Psychodrama and Reminiscence for the Geriatric Psychiatric Patient

RANDALL B. MARTIN
SALLY ANN STEPATH

ABSTRACT. Inpatients on a geriatric psychiatric unit were exposed to two forms of reminiscence groups: One in a traditional verbal format vs. one using psychodramatic techniques. Subjects were selected for analysis from groups differing on leader-rated action level. On rated functioning in the group, participants in the psychodramatic format tended to perform at a higher level. According to computer-monitored data from two groups, there was more leader activity in the psychodrama format.

AS PREDICTED IN 1959 by Rechtschaffen (1959), psychosocial interventions for the elderly have recently become the focus of interest and investigation. Traditional psychotherapy and cognitive-behavioral therapy (Gallagher & Thompson, 1982), and reminiscence (e.g., Lesser, Lazarus, Frankel, & Havasy, 1981) are modalities that have been reported to bring about positive change in such patients. A number of studies have investigated reminiscence phenomena, perhaps in part because they can be coordinated with a theory of successful aging (Erikson, 1963; Haight, 1986; 1988; Wong & Watt, 1991).

Group interventions using the above concepts have also been reported to be effective (Burnside, 1984). One group modality, psychodrama, has been discussed as a potentially useful method for the institutionalized and depressed elderly (Altman, 1983; Buchanan, 1982; Burwell, 1987; Carman & Nordin, 1984; Nordin, 1987). The use of drama therapy with the aged has also been discussed by Johnson (1985; 1986) and by Michaels (1981). However, only case-history and general information are presented in the above reports.

There has been increasing interest in assessing therapeutic processes (e.g., Beutler, 1990), both individual and group. Procedures have ranged from postsession ratings by group members, leaders, and observers, to ongoing computer monitoring (Fuhriman & Packard, 1986; Martin & Labott, in press). Although Moreno (e.g., Moreno, 1947; 1964) reported various process analyses of psychodrama, only sporadic attempts to deal with this com-

plex issue have been published subsequently (Boria, 1986; Clayton, 1977; Haas, 1948; Hare, 1976; Martin & Labott, in press). None of these studies involved work with the aged.

Combining research and clinical activity, particularly within areas such as the aged and psychotherapy, has perhaps been more apparent than real, in part because of the different priorities of researchers and clinicians. However, there has also been recognition that these two enterprises need to be integrated (Dies & MacKenzie, 1983; MacKenzie & Livesley, 1986). The present report represents an effort to accomplish this end: In a clinical situation where non-research and medical considerations were of the higher priority, therapeutic groups were begun and attempts were made to study and evaluate some of the group processes.

The techniques of psychodrama, often characterized as forms of roleplaying, are not tied to any particular theory and thus have the potential for use within different theoretical contexts (Kipper, 1986). Few studies, however, have involved comparison of psychodramatic approaches with other therapeutic procedures. Such information would seem necessary, not only to deal with such questions as cost-effectiveness but also to expand general knowledge about therapeutic processes.

In this article, we report the results of a pilot study whose overall purpose was to determine if psychodramatic techniques, particularly enactment of encounters, concretization of scenes, and role reversal could be applied effectively with elderly patients in an inpatient psychiatric unit in which the orientation was biological-medical. There seem to be little or no empirical data with respect to psychodrama and this population. In the present study, some psychodramatic techniques were used within a reminiscence context and were compared with a traditional verbal modality. It was expected that the action-oriented psychodramatic techniques would produce greater involvement than the verbal format (Buchanan, 1982).

The specific purposes of the study were: Apply psychodramatic techniques to inpatient aged; explore ways of assessing and describing individuals functioning during the group; and compare the traditional with the psychodramatic modalities on individuals' functioning in the group.

Method

Setting

The patients resided in a self-contained, 21-bed psychiatric-geriatric unit of a major medical center. The unit was administered according to a medical–primary nursing model. Activities deemed to be medical in nature were of the highest priority, occasionally leading to restrictions in patients' attendance or

removal from the groups. To an outside observer, the unit would be one composed of a group of elderly persons seated in a large circle, most of whom were engaged in solitary activities. Although supported and encouraged by the unit administration, the groups described in the present report fell into the lower priority category.

