Questions like these invariably provoke the late C.E.M.Joad's most frequent response - 'It depends what you mean,' - and indeed there are no firm answers. In a military or naval service situation the problem was simplified, in that an extremely sensitive and highly-strung boy would be unlikely to survive without personal damage the rough and tumble of life in the ranks or on the lower deck. Indeed, to some extent this applied to officer entry; alertness was called for but introspection could lead to problems. There were, of course, exceptions. I remember interviewing one highly intelligent young man for a National Service commission who was also 'a mass of nerves'. Remembering my training, I had scruples (which I overcame) about recommending him. In fact he did very well during his short period of service.

In general, I suppose one might safely say that the more intelligent and well-educated P can be happy and successful in many walks of life, but that difficulties arise in accommodating the less well-equipped person of similar temperament. However the class of P whose main characteristic is hypochondria does seem to encounter difficulties at almost all levels.

R. E. SHUTTLEWORTH

PSYCHODRAMA IN THE REHABILITAION OF CHRONIC LONG STAY PATIENTS

The term 'psychodrama' is used in the literature in two forms: One as an all encompassing term which includes under its umbrella sociodrama, role play and other 'action methods.' The other form is more specific. Blatner (1970) describes it as *a form of psychotherapy in which the patient or subject enacts his conflicts instead of talking about them.* The problem looked at is one in which the individual is privately involved.

In sociodrama the collective aspects of the problem are looked at, e.g. the social structure of a psychiatric ward. In role play the individual can look at ways of dealing with more specific problem tasks: e.g. applying for a job, being assertive. The 'action methods' include art, dance, games, play forms, guided fantasy, sensory awareness exercises, meditation and 'encounter' techniques.

I will use examples from work with chronic schizophrenics to illustrate some of these techniques later in the paper.

The technique is flexible enough to be applied from most theoretical viewpoints, ranging from that developed by the father of modern psychodrama - Moreno, with his philosophy of spontaneity, creativity, the moment and theories of role and interaction (Yoblansky and Enneis, 1956) through analytic applications (Polansky and Hawkins, 1969) to the behaviouristic schools, particularly those related to modelling theory (Bandura, 1970).

I use psychodrama with quite a wide variety of patients including disturbed in-patient adolescents of mixed diagnostic types, out-patient neurotics and chronic schizophrenics. With the two former groups I find it useful to work within the general

framework or the Group Analytic approach developed by Foulkes. With the latter I use a far more 'superficial' approach, aimed at the immediate problems of their institutionalisation and the means by which they can first want an independent existence and then hopefully achieve it. Hass and Moreno (1951) describe Moreno's 'socio interactional' theory of personality which I find very useful when looking at role play with chronic schizophrenics. Briefly they see a conception of self as a totality of social and private roles which the individual plays in his interpersonal and intergroup contacts. The way he plays these roles in relation to the counter roles of others and the several kinds of status he achieves in concrete social situations in which he is constantly responding gives him his uniqueness as a person. Moreno sees the ability to reach one's own role and the roles of others and then to produce appropriate role responses as a skill essential in furthering human enterprises. He suggests spontaneity as the basis of the therapeutic approach to unblock the factors causing us to misread roles. A person of low spontaneity will reflect his lack in stereotypes or conventional role playing, reading just enough of the situation of himself and of others to make a momentarily acceptable adjustment. The chronic patient can be seen as the far extremity of the stereotyped personality.

Moreno suggests various set role-playing activities not only as an action orientated projective test but also as means of teaching new roles and greater flexibility.

Some of the dilemmas of the chronically institutionalised patient have been covered in the previous paper. Goffman (1961) has provided one of the best sociological studies of the pressures that operate within an institution and the stereotyped behaviour that results. Dean and Hanks (1967) state that they are frequently impressed with the chronic schizophrenics' apparent lack of emotion. They see the schizophrenic as often representing the twentieth century's sickness of existential confrontation with nothingness and that treatment must attempt to link the intellect with emotions. They tried purely verbal techniques but found words too fragile and ephemeral to compete against the powerful screen separating the intellect and emotions. They claim that psychodramatic techniques managed to overcome this barrier.

Parrish (1959) describes similar success over a very short period using psychodrama with large groups of chronic patients. Success was measured by discharge rates and social interaction on the ward.

