THE USE OF PSYCHODRAMA TO DIMINISH TRANS-CULTURAL DISTANCE IN PSYCHOTHERAPY*

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INTRODUCTION

Since the end of the Second World War the number of foreign students, businessmen, scientists and scholars living in the United States for one to four year periods has increased dramatically. Separated from their native cultures and families, often under heavy work pressures, and relating in a foreign tongue, many of these foreign visitors develop psychiatric symptoms or frank psychiatric illness. When illness strikes, the therapist to whom they turn for help is often at a great disadvantage in treating his "foreign patient."

Several factors unique to the foreign patient's treatment situation tend to increase "therapeutic distance" and complicate the work of psychotherapy. Much of the difficulty may be related to the patient's own culturally based expectations of what therapy should consist of. For example, Morita therapy emphasizes bed rest, patient self-report by journal writing, therapist's authority, work, and an acceptance of what life brings—if it be anxiety, the Morita concept is that acceptance will handle it perfectly.[1] Leonhard, writing of the expectations of German patients, says that such an approach is totally unacceptable to that cultural group.[2] German patients, he emphasizes, expect to manipulate the phenomonological world by tangible interventive means, relying heavily on physical activities, prescribed medications and organic therapies.

Factors other than the cultural determinants of therapeutic method also play an important role in maintaining therapeutic distance. Suspicion, mistrust of foreign customs, and the notion that a foreigner no matter how well

* Some time ago the senior author had the pleasure of chatting with Dr. Moreno and at that time I recounted the case described in this paper and the success I had with the patient because of psychodramatic techniques. Dr. Moreno was equally enthusiastic and suggested I write up the case for publication.

** At the time the case cited herein was treated, the senior author was associated with the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Maryland.

1 Hiroshi, I. and Reynolds, D. K. "Morita Therapy: The Views from the West," *Amer. J. Psychiat.* 126:1031-1036, 1970.

2 Leonhard, K. "Die Japanische Morita-Therapie aus der Sicht Eigener Psychotherapeutische Verfahren," *Arch. Psychiat. Nervenkr.* 207:185, 1965.

educated cannot really understand one's problems also separate the foreign patient from his physician. The fear of disgrace if the patient's illness should become known to his countrymen and the notion of total isolation further increase the foreign patient's difficulties. When a language barrier exists, the patient often feels helpless due to the enormous frustrations of not being able to adequately express himself to his therapist.

The use of a modified form of psychodrama, in our experience, has been instrumental in decreasing the trans-cultural therapeutic distance and thus "permitting" therapy to take place. The goal of psychodrama with foreign patients is self-acceptance rather than the development of effective facades or the acquisition of an American style of culturally determined insight or behavior. Since the technique is motoric and requires active participation by both therapist and patient, it helps to establish the "therapeutic alliance" and provides the patient with a degree of control over his own therapy. The action of dramatic psychotherapy permits greater depth and breadth of awareness than is obtainable through verbal means alone. The following case is presented to exemplify the use of psychodrama with a foreign patient.

Case History

The patient was a male Japanese university professor in his late 30's on a one year visiting fellowship, who was admitted to the Henry Phipps Psychiatric Clinic following a suicidal attempt by wrist-cutting. The patient was described by both his wife and his colleagues as having been apprehensive, withdrawn and bizarre in his behavior for the two weeks prior to admission. On the insistence of an American colleague who had noticed his troubled manner, the patient had visited a local psychiatrist shortly before admission; the several visits were not, however, felicitous. At the time of admission he was living with his wife and two children in rented quarters; his youngest child had been born during his U.S. visit.

Communication with the patient was extremely difficult for the first several days after admission; during this time the therapist was using a conventional face-to-face interview technique. The patient was reluctant to speak and remained seclusive on the ward; during interviews he answered all questions politely, often with a smile, and nearly always answered "yes." At first this was attributed to language difficulty, but both his wife and his colleagues considered his English language ability as adequate for ordinary conversation. Whenever any mention of his behavior in the two weeks prior to admission was brought up, the patient principally remained silent or indicated that

he did not understand what the therapist was saying. Although the patient occasionally talked on very neutral data during these first sessions, it became clear that a conventional type of therapy would be entirely useless.

