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Experiences of Psychodrama Courses

PIRKKO HURME

ABSTRACT. I am convinced that each psychodrama instructor must form a personal relationship with his or her own views on psychodrama. This relationship, like all human relationships, presupposes a profound study of the other party and a fine tuning of the relationship from all angles. A working relationship cannot be formed unless one sees the other person as he or she really is. I shall relate my experiences in three psychodrama courses held in Finland for one week during the summers of 1983, 1984, and 1985, and describe how we lived during those weeks, what I learned from them, the questions they provoked, and the answers that were found.

PSYCHODRAMA COURSES are carried out in Finland in many ways, one of which is described here. The method was developed over three years as a result of cooperation between two instructors and will probably continue and change constantly with our experience.

The courses were carried out during these three years as *Ryhmatyo ry* (group work society) psychodrama courses. The course leaders were Piiju Laurio and I. We have both had psychodrama and group-work training. The 52-hour, live-in courses lasted from Monday to Saturday.

Participants

In principle, anyone over the age of 18 was eligible to attend the course, and consequently the participants formed a heterogeneous group in experience, education, and objectives. They came from various walks of life (therapy, social work, business); 70% to 80% were female, and ages ranged from 23 to 66.

The brochure describes the course as intended for "persons wishing to broaden and deepen their knowledge of themselves and others and develop their own creativity and powers of spontaneous self-expression" and "learn to use psychodrama as an instrument of group therapy, work supervision, human relations, or on-the-job training."

As an instructor, I try to satisfy the varying needs of the participants in such a way that the focus is on presenting psychodrama, enacting psychodrama, and, through this, analyzing the problem of the individual and the group. Methodological questions are treated normally in conjunction with processing. Processing frequently also includes an analysis of the dynamics of the individual or refers to group dynamics. In a psychodrama, the interpretation of the protagonist's role is always based on facts that come concretely to the fore and does not go beyond the events of the psychodrama.

Insofar as the course participants are interested in the applications of psychodrama, discussion has largely been restricted to evening sessions.

To summarize, the interest of the participants may be said to have determined the emphasis of the course and, on the whole, all those needs have been satisfied.

Dimensions of a Psychodrama Course

The psychodrama concept has, in my view, expanded over the years, with various dimensions emphasized at different times.

At a psychodrama course, an instructor is on genuine interdisciplinary ground and all aspects are sometimes difficult to take into account sufficiently. Initially, it was easiest for me, because of my work experience and psychology training, to remember the therapeutic emphasis. More recently, I have concentrated increasingly on the training aspect. I have stressed processing accuracy and the role of theory. Only during the past two years have I begun to recognize the importance to participants of the creative and artistic element, an element that gives them energy. This perception has increased my use of creative exercises during the courses and has also aroused my desire to study drama theory in order to improve the artistic level of my directing.

Methods

Health Check

From the point of view of the instructor, it is important to make some sort of preliminary diagnosis of the participants as persons and of the course as a whole. This information can be obtained through observation and is subject to change. Nevertheless, at the beginning of the course we hold a brief interview with each of the participants and refer to this as a health check. The state of the protagonist is analyzed in the initial interview of the psychodrama, but in the beginning we need an overview of

the course situation. Moreover, this arrangement also affords participants an opportunity of meeting the instructors in private at the start of the course without requesting this separately.

The following questions are usually asked:

1. Is there something about their physical condition that we should know? Are there any physical limitations to acting as a protagonist or auxiliary ego?
2. Is there something in their psychological condition that should be taken into account?
3. Is there anything else they wish to discuss at this stage?

Asking these questions, despite the fact that they may reveal nothing untoward, usually brings a feeling of confidence and security to the participants. The feedback obtained from the health check has been entirely positive. This preliminary information has been useful in forming an overall impression of the course and the interview has at the outset promoted contact between instructors and participants. Participants are also told that whenever they wish, they may speak to the instructors in private. This possibility has sometimes been made use of.

We also stress that a week's live-in course is not an alternative to a permanent therapy relationship, even though participants may feel a deeply therapeutic effect.

Lectures and Written Material

Lectures are held on the first and second day to explain psychodrama tools, the course, and sharing of psychodrama. The first three days, copies of general psychodrama outlines and summaries of the day's lectures are given out as evening reading. On the third day, articles on working as an auxiliary ego and acting as a double are provided. Other theory comes up in processing throughout the course, and psychodrama literature is also available.

Exercises

The aim of the exercises is initially to get to know each other, later to give proficiency in psychodrama work, to warm up the participant's own protagonist work and the audience, and to offer a means of releasing feelings aroused in following the psychodramas of other participants.

Different creative exercises also facilitate the participant's own psychodrama work.

Exercises are also necessary because they help to provide a versatile picture of the possibilities for using psychodrama. In the exercises, those who are unwilling to enact a full psychodrama may be protagonists.

For participants interested in using the psychodrama method in their own work, the exercises are suitable small entities with which to begin practicing after the course.

After the psychodramatic exercises such as social atom, role reverses, and stage building, it is often necessary to hold a sharing and conduct some sort of processing discussion, whereas creative expression exercises rarely require processing. If action sociometry is used to analyze the group situation or present the method, the emotions aroused must be considered. The use of sociometry frequently activates the need for psychodrama.

Psychodrama

This is the primary method for considering participants' problems. Some participants (often those with prior experience of psychodrama) know beforehand that during the course they wish to be a protagonist and sometimes know the subject in advance. Others would like to be the protagonist in several psychodramas, warm to the protagonist role as the course progresses, or are only interested in the method and are unwilling to be a protagonist.

Only 16 psychodramas can be enacted during the course. From Tuesday to Friday psychodramas are enacted at the morning and afternoon sessions in two different groups. Since not all the participants wish to be protagonists, it has been possible to keep to this same arrangement every year. This is fortunate, since from the point of view of the participants' receptiveness, two psychodramas a day appear to be the limit because exercises, also, arouse emotions. As a director, I have found that directing two dramas a day is suitable.

Satisfying the needs of participants interested only in the method is sometimes a problem. If they do not get the experience of psychodrama as a protagonist, how can they understand the method? If such a participant is chosen as an auxiliary ego for very stereotyped roles, or if he or she is not chosen at all, the individual's understanding of the question remains detached. This is regrettable from the person's own point of view and also from the point of view of psychodrama communication. Each participant communicates psychodrama to his or her environment after a course and what is communicated and how it is communicated are important.