From my experience, weekly psychodrama groups cannot remove the more bizarre symptoms of schizophrenia, e.g. fixed delusional states or marked thought disorder, but they can help to overcome the imposed effects of institutionalisation, e.g. the heavy dependency upon the staff and the poor motivation to lead an independent existence. Psychodrama can help with the re-learning of previously held social skills and generally help the individual to regain contact with a world outside from which he has cut himself off.

I work as part of a team at Phoenix Ward, Long Grove Hospital which has been set up by Dr. G.H.B. Baker with the specific aim of rehabilitating chronic long stay patients. The ward was originally the sanatorium and so far smaller and cosier than the standard psychiatric ward and, within the limitations of its setting in a hospital, attempts have been made to deinstitutionalise it.

The twenty patients are all from the North East London catchment area and are selected from the back wards of the hospital using fairly loose criteria - i.e. they are usually no older than sixty, not intellectually subnormal nor burdened with too severe symptoms. Most have been hospitalised from between ten and twenty years.

The Unit has close links with the social services in the catchment area and we are very fortunate in having a very well established PRA who provide day centres and recreational groups, help to find accommodation as well as giving general support for the patient and his family on discharge.

Each member of the team is responsible for several members of the Unit. The patients are encouraged to work, preferably in outside employment, although usually they have to start at the level of ITU and ITO before moving on to less sheltered work.

As well as psychodrama the patients are encouraged to attend more verbal community group meetings as well as educational classes and social functions.

The psychodrama group meets once a week for an hour. We usually begin by sitting in a circle and discussing Unit events, e.g. imminent discharges, attempts to find employment or accommodation, conflicts that have occurred on the ward or outside. Often situations arise which will become the major theme of the group and will then be dramatised.

I find it difficult often to get many of the group out of their chairs for very long periods. This seems to be due to the combination of the security found in being seated as well as their poor physical condition as a result of their medication, lack of exercise and years of hospital stodge. The task is made much easier with a number of enthusiastic helpers (ideally one helper for every regressed patient). I am consequently attempting to recruit local college students to come on a regular basis to help particularly with physical warm-ups and non-verbal exercises which require movement around the room.

I will now briefly describe some of the techniques I have found useful and the rationale behind them.

Balance and Mirroring. A prominent feature of chronic patients is their poor physical co-ordination and body awareness. I have found standard balancing exercises as well as mirroring techniques can greatly help improve this difficulty. In the latter the group separate into pairs and one of the pair leads with slow movements which the other follows, starting with very simple movements and leading gradually to more complex ones. There is some empirical support in the Goodmayes experiment for the efficacy of this technique. In this study (Nitsun et al 1973) a group of twelve patients were selected for twenty-two weekly sessions of an hour's movement and drama. The movement contained elements of that described above but much more elaborate and the drama emphasised the symbolic non-verbal form. They were matched with a control group of twelve patients who were given group psychotherapy. Both groups were assessed before and after treatment using clinical ratings, psychological tests and social ratings. The results indicated general improvements in both groups suggesting a generalised effect of the extra attention given to these patients. However certain

changes were specific to the movement and drama group. These included improved body image; greater acknowledgement of impulses and feelings stemming from the more primitive part of the personality, a decrease in restlessness and aimless activity and improved social behaviour as well as positive changes in verbal and non-verbal intelligence.

Spectogram. Often a useful method of clarifying an issue in a simple way, e.g. the general progress of the members. One of the group is invited to place the others in a line from good progress to poor progress. Others will rearrange the group according to their perception. The group may then be invited to place themselves on the spectrum where they would like to be. Bob, who had been seen by the others as making good progress, placed himself down at the poor end. He was invited to represent the obstacles to his progress with chairs, placing the emotionally greatest obstacles closest to him. He was then asked to move 'outside' the group and group members role-played Bob, discussing each of the obstacles as they saw Bob perceiving them and what he could do about it. The Group then constructed another group of chairs to represent his positive features for progress. Bob included his 81 year old mother at the head of his group. He felt that he could eventually live with her. The team has always felt this to be unrealistic because of her age and their poor relationship in the past. Bob was asked to imagine a situation in which he approached his mother to ask her to take him in. I role-played the mother and the rest of the group were asked to double, i.e. take over our role by standing behind us if they felt we were not saying what we really felt or avoiding some of the issues. Eventually Bob was asked to role-reverse, i.e. play the mother while I played Bob. The Group finished with the Group looking at some of the issues raised.