The format of the therapy session was then changed to one of modified psychodrama. Initially the patient was given a detailed explanation of what his role was and what a person with troubled or sad thoughts might reasonably expect from both himself and from a hospital. At this time, the therapist compared his own role to that of a computer (with which the patient as a physical scientist was quite familiar). In this model the patient was expected to furnish those thoughts and feelings that were unfamiliar, puzzling, or frightening to the computer; the computer would process the data and return information to the patient on his troubling thoughts that might clarify them. The patient immediately seized upon this model and for a number of hours engaged in a protracted, and much less guarded conversation concerning learning, problem-causing conflicts, models and roles. The computer concept was useful; as it finally emerged, the patient had not the slightest idea of the concept of thoughts and feelings leading to illness. Unlike the vast majority of patients treated with intensive psychotherapy, he lacked familiarity with the jargon and ideas of psychiatry that educated Americans so often learn from popular magazines and other mass media. For example, later in therapy, he shared with the therapist that he had been having auditory hallucinations of a persecutory nature. It had seemed perfectly logical to the patient that this should be combated by putting his fingers in both ears; he was puzzled and dismayed that, after hours of attempting this, no relief ensued.

After a number of sessions utilizing this computer model, the patient tended to compare some of the general concepts being discussed to some of his own problems. Following this initial advance it proved quite useful to have the patient assume other roles.

In bits and pieces garnered from the patient, his wife and his colleagues, it was learned that the patient had experienced a great deal of stress in the months preceeding his hospital admission. This stress was largely due to his guilt over frequent absences from work due to the birth of his second child and his wife's subsequent illness. The immediate crisis that had preceeded admission occurred during a formal presentation of his research findings. During this presentation the patient had been asked several difficult questions and, in one instance, a segment of his work was disputed. The patient had taken this as a severe blow; he had hoped, during his stay in the United States, to accomplish significant research and thus justify the faith his teachers had

placed in him. The result was a thought disorder accompanied by delusions of persecution, auditory hallucinations damning him and calling him insane, together with significant depression.

When this information was learned, the patient was asked to assume the role of student and to ask the therapist (in the role of teacher) the types of questions he had been asked during his formal presentation. This format was then changed to the patient's playing the role of how a student would ask similar questioning statements of a professor in a Japanese classroom. Following this, the therapist assumed the role of student and asked the patient to role play how a Japanese professor would handle such a situation, especially if the student was correct in his questioning. This role playing and role reversal continued through a wide variety of interpersonal situations of the type that the patient had found difficult. Much information emerged which helped explain why the classroom episode was perceived as such an ego blow.

Later, when the patient associated the classroom to a father-son relationship, the focus shifted to the traditional Japanese father-son relationship with the patient and the therapist alternating these roles. In every situation that was role played, comparisons were drawn between Japanese and American cultures.

Extremely helpful during the experience was the therapist's consultation with a psychiatrist born and educated in Japan, who illuminated the therapist's understanding of Buddhism and other aspects of Japanese culture.

The patient began to improve from the beginning of the modified psychodramatic treatment. He utilized information learned during the role comparisons of Japanese and American life styles in his conversation on the hospital ward; these conversations added to reality testing, enhanced verbal interaction and decreased loneliness. Despite his original suspicious rejection of drug therapy, the patient accepted Stelazine, 2 mg. three times a day as an adjunct after one week of psychodramatic therapy. Following approximately two weeks of role playing and role reversals, the hallucinations had cleared considerably and his apprehension was greatly diminished. At that time he was returned to his university position and he was maintained as a night patient; therapy sessions were continued during evenings. The patient was discharged before the end of his successfully completed fellowship period. A follow-up report from Japan received six months after discharge showed that the patient continued to function well.

Discussion

Section I: Motoric Interaction Unique to Psychodramatic Situation

The role induction interview[3] as described in the case history set the stage for therapeutic progress by clearly defining the format of therapy and the therapist's expectations of the patient. Once the psychodrama actually began the method itself seemed to decrease the patient's paranoid suspicions by giving him control over the flow of information and interpersonal boundaries. The motoric component of therapy provided the patient with a reality-based mirror of his own activity and de facto established his success in fulfilling his part of the therapy contract. His control over didactic and intrapsychic material coupled with the unconditional positive regard of the therapist permitted him to "teach and enlighten" his therapist about factors which he had previously felt were beyond the comprehension of a foreigner. As the therapist became more aware of the cultural determinants affecting the patient's illness, the patient's notion of trans-cultural isolation was diminished.