In such cases, I have generally tried to discuss (at least on an intellectual level) the essence of psychodrama, recognizing that one cannot know this method before applying it to oneself.

Perceiving the significance and manner of sharing are things that participants must be taught through practice. We have begun by explaining the principle. During the first sharing we are giving guidance; after that we give participants a paper on sharing to read.

Small Groups

On the first day, groups of five or six persons are formed, according to the participants' own choices. These small groups, which are maintained for the whole week, are a form of support and prevent the emergence of isolated individuals in the course sociometry.

In the beginning, the small groups' feeling of belonging is promoted by giving them joint tasks such as inventing a name and trademark for themselves so that they are able to work together. At each evening session, the groups begin with a brief discussion on standard subjects—each member's feelings, expectations, and anything else. The small groups report the answers to the large group. Group reports give the instructors a general picture of the course situation at that particular moment.

The small groups usually take care of their own members. In the large group, even the most sensitive student thus has supporters from his or her own group who, more or less in the role of a double, propose matters on his or her behalf.

The small groups increase the students' feeling of security, provide contacts, and quickly provide the instructors with diagnostic information on the course situation. If a psychodrama is revealing, the small groups may be described as supportive.

From my experience, the limited use of small groups assembled once a day for a specific task or group report reduces "unnecessary" (a provocative but deliberately chosen adjective to which I shall refer later) psychodramas arising out of a need for attention and out of isolation. The need for encounter exercises from these motives also decreases. In this way, participants have more opportunities for solving problems that affect their outside lives.

Processing

Psychodrama processing is not generally carried out in the presence of the protagonist if the protagonist is a psychiatric patient. In these courses I have found that attempts to determine who among us is a patient and

who is not are generally indeterminate and fruitless. We have, therefore, carried out the processing with all the protagonists and have noticed no harmful effects. The protagonist can occasionally refuse to participate in the processing, but this is extremely rare and the instructors have not restricted participation.

The director tends to receive very little criticism of this nature, since many of the participants are first-timers. Thus, the director's authority is not threatened, even in the eyes of a protagonist who may be highly dependent on the instructor, and no situation that could threaten the feeling of security of such a protagonist arises. On the other hand, Finnish culture is not so authoritarian that the infallibility of the director is a condition of general security. When open criticism has been expressed, it has served only to increase confidence. The director must, after all, be able to accept criticism; recognizing this may also be good for the protagonist.

When I have felt that, as a director, I have failed to achieve a therapeutic effect, I have tried to express this in the processing in a manner acceptable to the protagonist. How things are expressed at this stage sometimes seems more important from the protagonist's point of view than what is dealt with. Responsibility for the implementation lies with the instructor. In the processing, the instructor should also teach the group to deal with the drama in a way that will not offend the protagonist, making the fine distinction between frankness and tactlessness.

Free time

A psychodrama course is an entity, a process that lasts from the beginning of the week until the end. The process starts when a person decides to register for the course or begins to consider attending. As far as the participants are concerned, the course does not end at the close of the live-in week. The effects may be felt for days, weeks, even months afterward. Some things may change permanently.

It should be clear that any line drawn between work time and free time is artificial. Both periods feed one another, affect one another; no line really exists for either participants or instructors.

When I have pondered the various elements of a psychodrama course: "psycho" = therapy, "drama" = dramatic art, and "course" = training, I have noticed that free time supports all of these elements.

During the last psychodrama course that I held, evening programs included, in addition to two sauna evenings, an extemporaneous picnic on a neighboring beach, a visit to a dance restaurant, and on the last night a party organized by the participants. All these events broadened, deepened, and facilitated the enacting of psychodramas. The participants' sponta-

neity in the restaurant, for example, led the rest of those present to participate in a common creative dance.

Free-time activity has a distinctly therapeutic and liberating effect on the more inhibited participants. In a safe course atmosphere, they find the courage to try things they were afraid of before. During a course, participants also seem to show a greater than normal interest in all forms of creative activity. Eyes are opened to beauty; participants visit art exhibitions during the brief daily break and spend a great deal of time outdoors. Dress and movement also become more free and creative.

On the basis of the foregoing, I have considered the importance of bringing a creative viewpoint to the implementation of a psychodrama course program. People are creative if they receive a stimulus. A story-telling evening was included in the program this year; its self-invented stories seem to answer this need. Dramatizations of fairy tales and stories also serve these needs.

Course Rules and Recommendations

A psychodrama course needs some definite rules. These rules are for the well-being of the protagonist and the participants and ensure the useful effect of psychodrama work. We have also made recommendations, but have not enforced them. These include:

1. In sharing, analysis of the protagonist's motives and emotions is forbidden; everyone speaks only of himself or herself.

2. After the psychodrama, the protagonist has a recovery period. He or she may rest, be excused from the remainder of the program, or receive special attention. The protagonist may not take on the strain of an auxiliary ego role immediately after his or her own psychodrama. Before the psychodrama processing, group members may not try to analyze the protagonist's situation or give negative feedback. The director keeps a closer check than normal on the protagonist's state immediately after the psychodrama.

3. Absences from course program events must be reported to the instructors so that they and the group know the reasons for this and no one is unnecessarily worried.

4. In a psychodrama, as much care as possible must be taken to ensure the safety of the protagonist and the auxiliary egos. The director must protect everyone from being hurt in violent scenes, in spite of the fact that some scenes may require that the protagonist actually be struck.

5. Personal matters that may come to the fore during the course are confidential. Other people's private business is not discussed with outsiders, and participants are requested to take a vow of secrecy. Everyone is, however, free to speak of his or her own experiences.

In addition to the rules, some serious recommendations are given to the students:

1. Drinking. In Finland, heavier than normal drinking frequently occurs during free time on courses (and not only psychodrama courses). Many people try to alleviate anxiety and difficult emotional processes through drinking. Since alcohol and psychodrama are not compatible, we have considered it necessary to make this clear at the beginning of the course.

2. Sleeping. An adequate night's rest is advisable despite the fact that it is pleasant to stay up late talking with other participants, for the psychodrama course demands mental and physical strength. For some, late nights increase the danger of psychosis, and it may well be an alarm signal if a participant persistently keeps late hours. The director should watch such persons more carefully to find out whether they are aware of reality.

3. Contacts outside the course. These are permitted, but course time should not be overloaded with external matters, since this disturbs concentration. It is difficult to report to friends and members of the family during the course if they ask questions, and this easily leads to arguments and misunderstandings.