Subjects

Group members were recruited by the investigators immediately before each session and tended to be the higher functioning patients on the unit. Criteria for inclusion mainly involved the participants' willingness and ability to function in a group, as judged by the staff. The present report is based on a total of 53 patients (40 women, 13 men), ranging in age from 62 to 87 (median = 75; mean = 74). For approximately 95% of the female patients and for 76% of the men, the primary diagnosis was depression. Other diagnoses were dementia, paranoia, bipolar disorder, and schizophrenia.

Procedure

During the first 6 months of the project, in which approximately 20 group sessions were completed, the leaders practiced working with this population in the reminiscence and psychodrama format. The data to be reported were developed, following the initial phase, over a period of approximately 4 months, during which 14 group sessions were completed.

The groups ranged in size from 3 to 9; the modal size was 5 and the median size was 4.3. The number of sessions attended ranged from 1 to 8, median = 1.5, mode = 1. Each group lasted approximately 1 hour, meeting once per week. Structure common to all groups involved a short initial period in which each patient introduced himself or herself, followed by practice in the recall of the names. After this period, which typically took about 5 minutes, the theme of the group was introduced. Themes were developed from the list reported by Haight (1986), involving experiences throughout one's life. Examples included describing the house where one grew up, a memorable teacher, one's first job.

Traditional verbal mode. After the theme was introduced, patients were encouraged to describe their experiences, following the reminiscence format. Group leaders attempted to facilitate integration of these experiences and to encourage other group members to share their own issues and experiences.

Psychodramatic mode. After the theme introduction, patients were encouraged to describe their experiences as they had in the verbal mode. However, as soon as feasible, a patient's experience was translated into action. In this

case, the group leaders facilitated overt activity in the patient by setting scenes and choosing characters in these scenes from the group. Often, the leaders themselves served in these auxiliary roles.

The most frequently used psychodramatic technique involved the enactment of the theme in an encounter. For example, the participant described a person who had had a great influence on his or her life and then chose someone from the group to represent that person and a place in which an interaction between them occurred. Role reversals were common components of the encounters. Encounters involving a given patient ranged from less than a minute to as long as 15 minutes. Occasionally a playback mode was used when a group member was reluctant to participate. Although a few sessions in the psychodramatic format led to relatively intense therapeutic work, most did not go beyond the initial action. The psychodrama and verbal methods were alternated from session to session.

Group leaders. For about one-half of the groups, there were three leaders; for the other half, two of the three were present. One of the leaders was a unit nurse (female); one, a unit occupational therapist (SAS); and one, a clinical psychologist (RBM).

Measures

Immediately after a session, each leader rated the individual patients on an instrument under development, the Group Behavior Assessment Scale (GBAS) (Foran, 1986). This instrument obtained ratings on 4-point scales for eight dimensions of performance in the group: affect, anxiety, concentration, frustration, interaction, orientation, participation, and physical impairment. The higher the rating on each scale, the more functional the patient was in the group. (For example, higher affect scores represented more appropriate and facilitative emotion; higher anxiety scores represented less anxiety.)

Following each session, one of the leaders wrote a narrative description detailing qualitative aspects of each patient's participation. From this information, an index was derived that reflected the action level of the group, ranging from 0 (all verbal) to 10 (a high percentage of the time involving a psychodrama technique).

In three groups, one of the leaders monitored the participation of each member of the group by means of a notebook computer, using a modification of a procedure developed by Martin and Labott (in press). From this information, it was possible to extract estimates of the time each participant spoke or was involved in an active role; in addition, duration and frequency of periods of silence (of a minimum of approximately 2–3 seconds) could also be estimated from the data.

The original intent had been to obtain ratings from group participants. However, this procedure proved unfeasible, given patient reluctance, capability, and staff time restrictions. Although the data that were generated, with the possible exception of the computer-derived information, were developed by the group leaders and thus clearly were subject to biases, the data were deemed useful as rough but relevant indicators of the individual's and group's functioning. Furthermore, the group leaders were not equally disposed in favor of the psychodrama techniques.

Results

In this section, we deal first with the overall impression of the group process and its effects, as garnered from unsystematic interviews with staff and patients. Because two of the leaders were assigned to the unit as part of the treatment team, opportunities for obtaining information and evaluation were fairly broad.