The drama provided objective evidence to the patient of developing social skills, thus reversing his pattern of increasing regression. As the patient incorporated the social skills learned in the psychodramas into his behavioral repertoire, his interactions on the ward improved dramatically. The drama helped the patient to test and validate his impressions of intra- and extra-psychic tensions and provided him with tangible evidence for his increasing feelings of being understood and supported by the therapist and the hospital staff.

Section II: Meaning to the Patient of Psychodramatic Interaction

The therapy employed in this case also permitted the patient to assume a "teacher" role; he took pains to familiarize the therapist with the cultural differences in school, home and other interpersonal interactions between the United States and Japan. Also, such therapy moved the patient into a familiar mode of relating, as his "normal" profession involved a great deal of teaching. As the patient felt more at ease with his teacher role in the therapeutic interaction, his feeling of self esteem increased and it was evident to the therapist that he took pride in his participation. His success in this therapeutic transaction appeared to give him greater confidence in socializing with others on the ward.

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[3] Hall, R. C. W. and Neuman, G. "The Role Induction Interview for Group Psychodrama" (in preparation).

Importantly, the modified psychodrama met the patient's need to produce in order to "feel worthy." He had been greatly troubled by his inability to comprehend what was expected of him in the hospital. Also, he felt a strong need to fulfill the expectations of his American colleagues by working at therapy. Here was a way that he could work hard within a defined role knowing that his productions were useful.

As the interactions increased with the therapist and the staff, the patient found his situation more understandable, his efforts goal-oriented and his isolation decreased. This in turn decreased his fear of insanity. Earlier, nothing had been understood; voices called out to him saying: "Dr. ___ is insane." Now, as his behavior could be seen as a response to stress, worry and lack of diversion and his efforts seemed directed toward easing that situation, the voices diminished, then disappeared within several weeks. The specific behavioral problems dealt with in the context of the psychodramatic therapy included the patient's persistent worrying, his lack of a hobby or any other diversion from his demanding work and his inability, especially during stressful times, to "step back" for a perspective of the relationship of some current problem with his hard, driving work pattern.

Section III: Meaning to the Therapist of Psychodramatic Interaction

Psychodrama allowed the therapist to transform a frustrating case into an enlightening one; importantly, it decreased the therapist's anxiety in dealing with a patient where significant trans-cultural distance made communication between patient and therapist extremely difficult. The experience enhanced the therapist's sense of worth as well as the patient's.

Once the initial impasse was breached, psychodrama assisted the therapist in defining realistic expectations for the patient, as well as gauging the pace of therapy. The therapist was able to deal with specific behavioral problems that were present and amenable to change without threatening the patient by confronting a total pathologic picture that seemed anchored in and reinforced by cultural patterns.

Section IV: The Effect of Psychodrama on the Patient's Utlization of the Hospital Milieu

The effects of psychodramatic therapy persist long after the actual therapeutic session ends. Participation in this form of therapy increases the patient's self concept and self confidence, promotes appropriate means of social interaction, and helps the patient's behavior seem less strange to those about him. As therapy proceeded in this case, the patient's interactions with the

hospital staff and other patients increased markedly; his physical isolation decreased and he verbalized his own increased confidence in dealing with social situations. He became less suspicious of those about him and began to actively involve himself in ward activities. Behavioral analysis of ward behavior showed an increase in his one-to-one interactions, increased participation in sports such as ping-pong, increased attendance and participation in the occupational therapy program and at ward community meetings. He experienced less fear of the hospital and began thinking of himself as a member of the ward rather than as a "foreigner imprisoned in a hospital environment." Thus, his increased involvement in hospital activities made him less dependent upon his therapist and more accessible to the influences of the total therapeutic milieu.

Conclusion

We feel that the use of psychodrama can be of great benefit in decreasing the trans-cultural difficulties in the treatment of the ever-increasing numbers of foreign visitors seeking psychiatric help in this country. The case discussed demonstrates (in one area) the value of psychodramatic principles included in the education of psychiatric residents; there are, of course, many other areas for its use. By increasing the patient's participation in therapy and giving him control over the therapeutic situation, by promoting the flow of communication between patient, therapist and staff, decreasing the patient's suspicion of foreign physicians and making the therapeutic milieu more available to the patient, psychodrama seems ideally situated to the treatment of foreign visitors.

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