Conclusion of the Course

In one week a participant lives through many emotional experiences and perceptions that, if measured in time, could correspond to years or decades of his or her normal life. The participant's family has possibly not spent this time as intensively, but is eager to hear about the course. On the other hand, psychodrama is a subject that is extremely difficult to communicate properly to someone who has no experience in it. This may be frustrating for both parties.

These points are explained to the participants on the last day of the course. We recommend that they not discuss the course in great detail until a couple of weeks afterward. Then their own experience has become more ordered and sharing it with someone else no longer detracts from it. One is then also less sensitive to possible thoughtless feedback.

Should participants be disturbed by course questions afterward, they can telephone the instructors after the course is over.

Group Dynamics of a Psychodrama Course

General

In a psychodrama course, it is the individual's dynamics that come to the surface. It is not a question of the study of group dynamics as such, even though psychodrama is group therapy and familiarity with and recognition of group dynamics are part of the director's work. Handling group dynamics is an essential prerequisite for the success of the course. The instructor's actions must be adjusted to the group situation, though this aspect frequently goes unobserved by the students.

The work of a psychodrama course director is a balance between warming up the consideration of problems and relieving tension without forgetting humor and fun. It is also a question of creating sufficiently safe conditions for psychodrama work for a heterogeneous group in which everyone's experience is significant. This is not an easy task.

The instructor must be able to see every aspect of the course: the individuals, the small groups, unofficial groupings (pairs, cliques), the large group (the entire course), interest groups (present—the course center staff and students of other course members, and absent—participants' families, employers, friends). The instructor comes indirectly or directly into contact with these groups and in his or her behavior must take these factors into account.

Methods

We have made regular use of certain methods in order to acquire a knowledge of the group situation or to handle the group:

(a) Health check and use of small groups

(b) Continuous, almost automatic study by the instructor of nonverbal expression (gestures, expressions, the language of proximity and distance)

(c) Playing the part of a double for a withdrawn person or one who otherwise finds it difficult to express himself or herself

(d) Psychodramatic techniques such as role reverses and the use of an empty chair

(e) Fantasy trips containing positive suggestions

(f) Sociometric techniques

(g) Movement, dancing, music

(h) Different rounds of questioning in the large group, saying "tell how you feel physically and mentally at this moment, using a scale 1–4," or "tell how you feel in ten words" is another useful technique. A feeling of malaise can be eased or made concrete as a need for psychodrama or some other analytical discussion when it can be expressed. This round may be nonverbal or expressed physically. It is also important to pay attention to symbolic expressions, since these can reveal a weakening of realities.

These means do not always help solve the group's problems, but extensive use at least guarantees that the instructors become aware of what is going on in the group.

Protagonist Selection

Everything that is done has an effect on the whole group, including selection of the protagonist and division into two psychodrama groups. Here are some practical examples, observations, and conclusions:

(a) The protagonist may be chosen by the director or the group, but it is the director who decides who shall do the choosing. This is to be done after evaluating the whole group. The director's decision may lead to jealousy, competition, desire to cooperate, or satisfaction, but it always has an effect. Psychodrama is group therapy; when the director appears to be working with the protagonist he or she is, in effect, always working with the whole course.

(b) In these courses, two instructors direct psychodramas at the same time in different groups. The large group is divided into two at the beginning of each psychodrama session. In the session the groups experience things that increase closeness. This is repeated in different compositions and has a positive, unifying, security-building effect on the dynamics of the whole course.

(c) The course has regular small groups that assemble at the beginning of the evening session. Some exercises are also done in groups of the same size (four to six persons), but the composition of these groups is not always the same. This avoids the members becoming too attached to one

another and becoming isolated units, which adversely affects course activity.

(d) The interest groups of a psychodrama course must be taken into account, since they can affect course events in different ways. In a psychodrama course, one lives as part of the environment and according to the rules of one's own psychodrama world.

Pseudopsychodrama

In both the large and small groups, interaction activates different emotions, which may lead to a psychodrama need. The confidence and security that are the preconditions for psychodrama work are created, or fail to be created, in the group. For some, the large group is oppressive because it activates unpleasant memories or is distressingly large and they cannot identify with it. For others, the small group may be oppressive because of the person's own history or as a result of unclear relations between group members.

Where does the psychodrama material originate when it appears to be activated spontaneously and not premeditated at the beginning of the course? Is it always a question of today's situation activating an irritating emotional memory? Generally this is the case, but there are also interesting exceptions.

Let us take a more detailed look at these exceptions. I have already mentioned that sociometrically isolated persons with manipulative behavior may find themselves protagonists in a psychodrama or encounter arising out of a need for contact and attention, rather than from a genuine desire to face the problem in question. If such a psychodrama deals with the person's problem at a profound level (revealing the person's basic psychodrama motives, such as isolation) and not merely at surface level (remaining at the level of the problem initially presented by the person, even though this is not relevant and merely conceals the true problem) no damage is done and the protagonist may benefit from the work. Sometimes, however, the protagonist is so defensive (or the director so lacking in understanding) that a "pseudopsychodrama" is enacted.

In a pseudopsychodrama, the instructor agrees to enact a psychodrama originating from motives such as those just described that fail to reveal. It does not peel the subject as one peels an onion, layer by layer, but remains at the first defense level of the protagonist.

The depth of psychodrama work is always determined by the preparedness of the protagonist. I do not wish to call this into question. However, in special cases where the protagonist is in a psychodrama

originating solely from other motives, the director should at least try to make these motives clear.

If in such a case the psychodrama does not reveal anything to anyone, this is because of the director's incompetence. The situation may also be affected by the group's defensiveness and transference. The group or the protagonist (or both) may try to punish the instructor by setting a trap: Now make a psychodrama of this subject. Motives such as these tend to be rather unconscious.

Despite all precautions, and even though this should never happen, the protagonist may find himself or herself in a psychodrama prostitutionally. By that I mean with no personal contact with the subject, drawn by complicated group phenomena or to please or punish the director. It may then happen that the director directs in good faith or with a sense of foreboding, the protagonist experiences or appears to experience different emotions, the group follows the situation with interest or astonishment. If the protagonist also appears to experience relief, even though it is not real, the result is generally a later feeling of malaise in the protagonist and the group, as well as strong feelings of deceit and hostility. One difficulty in teaching is how to avoid prostituting psychodrama, leaving it at a false and superficial level when it seems that something can always be done with it.