Overall results. The groups were generally well received by the patients, leaders, and unit staff. Occasionally, patients were referred to the group for specific issues, but by and large the groups did not become an integral part of the unit treatment program. The groups were seen as more important by some staff than others, and rarely did the group process conflict with the primary model of the unit. The overall impression was that individuals who participated experienced both groups as positive and beneficial and that there was at least temporary generalization of interaction from the groups to the ward.

Empirical data. Interrater reliability was assessed for each of the eight GBAS dimensions and for the overall mean score. Product-moment correlations were computed for each pair of raters on each of the measures. Reliability between one pair of observers for the physical impairment dimension could not be determined because of the lack of variance in one rater's scores. For individual scales, the correlations ranged from .14 (orientation scale, Raters 2 and 3) to .68 (interaction scale, Raters 1 and 2). Medians of the correlations among the raters were .39, .48, and .40, ($ps < .05$). However, when mean ratings were used across dimensions, the correlations were substantially higher: Rater 1 $\times$ Rater 2 = .67; 1 $\times$ 3 = .67; 2 $\times$ 3 = .68. Thus, although some individual scale items were low in interrater reliability, the mean scores represented reasonable agreement with these kinds of data.

To examine the factor structure of the ratings, we used the data of the one leader who was present at all of the groups. A principal component factor analysis was performed on these ratings. One factor accounted for 52% of the variance. These results, along with the interrater data, suggest that the mean of the ratings is a meaningful measure for analysis.

Comparison of high- and low-action groups

To insure that the subjects to be compared had been in groups that differed meaningfully on the psychodramatic variable, we chose the subjects constituting the high-action sample from groups rated 5 or above on action level (n = 12), whereas those in the low-action sample came from groups below 2 (n = 20) on the action rating. When an individual had been in more than one group, only the first group assessments were used. On the GBAS scale, the high-action group obtained an overall mean of 3.2 (SD = .55), whereas the low-action group obtained a score of 2.6 (SD = .66) $t(30) = 2.39$, p = .02. Men and women did not differ on this measure.

A multivariate analysis of variance was also performed with the eight subscales as dependent variables. There was a near significant overall F: $F(7,34) = 2.20$, p = .058. Significant differences occurred on the interaction, orientation, and physical dimensions. Means and standard deviations are reported in Table 1.

Two of the computer-monitored sessions yielded usable data; one was classified as high in action level and one low. Table 2 presents duration and frequency of each individual's participation. In the high-action group, there were six participants; in the low-action group, there were four. As shown in Table 2, the major difference between these two groups was in the duration and frequency of silent periods and leader participation: In the high-action group, less than 1% of the time involved silent periods (frequency = 2%), whereas in the low-action group, the percentage of time was 7 (frequency = 15%). Complementary to the group silence differential were differences in leader participation: There was a greater duration and frequency of the leader's par-

TABLE 1
Means and Standard Deviations of High- and Low-Action Groups on Each Dimension

Dimension	Low action		High action		
	M	*SD*	*M*	*SD*	*p*
Affect	2.7	.65	3.0	.68	.21
Anxiety	2.6	.60	2.9	.75	.17
Concentration	2.5	1.00	3.1	.68	.12
Frustration	2.5	.87	2.9	.83	.15
Interaction	2.1	.75	3.0	.83	.01
Orientation	3.0	.80	3.6	.42	.03
Participation	2.6	.83	3.1	.75	.08
Physical	3.5	.47	3.9	.30	.03

TABLE 2
Duration and Frequency of Participation for Each Group Member in a High- and Low-Action Group

	Low action				High action			
GM	DUR	%D	FR	%F	DUR	%D	FR	%F
A	24.23	44	98	15	18.38	33	99	17
B	4.78	9	71	11	6.80	12	53	9
C	5.93	11	62	10	6.12	11	39	7
D	2.08	4	38	6	3.58	6	34	6
E		—			1.58	3	27	5
F		—			1.28	2	31	5
S	4.03	7	93	15	0.48	1	10	2
1	10.22	19	169	27	9.77	17	140	24
2	1.70	3	54	8	5.63	10	111	19
3	1.83	3	50	8	2.50	4	32	6
T	54.80		635		56.12		576	

Note. GM = group members; DUR = duration in minutes; %D = % total duration; FR = frequency; %F = % total frequency. Group members A–F = patients; S = silent periods; 1–3 = group leaders; T = total.

ticipation in the high-action group. However, patient duration and frequency did not differ between these two groups.

