: Many patients drink as a tranquilliser, as a sedative. This means they have a lot of anxiety, and if they have a lot of anxiety there are also situations in their lives which bother them in retrospect where they were anxious and where they would have liked to do things they didn't do. In those cases, I think psychodrama has an important part to play.

Nurse B: Because the alcoholic usually finds it very difficult to express and to talk about emotions, and to communicate, I find

this /psychodrama/ gives him ample opportunity, once they are involved in it, to really give of themselves, and perhaps for the first time really face themselves, and realise what they are feeling and why they are feeling this. I feel it is very valuable in this specific area. You could do it each and every time, you know, get the person involved, but it would need a specially trained person to do that. I really think that in this area it would help a lot with alcoholics.

Sister C: That perhaps is where you put the emphasis. Is it on the alcoholism or on the fact that the patient has a problem? And I think I am inclined to be more oriented in the direction that it is the patient who has got a problem, not so much that it is the alcohol that is the major thing. However, it is a problem and that person has to try and work through that problem, whether it causes him to be addicted to alcohol or drugs or to anything else. The major thing is the concentration on the problem, and I think psychodrama can have a terrific influence on helping people to sort out and see what the problem is.

Sister D: You possibly can achieve insight more quickly because you're working through an active situation; role play takes longer.

Sister E: Problems in communication are often found in alcoholics. Therefore, because psychodrama is able to bridge communication gaps this is a big step in its favour. In denial as well, psychodrama seems to help. The person is facing the actual situations in front of him. They cannot deny, they have to act out. They always deny and minimise everything.

Mr N: Psychodrama is a way of getting through to patients, perhaps more effective than any of the other ways we use here. For the right kind of patient you get through to them, having got through to them and reached some catharsis, I think this catharsis can motivate the patient for further involvement in therapy.

Mrs O: Psychodrama is very valuable, and in terms of effect, judging from the people who have been protagonists it has definitely affected them afterwards. They feel more accepted maybe, and they feel more, they seem to accept themselves more.

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