Sometimes a psychodrama begins as a pseudopsychodrama but develops into the real thing. This is possible if the director realizes what is happening and agrees with the protagonist to enact it at a deeper level. I, for instance, once directed a psychodrama that began as a pseudopsychodrama from a repairing experience and ended as a real psychodrama—murder, the committing of which was a highly liberating experience for the protagonist.

In a pseudopsychodrama, the director either semiconsciously or through incompetence agrees with the protagonist to enact a psychodrama that fails to deal with the actual problem and makes no attempt to be revealing. The protagonist often directs such a psychodrama from uncommunicated defenses and the director surrenders his or her position. Generally this also happens at the wish of the group. Everyone's treachery against everyone leaves the whole group with an unpleasant taste of deceit and hostility.

In what I have said, I have no desire to underestimate or question the fact that a psychodrama should develop on the protagonist's terms. I merely feel that the director should recognize the situation if it occurs and let both the protagonist and the group know what is happening. This should be done gently and in an acceptable manner. It is the director's duty to try to make the drama revealing, even if it is not possible to pro-

gress otherwise. Sometimes making the situation known may occur only during processing. The main thing is that it does occur, or at least that an attempt is made to ensure this.

The Course Lifespan

Group dynamics also involve taking the lifespan of the course into account. At the beginning of the course, participants are on the alert and uncertain. They don't know one another, the instructors, or the method. At this stage, participants generally tend to ask a lot of questions about psychodrama theory; they have had no experience yet. Things are dealt with on an intellectual level, since this seems safer. The course program fits in with this phase. It includes lectures, discussions, and the distribution of study material.

On the second day, the course begins to get under way and to make the first plunge into the world of psychodrama. Theoretical questions begin to get practical answers. Rather quickly the whole course begins to come to grips with psychodrama work, though there are individual differences. There is a transfer to the emotional level, from which organized discussion and processing provide only a momentary break.

During the fourth and fifth days, there is a gradual move toward end-of-course work and a feeling of sadness that the course is ending. Psychodrama work continues during the day, but the evening program and organized discussion also deal with winding up the course. Acceleration of the emotional process gives way to a deceleration. On the final day the general tendency is to discuss how best to behave in everyday life immediately after the course.

A Psychodrama Course and the Bionic Frame of Reference

The group dynamics of a psychodrama course may also be studied on the basis of a bionic frame of reference as the forms of expression of a working group or basic assumption group. A working group's function in a psychodrama course is to study psychodrama using the method for the treatment of subjects chosen by the course members. I have observed all the forms of expression of a basic assumption group in a psychodrama course, with slightly different emphasis in different courses.

Pairing and associated messianic expectations may be seen as related to the instructor pair and to pairs formed by course members. The course members frequently form pairs on the basis of profession, such as psychologists, doctors, artists or businessmen, or romances, pairs that spring up between course members. The rest of the course follows the behavior

of the pairs and projects on these their hopes and expectations for a solution to the problem of the individual and course cooperation.

Occasionally a surprisingly harmonious and unanimous atmosphere seems to pervade the course (apparent unanimity), and this may affect work positively or negatively.

The flight-fight phenomenon reveals itself in many ways. It appears in each psychodrama and also in the large and small groups as a continuous movement: defenses advance and retreat, turn and turn about. The flight-fight phenomenon can also be seen in the attitude toward the instructors and their competence. They are feared and retreated from, sometimes attacked, and their competence is called into question.

Charismatic leadership is always an offshoot of the psychodrama method. First, because the method is such that even a director with only modest talents appears skillful to a beginner. Second, psychodrama also demands a certain charisma of the director and every director has at least some of it. Protagonists who have experienced relief frequently project their feeling of strength onto the director, and the group is given further cause to see the director in a positive light. From the director's point of view, this is one of the pitfalls of psychodrama.

The Role of the Instructor and Cooperation

The role of a psychodrama course instructor is broader than that of a psychodrama director. It includes the roles of psychodrama director, instructor, and several others.

I will not go into the director's work during the psychodrama itself, but will try to give a general idea of the many subroles of a psychodrama course instructor and touch briefly upon phenomena related to these.

In a classic psychodrama, a director is drama therapist, group therapist, stage manager, theatrical director, and psychologist. A psychodrama course instructor is also a lecturer, instructor, work health nurse, group worker, free-time supervisor, sociometrist, teacher and certificate issuer, transference object (more often positive than negative), and a foreign minister responsible for handling relations with the course center staff and other interest groups, since courses have been held at a training center where several other courses were going on at the same time.

The roles are many and the most fascinating and difficult is that of drama director. This is also a role on the performance of which reliable feedback is not forthcoming from inexperienced course members. Processing in which the work supervisor is not present is less rewarding from a director's standpoint. Self-criticism should be remembered even if the feedback from course members is positive (as it frequently is). Discussion

with one's fellow instructor on directed psychodramas is important so that one's self-concept does not become unrealistic.

Since two psychodramas are being enacted simultaneously and both instructors are acting solely in the role of director, they cannot work as auxiliary egos. Thus, the instructor misses the spontaneity and stimulating impact of auxiliary ego work. Nor can the instructor receive support from the other director when he or she is directing. For this reason the instructors should spend their breaks together discussing and formulating their experiences. It is particularly important that they support and warm up one another, since the director also needs care and attention. The director operates with the group's energy and has the use of this, but the support of a colleague doing the same work is still important.

Before the morning and afternoon psychodramas, the whole group spends a short time together, possibly performing a joint warming-up exercise, splitting up into two smaller groups again for the psychodramas. The whole course spends the evening session together and the instructor should also, for diagnostic reasons, see everyone in one place at one time. The large-group evening session is also good from the point of view of the instructor's own education, since he or she can observe the other director's way of directing exercises and the large group.

Creating Confidence

An interesting aspect of the work of a psychodrama instructor and director is how to create the confidence and necessary feeling of security among the participants and in the group. Confidence that nothing bad will happen when one encounters unknown matters in a psychic reality is a condition of psychodrama.

Creating this confidence takes time; some sort of probing is always a feature of the initial phase of a course. With every protagonist, the director is up against the same problem and every new psychodrama group needs to feel confident that the participants can work together.