Discussion

The results are consistent with expectations that some aspects of functioning in a reminiscence group session would be higher when psychodramatic techniques are used than when traditional verbal techniques are used. Although many authors have implied such a result, this is one of the first studies to present data. The major dimensions on which the effects occurred involved interaction, orientation, and physical activity, suggesting that the psychodrama techniques not only facilitated interaction among group members but also stimulated attention. Given the tendency of this population to withdraw from social roles, increasing these functions is clearly desirable. Thus, psychodrama as a method of facilitating role re-engagement (Altman, 1983) receives support from these data.

Some qualifications need to be applied to conclusions drawn from the present data. First, the basic data consisted of ratings by the same investigators who conducted the group and, as noted, may reflect a bias toward the method. Second, the interrater reliability for some of the ratings was low, suggesting some ambiguity of meaning. Also, no information exists about the validity of

the ratings; on the other hand, the lack of validity information is common at this stage of investigation with respect to group process measures (Fuhriman & Packard, 1986). However, the data suggest that the overall score constitutes a useful measure because interrater reliability was reasonably high and because factor analysis yielded only one factor.

Although the difference in the mean rating was statistically significant, there was overlap between the groups, indicating that the specific procedure was not equally effective for all patients. Such a result is to be expected because the effect of a given technique is likely to depend on individual patient characteristics. There is a clear need to identify these characteristics.

The computer-monitored data suggested more active participation by the leaders when the psychodramatic techniques were used, a potential source of the patients' more functional participation. It is likely that the increased leader activity involved their participation as auxiliaries. However, there are also several qualifications to these data. First, information from only two sessions was obtained; a broader sample is necessary for confidence in the conclusions. Second, other factors—for example, the groups differed in size and in specific individuals—might have produced the same pattern. Finally, reliability of the definition of silent and active periods needs to be studied. In spite of these qualifications, this procedure has promise as a method of obtaining process data. For example, interactions could be monitored in a relatively straightforward way.

Should future studies replicate the above findings, questions regarding how and for whom these techniques facilitate involvement would still remain. Kipper (1986) has proposed possible mechanisms: Types of roleplaying were shown to differentially facilitate involvement.

Because less than one half of the patients attended more than one group, the life-review process could not be implemented as a continuing experience over several sessions. Had more patients attended repeatedly, then a more prolonged review could have occurred and comparisons between psychodramatic and traditional techniques would have yielded individual information on differential therapeutic effectiveness.

Based on our experience, we believe that the psychodramatic modality has promise both as an applied tool and as a research tool in contexts such as the present one. On the other hand, psychodrama requires uniquely trained leaders, and thus effort must be made to insure competence. Integrating this procedure with the unit philosophy is a crucial consideration because this group of patients presents an initial pattern of withdrawal and resistance. Although some patients may be generally responsive to reminiscence and enactments, their ability to intensify and heighten experiential components (Corsini, 1966) may be limited by both psychological and physiological processes associated with aging (e.g., Levenson, Carstensen, Friesen, & Ekman, 1991).

An important and seemingly neglected issue has to do with the empirical data on psychodrama outcome. Given the attention in the literature to comparative effectiveness of therapeutic modalities, it is important to obtain information on psychodramatic techniques and groups, including, most certainly, the elderly. Although clinical and case history reports serve a useful function, more sophisticated studies of process and outcome are necessary if psychodrama is to be perceived as a viable therapeutic option.

NOTES

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2. A portion of this paper was presented at the Third Congress of the International Psychogeriatric Association, Chicago, IL, August 1987.

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RANDALL B. MARTIN is a professor of psychology at Northern Illinois University in DeKalb. SALLY ANN STEPATH is a doctoral student at the Illinois School of Professional Psychology

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Address:
Randall B. Martin, PhD
Department of Psychology
Northern Illinois University
DeKalb, IL 60115-9892