BRIEF REPORTS

These brief reports were written by psychodrama trainees who have been working with Antonina Garcia, an executive editor of this journal. The editors of the journal invite psychodrama trainers to have their trainees write brief reports and submit them for review.

A Year of Psychodrama Training

Our group of 14 met for 2½ hours weekly. For the first 2 months, our director–trainer taught us various warm-up exercises and directed several of our own psychodramas. Then it was up to us to lend ourselves to the learning process.

At first, I thought I could only learn psychodrama from watching my instructor work as an experienced director–trainer. I was amazed and pleased to find out how much we in the group could learn from each other, acting as inexperienced directors, and trusting in our supportive process.

I learned to trust that each person's psychodrama would go where that person needed to go. I did not need to waste energy worrying about whether that person was having a deep enough experience. This was often borne out by how much happened in the protagonist's life in the week following the drama.

I began to relax and trust the reality of "tele" and its contribution to such aspects of psychodrama as the choosing of group members for particular roles and the members' capacities to be creative, astute, and empathic auxiliary egos. I became aware of the importance of the warm-up segment, not only to connect individuals to their issues but also to reveal group themes. I realized that the director has to keep both individual and group themes in mind while helping the protagonist flesh out the drama.

I saw how important it is for a director to believe that it is possible to construct a safe environment for any issue that is being explored. By this, I mean that the director must take the time needed to set up roles; to create actual safe places within the drama; and to work toward some sort of healing, empowering, and corrective experience.

I learned about the possibilities and responsibilities of the auxiliary ego. In these roles, I began to trust that I could work from a hypothesis and that I could offer statements that revealed what I was feeling in the

role with the reassuring knowledge that the protagonist was free to accept and reject, according to his or her needs.

I began to understand about the importance of the positioning of the director, who needs to be at once supportive of the protagonist and able to double with empathy, but who also needs to have enough perspective to see the entire drama as it unfolds. Moreover, the director must know when his or her issues are being evoked by the psychodrama and how to distinguish these feelings from empathy.

I continued to be impressed by the reality of the molding of our beings in the crucible of our families of origin. I recognized that one can experience the possibilities beyond these boundaries through psychodramatic renderings of past, present, and future.

I realized how useful props can be in providing concrete representations of issues first presented as vague abstractions. I want to begin to collect scarves, hats, masks, musical instruments, stuffed animals, or anything else that would contribute to this purpose.

I experienced the importance of motion and physical action to the uncovering of the protagonist's feelings and insights and realized that this physical energy is very powerful and has to be used by the director in close cooperation with the wishes, instincts, and intentions of the protagonist.

I became aware of the difference in quality and purpose between the personal sharing at the end of the psychodrama and the in-depth processing of the psychodrama the following week. For me, it was very satisfying to be able to explore all aspects of the drama from differing points of view. Our trainer was an important model here, one who demonstrated the power of "I statements" without judgment or advice and showed us how to discuss an inexperienced director's work with sensitivity to what was accomplished through intuition, creativity, spontaneity, and intelligence, in spite of the expected technical flaws.

I came to appreciate Jacob Moreno's contribution as the creator of the concepts and techniques of psychodrama in an era in which most of the medical profession were unprepared either intellectually or emotionally to understand the significance of his work. I am only sorry that he insisted on doing the English translation himself, because his insufficient knowledge of the intricacies of English vocabulary and syntax obscures his meaning and makes it necessary for others in the field to interpret him to the rest of us.

In the final meeting of the group, we reviewed all the psychodramas we had shared as directors, auxiliaries, and audience. We highlighted our favorite roles and moments. We acknowledged what roles and dramas we still wanted to experience. Many of us will have the opportunity to

continue our training for another year. It is exciting to imagine how far we can now stretch ourselves within the framework of trust, support, and enthusiasm for our own growth.

HELEN GREVEN

Discovering the Healthy Self: The Use of Future Projection in Acute Care Settings

The average length of the stay of inpatient hospitalization is 21–28 days. After patients have been assessed and referred, they may attend four or five psychodramas. Patients warm up differently to the groups, depending on size, population, and severity of treatment issues. Future projection has become a valuable tool in helping patients at all levels of treatment.

The technique of future projection of the healthy self offers a safe and structured means to work with the inpatient population. It helps the patients to build psychodramatic roles that will aid in their recovery process. Patients begin to build hope and set achievable goals. Aside from its treatment values, future projection also offers the psychodramatist a diagnostic tool and a measure for reality testing.

The therapist instructs patients to project what they will be like when they are healthy. It is important that the clinician chooses the descriptor for the projection carefully. Descriptors such as happy or all better can be misleading for patients. It encourages them to believe that once they have completed treatment they will always feel good. This sets them up for disappointment and relapse. It also sets the therapist up for negative projections and transferences. Healthy, as a descriptor, allows for more balance in the projection. It permits the patient more freedom in creating a definition for being healthy and aids in the development of hope.