Warming-up exercises contribute to the creation of confidence, as does the initial interview, but one faces the same problems throughout the psychodrama. To a considerable extent, how the director achieves this feeling of confidence is based on emotional and relationship factors, not so much on external factors and techniques. It is a question of both the director's relationship with the protagonist and the group and his or her relationship with himself or herself and psychodrama. If the director is to inspire confidence, he or she must have confidence in the psychodrama process. In a psychodrama, one is on constantly changing and frequently unknown ground in the subjective world of the protagonist. A

director who has confidence in his or her own abilities but not in the source value of the external world and the process is unrealistic and will not survive in the protagonist's world. Self-confidence is necessary, but it is not enough, since psychodrama is interaction.

The director's ability to form a close relationship with both the group and the protagonist is a condition for being able to influence these therapeutically. This feeling of closeness can be formed only if there is no fear and if confidence is built up. What makes it possible for the director to get really close to the protagonist, the participants, the group, other people? The instructor must have no internal inhibitions. When working, this person must be at peace with himself or herself. This presupposes a knowledge of his or her own way of working and the ability consciously to push personal problems into the background.

In conclusion, the director's internal world with its significant relationships and the protagonist's world with its significant relationships will always stand between director and protagonist. The borders of another person's world cannot be crossed completely, nor can the director overcome subjectivity, except during those amazing moments that J. L. Moreno describes:

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

Einladung zu einer Begegnung. Vienna 1914.

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The Measurement of Social Support: The Use of the Social Support Questionnaire as a Means of Examining Differences Between Acute and Chronic Hospitalized Psychiatric Patients

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ABSTRACT. This study used the Social Support Questionnaire to examine the perceptions of two groups of hospitalized psychiatric patients with regard to their social support system. The findings indicated that the chronic group of patients more frequently reported perceptions of supportive others in a more unrealistic fashion than the comparison group composed of acute psychiatric patients. Some important therapeutic implications are discussed in relation to the results.

THE CONCEPT OF SOCIAL SUPPORT has increasingly become the subject of attention among social scientists from various disciplines. Empirical efforts to study the phenomenon have greatly intensified, as is shown by major research findings in the area (Henderson, Duncan-Jones, McAuley, & Ritchie, 1978; Mitchell, Billings, & Moos, 1983; Norbeck, 1982; Sarason, Levine, Basham, & Sarason, 1983; Tolsdorf, 1976; Turner, 1981; Vaughn & Leff, 1976; Williams, Ware, & Donald, 1981). Even though the study of social support and such related concepts as social networks and social bonding is quite popular in the recent literature, this certainly does not reflect the discovery of new ideas (Turner, 1981). In fact, in the field of sociology a major focus has always been on investigating and analyzing basic social systems and structures, such as the formation, maintenance, and termination of relationships in both primary and secondary groups (Henderson et al., 1978; Hammer, Makiesky-Barrow, Gutwirth, 1978; Turner, 1981). In addition, the role of social

support or some form of meaningful social contact with another person has a tendency to lead to higher levels of physiological and psychological well-being while simultaneously defending against stressful life events (Cassel, 1974, 1976; Pilisuk, 1982). Furthermore, supportive others are able to play positive roles in terms of better psychological adjustment and health to those persons in need of assistance (Brown, Bhrolchain, & Harris, 1975; Henderson et al., 1978; Norbeck, 1982; Turner, 1981). Henderson (1977) and his research associates (1978) firmly believe that a number of mental disorders are closely related to deficiencies in social relationships or attachments to others (Bowlby, 1969, 1973, 1977), and that psychiatric problems and conditions can be corrected through caring and supportive relationships offered by others.

At the present time, it appears that the primary elements within the global concept of social support (and the related term social networks) are the individual's perception that: (a) there is an adequate number of available others to whom one can turn during periods of emotional, social, and psychological turmoil (Sarason et al., 1983); (b) the available supportive other (or others) is satisfactory (Sarason et al., 1983); (c) the quality of relationships established within a social network is positive (Gottlieb, 1983; Norbeck, 1982), or if negative they can be modified (Hale, 1981; Moreno, 1951); (d) the relationships within the social support system are relatively stable over time (Norbeck, 1982; Pilisuk, 1982); (e) interpersonal relationships with others (whether dead or alive, real or fantasized) are that individual's personal sociometry (Moreno, 1951); (f) situational properties influence the availability of supportive others (Norbeck, 1982); and (g) the meaningful others express positive affection, affirmation, and give assistance when needed (Kahn, 1979). These key ingredients in the social support equation may vary in accordance with their importance to each person and must take into consideration individual personality differences and concomitant societal and cultural conditions. For example, some people may require a large number of supportive individuals within their social network in order to function satisfactorily, whereas others may only need one or two persons to be satisfied (Henderson, 1984; Norbeck, 1982; Sarason et al., 1983).

The authors believe that persons who are judged to be seriously mentally ill and subsequently hospitalized may demonstrate different degrees of satisfaction with available others (Brown et al., 1975). They may require certain numbers of people to assist them through stressful periods in their lives. Furthermore, we believe that measurable differences exist between patients who have been operationally defined as "acute" and "chronic" (Cohen & Sokolovsky, 1978). These differences will largely determine the individual's level of motivation to return to the commu-

nity, based on the perception of accessible meaningful others, or the belief that his or her social support system is more hospital based, which leads to behaviors that are more institutionalized, such as withdrawal and isolation (Jaco, 1954; Kohn & Clausen, 1955; Vaughn & Leff, 1976).

This study was an empirical investigation using an interview method (Norbeck, 1982; Post, 1962; Vaughn & Leff, 1976) with the Social Support Questionnaire (SSQ) (Sarason et al., 1983) to determine which social support variables could discriminate between an acute and a chronic group of psychiatric patients. Even though a number of research hypotheses were generated owing to the exploratory nature of the work, our study concentrated on the question: Are there significant differences between the two groups of patients in terms of their total number of kinship choices (both realistic and unrealistic); total number of nonkinship choices (both realistic and unrealistic) from the community; and total number of nonkinship choices (both realistic and unrealistic) from the hospital?