This session illustrates a number of features of psychodramatic technique:

a) the use of simple props to help clarify quite complex feelings systematically. This is particularly useful with chronic patients where verbal means of communication is often poor.

b) The Group as a whole has a direct chance to empathise and share their common fears with each other and offer mutual support.

c) We ended by setting up a situation close to reality where the protagonist can examine a potential situation fairly realistically and experience direct involvement and support from the rest of the Group. The other participants will of course project a great deal of their own needs during the psychodrama which can help the therapist as well as the other Group members to understand them more adequately.

Sociodrama. A useful way of allowing the Group to examine their feelings toward treatment and the institution is to set up a staff conference with patients role-playing the various disciplines. I have been encouraged to find that whereas in the early weeks of the Group, when this situation was looked at, the staff were seen as all-knowing and in complete control of the patients' destinies, with the patient as the pawn, in later weeks, when we repeated the process, the patient was seen as having more to do with his treatment. Every effort is made in these sessions to reinforce the patient's ability and need to apply for his own job etc., rather than expect some hospital official to do

it for him. Often this sort of situation leads to role playing of job applications with other members of the Group playing bosses, secretaries etc. or doubling for one of the participants. Many real problems emerge from these sessions - e.g. How do you explain your long absence from employment? Do you need to explain what sort of illness you had? (The Group have decided that 'depression' is the most non-threatening diagnosis to give them.) By various members taking on the applicants' role the Group can help each other to decide upon the best approach.

Observation. To help the patients to become more attuned to others we will place a Group member in the centre and take it in turns to observe his physical features, purely at a descriptive level. As the more obvious features are exhausted, observations may lead to more personal ones, e.g. 'Your shirt is very dirty', 'Your appearance makes you look like you are from the nuthouse', 'Your trousers are too short.' The Group is then encouraged to say how the patient can overcome these various disabilities. (One patient stated after one of these sessions that he couldn't change his shirt more than once a week because the laundry was collected once a week and he only had two shirts. The possibilities of him acquiring more shirts and doing his own washing was put to him.) All the Group can benefit from direct methods like this, as physical appearance is a shared problem.

Plays. I find the Group enjoy fairly simplified improvisations, melodramas, trials, elections, meetings etc., preferably with them suggesting the subject. This has the advantage that all members can be given parts in which they can practise role playing in a fairly non-threatening way and if nothing else it provides an outlet for creativity which has probably not been exploited for many years.

In conclusion, I hope that I have managed to give you at least the taste of psychodramatic technique - I feel it is particularly suitable for chronic groups in achieving what Dean and Hanks describe as 'a true rehearsal for living.'

References:

Bandura, A (1970) *Principles of Behaviour Modification.* Holt, Rinehart and Winston. **Blatner, H (1970)** *Psychodrama, Roleplaying & Action Methods. Theory & Practice.* Private printing available for the author. **Dean, W.N., Hanks, V.A. (1967)** *Helping chronic schizophrenics to experience their true feelings by means of psychodrama.* Group Psychotherapy 17, p.3. **Haas, R.B., Moreno J.L. (1951)**Psychodrama as a projective technique (Chap.3) in Anderson H.H. and Anderson G.1. (Eds.) *Introduction to projective techniques.* Prentice Hall. **Nitsun R.M., Stapleton J.H., Blender M.P. (1973)** *Movement and Drama Therapy with Long Stay SchizophrenicssPR-8-M, (Accepted for publication in British Journal of Medical Psychology.)* **Parrish M. (1959)** *The effect of short term psychodrama on chronic schizophrenic patients.* Group Psychotherapy 21. P. 259. **Polansky N.A., Harkins E.B. (1969)** *Psychodrama as an element in hospital treatment.* Psychiatry 32, p. 74. **Yoblansky L., Enneis J. (1956)** *Psychodrama, Theory and Practice* in Fromm-Reichman F., Moreno J.L. (eds.) *Progress in Psychotherapy Vol. 1.* Arune and Stratton Inc.