In developing hope, the therapist should help the patient set realistic goals but should never disparage what the patient projects. Although some patients may not have realistic future roles, the fantasies projected can serve as a diagnostic tool for the therapist. For example, a patient may see himself or herself as receiving the Nobel Prize for discovering a cure for depression. This may not seem realistic but does display the patient's commitment to his or her recovery.

The qualities ascertained in the activity may be population warranted. Clinicians may wish to focus on disease-related issues for both treatment

and diagnostic reasons. For example, with eating-disorder patients, the clinician may want to find out the patients' ideal future body weights or how they are dealing with food issues. If a patient projects continued activity of eating-disorder behaviors, he or she displays diminished hope for recovery. This is important information for the therapist.

With patients who suffer from flashbacks and dissociative disorders, the clinician may question the frequency or severity in which these continue to occur in the future. A clinician may check to see if the patient is still in therapy and what other supports and coping skills the patient will be using. This helps both to explore the patient's expectations and to plant the seed for continued work. The focus of the projection depends on how the therapist wishes to use the information gained. I have found that patients respond well when they are asked specific questions about family, job, and relationships. For example, I may ask if they are in relationships and then ask them to describe their significant other. This gives much information about how the patient sees recovery and about the patient's ability for trust and intimacy. Questions about job and/or school help the patients to focus on their personal goals.

The length of time that the patients project for their recovery is important for both treatment and diagnostic reasons. Patients who give themselves a few years for recovery have a stronger base in reality. They also have a greater chance for integration of treatment and a more successful recovery. Patients who give themselves a hospital stay or a few months of treatment are less founded in the reality of full recovery and have a greater chance for relapse. Patients also reveal much in their aspects of dependency and intimacy. Patients may project a love interest as a necessity for recovery or project counterdependence. Adolescents often want a baby, which is indicative of their desire to be loved and have a corrective experience. Any information gained from these projections will help the therapist in future sessions.

It has been my experience that patients at all levels of treatment become stuck in the "when" and "why bother" phase. This is a time when they feel that there is no end in sight and that it is useless for them to continue to work. Future projection builds hope for these patients. Even the most traumatized patients benefit from imagining what they will be like when they have achieved their goals for emotional recovery. It is also a way for them to set concrete goals. Patients in acute stages of treatment are often indecisive and abstract in their goal setting. They make such statements as "I want to feel better," or "I don't want to feel this way anymore." Without having a concrete means of measuring their progress, these patients can easily become caught in the nothing-is-happening frame of mind. For patients who are stuck in their patient

role, it often helps to give them a more-concrete time frame for their projection. When they have achieved a goal, they can then repeat the exercise. It has been my experience that as they achieve these goals, their spontaneity begins to increase and they can eventually imagine the healthy self as a possibility.

Occasionally, patients are unable to project because of their hopelessness or suicidality. Future projection can be approached in a few different ways. As mentioned above, the therapist may wish to give time frames for the more hopeless patients. As with any patient feeling stuck, any movement within the role is beneficial. Future projection for a set time can help patients begin to set small, achievable goals. With each goal achieved, they can then set another. With each step in the process, the patient learns success, builds new roles, and increases spontaneity. Eventually, the patient may be able to project the healthy self. This may take more than one hospitalization or continued intensive outpatient treatment.

For patients who are suicidal, one may wish to suggest they enact what they would like their lives to be like if they continued to live. When patients are able to express this, I reinforce the fact that they're imagining a healthy, happier life could make that possible. Patients usually respond positively to this tactic.

Although I use it less frequently, I have found success in permitting patients to project their deaths. Adolescents, because of their limited sense of mortality, often enjoy playing such a scene out. This can lead to many other dramas, such as acting out the funeral or playing out situations similar to those in *It's a Wonderful Life*. Playing dead also allows individuals to use the voice they felt they could not use when alive. Once given voice and catharsis, patients generally decrease in suicidality. Future projection works well even in these seemingly hopeless cases.

Future projection serves as an excellent group warmup. When future projection is the result of the group warmup and patient's act hunger, it is extremely effective as the group activity. As with the dramas resulting from the "dead" projections, patients may wish to move into more intensive psychodramas. Individuals may find voice through their healthy selves. They enjoy enacting reunions so they can showcase their healthy selves. Patients benefit greatly by speaking to their healthy selves and asking themselves questions. They can explore what their journey will be like and what roads they need to follow. The healthy self is often confrontational and empowering to the hospitalized self. Patients usually leave the group with a new sense of direction.

Classical psychodrama during inpatient hospitalization can be difficult to achieve because of the acuity of the patients and safety issues. Future

projection has proved to be a valuable tool on many levels. The groups are always moved to action by the nature of the activity, and the activity almost always sets the stage for futire psychodramas.

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