Social Support Questionnaire

At the present time, a number of assessment instruments to measure social support are available. Some of the more frequently used are (a) the Social Support Network Inventory (Flaherty, Gaviria, & Black, 1981), initially used on patients with affective disorders; (b) the Social Atom (Moreno, 1951), a projective paper-and-pencil device that examines a person's subjective perceptions of others in different roles (real/fantasized, dead/alive) in one's life; (c) the Social Network Measure (Mitchell, 1982), which examines the number of intimates and average support from family, peers, and others; (d) the Norbeck Social Support Questionnaire (Norbeck, Lindsey, & Carrieri, 1981), which explores multiple dimensions of social support such as affection, affirmation, and assistance; (e) the Social Assets Scale (Luborsky, Todd, & Katcher, 1973), which measures interpersonal assets and liabilities; (f) the Interview Schedule for Social Interaction (Henderson, Duncan-Jones, Byrne, & Scott, 1980), which assesses the availability and perceived adequacy for any person on a number of facets of social relationships; and (g) the Social Support Questionnaire (Sarason et al., 1983), which examines an individual's perceived number of social supportive others and satisfaction with the social support that is believed to be available.

Of all the instruments described, the Social Support Questionnaire (SSQ) emerged as the authors' preferred measuring device, based on the psychometric properties of the instrument and the target sample of subjects under investigation. The SSQ consists of 27 items, each of which asks a question that requires a two-part response. Each item asks the

respondents to (a) list any persons whom they perceive as reliable sources of social support, given certain specified circumstances, and (b) indicate the degree of overall satisfaction obtained from the supportive others chosen (Sarason et al., 1983). The SSQ yields four basic scores: (a) the SSQ-N score, the number of supportive persons listed by the subject; (b) the SSQ-S score, the perceived degree of satisfaction available from the supportive others selected (a score of 6 indicating very satisfied, 1 indicating very dissatisfied); (c) an overall SSQ-N score for the total number of items calculated by dividing the sum of N by the number of items (27 in all); and (d) a total score for the entire number of items, which is found by dividing the sum of S by the number of items (27).

A number of studies were conducted to determine various psychometric properties of the questionnaire. The principal investigation was conducted with a sample subject pool of 602 undergraduate college students. The results indicated an alpha coefficient of internal reliability of .97 for the SSQ-N score and .94 for the SSQ-S score. A test-retest correlation at a 4-week interval for 105 of the original respondents yielded an N score of .90 and an S score of .83. Furthermore, a factor analysis for the N and S scores indicated that 82% of the common variance was accounted for by the N score and 72% by the S score. According to Sarason and his associates (1983), the research results strongly suggest that each score measures a different dimension. Finally, other studies conducted by Sarason and his associates (1983) have reported the SSQ and its correlations with certain commonly used personality measures, including the Eysenck Personality Inventory, Marlowe Crowne Scale of Social Desirability, and Rosenberg's Self-Esteem Scale.

The SSQ, however, was not without some limitations that were modified by adding three additional questions at the end of the 27-item questionnaire so as not to compromise its original standardization procedures. Because the overall satisfaction rating on the SSQ, ranging from 6 (very satisfied) to 1 (very dissatisfied), only gives an average or global rating score for each question, regardless of the number of persons listed per item, the authors constructed three more questions (numbers 28, 29, and 30). Briefly, respondents were asked to rank order their choices for each question and make an individual rating per selection. For example, a respondent might choose "mother" as the first choice and give her a 6 score (very satisfied), then select a second choice, such as a friend, and give that person a 5 score (fairly satisfied), and so on until the subject had exhausted his or her social support system, or made 9 selections, which was the limit of spaces per question similar to the SSQ. In addition, each item was constructed to explore a different dimension of the global concept of satisfaction with social support from others, that is, af-

fection, affirmation, and assistance (Kahn, 1979; Sarason et al., 1983). Two sample questions are provided for the reader. One is from the original 27-item SSQ and the other was developed by the authors. Item 24 from the SSQ reads: "Whom do you feel truly loves you deeply?" The first item constructed by the authors reads: "List every person in your life whom you feel truly likes you, cares for you, appreciates you, loves you, or respects you. Place the name of your first choice by the number 1, the name of your second choice by the number 2, and continue on all the way down to the number 9. Also, for each person you have listed, circle the number of how satisfied you are with the support you have from that person."

Method

Subjects

Subjects selected for this study were volunteers from the roles of the admission wards of a large public psychiatric hospital in the greater metropolitan area of Washington, D.C. They were divided into two principal categories, one group was called "acute" and the other labeled "chronic." In order to classify each patient into the appropriate group, these operational guidelines were followed: (a) the patient must have had a major mental disorder diagnosed on Axis I that occasioned admission to the psychiatric hospital within the past 4 years (1981–1985); (b) the patient's age must be between 18 and 45; (c) the frequency of hospitalizations at the psychiatric hospital within the past 4 years for the acute group must have had no more than two admissions, and for the chronic group three or more admissions; and (d) the total amount of time hospitalized at the psychiatric hospital during the past 4 years for the acute group must have had no more than 179 days, and the chronic group 180 days or more, either continuous or all days totaled.

Eighteen subjects were tested with the SSQ during a 3-week interval. Two of the respondents' questionnaires had to be rejected from any statistical analysis because they were not valid according to preestablished criteria. These criteria for a valid protocol were: (a) the subject was cooperative and willing to take the instrument when approached by the author concerning the study; (b) the respondent was oriented and knew his or her name, age, place of residence, and the approximate calendar date (month and year); and (c) the subject had to complete the entire questionnaire within one testing session without terminating the interview because of problems such as stress, fatigue, or anxiety. In all, 16 valid questionnaires were analyzed for statistically significant differences. Table 1 describes the demographic characteristics of the subjects in the investigation.

TABLE 1
Demographic Characteristics of Acute and Chronic Patient Samples

Variables	Acute	Chronic	*p*
	Hospitalization		
Mean number of days hospitalized	58.29	472.89	
SD	51.14	337.22	.003**
Mean frequency of hospitalization	1.14	3.33	
SD	.38	2.65	.024*
Mean age at first hospitalization	25.43	23.78	
SD	4.76	8.60	.328
Mean age at testing	29.14	33.22	
SD	4.33	6.85	.096
Mean educational level	12.29	12.22	
SD	2.06	2.95	.481
	Sex		
Male	4.00	7.00	
%	57.10	77.80	.206
Female	3.00	2.00	
%	42.90	22.20	.206
	Race		
Black	6.00	7.00	
%	85.70	77.80	.355
White	1.00	1.00	
%	14.30	11.10	.430

(table continues)

Procedures

The authors got in touch with those patients entering the admissions wards of the psychiatric hospital who met the established criteria. As many as 30 different patients were approached by one of the authors, but only 18 were willing to volunteer.

The SSQ was originally developed as a self-administered questionnaire. However, given the special population under investigation—patients with major psychotic disorders and on some type of powerful medication—one of the authors read the instructions and questions and recorded the subjects' responses on the author's copy of the instrument. Before asking any questions, the basic instructions were read to each sub-

TABLE 1 (*continued*)
Demographic Characteristics of Acute and Chronic Patient Samples

Variables	Acute	Chronic	*p*
Asian	0.00	1.00	
%	00.00	11.10	.198
	Occupation		
None	0.00	3.00	
%	00.00	33.30	.051
Labor	4.00	1.00	
%	57.10	11.10	.026*
Sales	2.00	2.00	
%	28.60	22.20	.394
Other	1.00	3.00	
%	14.30	33.30	.208
	Marital Status		
Single	4.00	6.00	
%	57.10	66.70	.360
Married	2.00	0.00	
%	28.60	00.00	.049*
Divorced	1.00	2.00	
%	14.30	22.20	.355
Separated	0.00	1.00	
%	00.00	11.10	.198

Note: A point biserial correlation was used to analyze the data and an assigned alpha level of .05 for a two-tailed test was considered statistically significant (Friedman, 1986).
*< .05.
**< .01.

ject with an example. The face-to-face standardized and structured interview situation had the distinct advantage of the questioner's knowing firsthand whether the respondent understood a question and could, within limits, repeat the question for clarification or respond appropriately. Furthermore, the author at the test site was able to discern whether or not the subject's selection of supportive others was realistic or not (i.e., some type of correspondence with the chosen supportive other—seen, heard from by telephone, or written to—within the past year). Simply asking the respondents when they had last heard from, seen, or received mail from the significant other determined whether or not the selection was realistic.

Results

The particular methodology used permitted two distinct types of data analysis: quantitative and qualitative. The quantitative data are summarized in Table 2; qualitative data gathered through interviews will be examined in the discussion section.

Four variables were found to be statistically significant and to discriminate between the two groups: mean number of days in the hospital; mean frequency of hospitalization; occupation (laborer), and marital status (married). The first two variables were highly statistically significant and essential to the research. Those two discriminating variables were both principal factors in the operational definitions of the two groups under investigation; without their being found statistically significant, there would not have been two distinct groups of subjects. The other two variables were also found to be statistically significant, yet were not subjected to further analysis (e.g., analysis of covariance). Because of the exploratory nature of this study in conjunction with the rather small sample (total $N = 16$), the authors used age, sex, educational level, and race as covariates in accordance with reviews of past research that emphasized certain demographic variables being used more frequently because of their research importance (Newman, 1983).

The findings of the study indicated that the acute group of subjects was significantly different from the chronic group of psychiatric patients on eight social support variables. Factors that produced significance between the two groups are reported as follows: (a) total number of nonkinship choices (realistic and unrealistic) from the community; (b) total number of kinship choices (realistic); (c) total number of kinship choices (unrealistic); (d) satisfaction of kinship choices (unrealistic), questions 28 through 30; (e) total number of nonkinship choices (unrealistic); (f) satisfaction of nonkinship choices (realistic) from the community; (g) satisfaction of nonkinship choices (unrealistic) from the community; and (h) total number of supportive others (unrealistic), kinship and nonkinship.

Of the eight variables that were found to yield statistical significance between the two groups, perhaps the most important common denominator was the fact that the chronic group typically made more unrealistic choices of both kinship and nonkinship persons from their social support system. As a group, they perceived meaningful others as being more readily available and supportive of them when, in fact, they had not corresponded with the significant other by letter, phone, or in person for over 1 year. Some individuals within the chronic group of subjects still believed that significant others as far in the past as 3 to 10 years would be available and supportive of them if needed. It appeared as if their ability to test reality was distorted along with their impaired judgment. In addition,

TABLE 2
Tests of Significance for Acute and Chronic Psychiatric Patient Groups with the Social Support Questionnaire

Dependent variables	*F* ratio	*p*	Acute *M* (*SD*)	Chronic *M* (*SD*)
Total kinship choices, realistic and unrealistic	2.76	.080	26.57 (16.48)	46.11 (38.09)
Total nonkinship choices, realistic and unrealistic, community	6.47	.007**	18.14 (15.24)	29.67 (34.82)
Total nonkinship choices, realistic and unrealistic, hospital	1.57	.260	14.14 (20.62)	27.22 (54.73)
Total kinship choices, realistic	3.45	.047*	26.57 (16.48)	38.78 (42.85)
Total kinship choices, unrealistic	5.63	.010**	00.00 (00.00)	7.33 (12.31)
Total nonkinship choices, realistic	.89	.390	30.57 (34.96)	48.33 (57.56)
Total nonkinship choices, unrealistic	3.29	.050*	.43 (1.13)	8.00 (12.01)
Wished-for or fantasy choices[a]	.54	.540	5.43 (9.16)	2.89 (3.69)
Overall degree of satisfaction	1.02	.330	145.57 (15.81)	147.22 (14.89)
Satisfaction of kinship choices, realistic[b]	1.27	.290	31.29 (22.00)	37.67 (37.57)
Satisfaction of kinship choices, unrealistic[b]	81.55	.000**	.86 (2.27)	14.56 (32.02)
Satisfaction of nonkinship choices, realistic, community[b]	4.07	.029*	17.14 (16.96)	22.11 (30.96)
Satisfaction of nonkinship choices, unrealistic, community[b]	11.75	.001**	2.29 (4.07)	11.33 (17.53)
Satisfaction of nonkinship choices, realistic, hospital	1.47	.270	15.71 (36.56)	20.78 (52.94)
Total supportive others, kinship and nonkinship, realistic	2.86	.060	55.57 (35.74)	87.11 (76.73)

(*table continues*)

TABLE 2 (*continued*)
Tests of Significance for Acute and Chronic Psychiatric Patient Groups with the Social Support Questionnaire

Dependent variables	*F* ratio	*p*	Acute *M* (*SD*)	Chronic *M* (*SD*)
Total supportive others, kinship and nonkinship, unrealistic	8.84	.003**	.43 (1.13)	16.22 (25.99)
Self-placement on questionnaire[a]	.30	.641	5.00 (5.51)	.78 (1.30)
Satisfaction with self when placed on questionnaire[b]	.27	.650	4.00 (6.63)	00.00 (00.00)
"No one" placed on questionnaire[a]	.96	.370	1.86 (1.77)	1.22 (1.64)
Satisfaction of wished-for or fantasy choices[b]	.90	.380	4.27 (7.52)	2.00 (4.24)

Note: An *F* test was used to analyze the data and an assigned alpha level of .05 for a two-tailed test was considered statistically significant.
[a]Questions 1–30. [b]Questions 28–30 only.
*$p < .05$.
**$p < .01$.

there seemed to be a yearning to return to the "good old days" when life was better and a greater sense of psychological well-being existed.

On the other hand, the acute group of psychiatric patients selected fewer numbers of meaningful others from their social support system who were unrealistic choices. Instead, they chose individuals with whom they had had contact in some fashion (by letter, telephone, or face-to-face) within the previous year. Their selections seemed to be more reality based and their choices more realistic in terms of potentially obtaining social support. In conclusion, the chronic psychiatric subjects reported more unrealistic perceived relationships with socially supportive others than did the acute group of patients. Conversely, the acute group indicated by their choices that their perceived social support system was more reality based and potentially more realistic in terms of obtaining needed or requested assistance.

A further examination of the other statistically significant results indicated that the chronic group was *also* able to perceive significant others in a realistic manner in a few cases, such as total number of nonkinship choices (realistic and unrealistic) from the community; total number of kinship choices (realistic); and satisfaction of nonkinship choices (realistic) from the community.

In summary, it appears that the group of chronic psychiatric patients were most frequently unrealistic in their selection of meaningful others. Yet they were, on occasion, capable of realistic choices based on their perceptions in a higher proportion than the comparison group of acute subjects. Finally, it seems that the chronic group were most characteristically inconsistent or unpredictable in their choices, making some realistic but mostly unrealistic choices, whereas the acute subjects were more consistent and predictable.

Discussion

The research study suggests that use of a social support questionnaire, administered as a structured interview procedure with acute and chronic psychiatric patients, could produce valuable quantitative results as well as providing additional information of a qualitative nature. With regard to the qualitative dimension, clinical practitioners could examine idiosyncratic responses to each question and assess the patients' psychopathology in relation to interpersonal relationships of a supportive or nonsupportive nature. For example, in answer to the question, "Who will comfort you when you need it by holding you in their arms?", one female subject from the acute group stated, "Mother . . . if suicidal." This information was quite revealing, unsolicited, spontaneously emitted, and had a direct correlation with the subject's underlying psychopathology and reason for psychiatric admission (self-injurious behaviors during a suicidal attempt). Another subject, a male from the chronic group, was asked, "Whom could you realistically count on to help you out if you had just been fired from your job?" He responded, "They [his dad and brother] don't care that much," then launched into a fantasy about himself being an "international superstar." This particular respondent could not effectively deal with the painful fact that there was meager, if any, support for him on that question. He needed to compensate for his lack of support by projecting himself as an important person who might be accorded some status, prestige, and influence through his fantasy role of superstar. It seems that psychiatric patients, more than any other special population, would be likely emit spontaneously subjective material that might reveal their underlying personality structure, especially in the area of object relations.

The research findings suggest that acute and chronic psychiatric subjects were significantly different with regard to their realistic and unrealistic choices of perceived social supportive others. In particular, the acute group selected more realistic choices of supportive others (less perceived distortion), whereas the chronic group chose more unrealistic support persons (more perceived distortion). The results from the multiple regres-

sion analyses indicated that the SSQ used with an interview method could determine differences between two groups of psychiatric subjects, suggesting that social support data could be used effectively to discriminate among acute and chronic hospitalized patients.

While the results presented here contribute to some understanding of perceived social support between two groups of hospitalized patients, they also raise questions that point toward additional research. Here are some of the more salient research areas to be investigated.

1. Why was the number of wished-for or fantasy choices (e.g., God, Jesus, Allah, Almighty, etc.) that were more physically removed from each subject than their unrealistic choices not significantly different between the two groups, as originally believed, but higher for the acute group than for the chronic patients? This may be the result of cultural factors—that is, cultural support versus social support.

2. Why was "oneself" placed on the questionnaire as a response more frequent for the acute than the chronic subjects (even though the instructions at the beginning of the questionnaire clearly indicated that the respondent was to *exclude* oneself from the selection of supportive others)? Perhaps this can be attributed to the acute group's psychopathology.

3. Why was the total number of nonkinship choices (realistic) for the acute respondents (nonkinship and realistic) and chronic subjects (nonkinship and realistic) not significantly different, whereas both the total number of kinship choices (unrealistic) and the total number of nonkinship choices (unrealistic) was found to be statistically significant?

An additional concern that requires attention is the question of generalizability of these research findings. The major goal of this study was the modest one of attempting to discriminate between two groups of psychiatric patients in relation to their perceived social support system (significant or meaningful others). However, because of the small sample and the use of only two admission wards in a large, public psychiatric hospital, generalizing from these results must be done with caution. Future research will show whether these findings, given a larger sample and more admission wards, are confirmed or not.

Some practical therapeutic considerations would be advised, given these findings. Of primary importance would be development of some type of therapeutic strategies to deal effectively with the chronic patients' distorted sense of reality and their impaired judgment, particularly their perceptual appraisals and evaluations of significant others from their social support network. A number of diverse interventions could be utilized. For example, an action format as practiced by psychodramatists, using role training techniques, might be effective in reorganizing the pa-

tients' perceptions of potentially supportive others. In addition, some form of cognitive verbal therapy might assist in restructuring internal cognitions to ensure a more effective appraisal of significant others. Finally, a psychoeducational intervention might be helpful through a structured teaching method. Whatever the technique used, the assessment and evaluation of their social support system must be made more realistic, so that patients can better receive what they desire, based on their current social support needs.

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The Covert Psychodrama of Phobias

HOWARD M. NEWBURGER

ABSTRACT. People who suffer from phobias may be treated through group covert psychodrama.

During eight weekly 2-hour sessions, 10 young adults were trained in relaxation technique and were encouraged to maintain inner tranquility while visualizing the events leading to their phobic reactions. Reconditioning occurred as a result of repeated imaginary experiences in which superimposed relaxation replaced anxiety. Seven months after the experiment, 8 subjects continued to report themselves symptom free.

RECENT DEVELOPMENTS FOR THE TREATMENT of phobia and other systemized fears and anxieties offer hope for short-term symptom amelioration. The work of Wolpe (1973) has contributed a great deal toward the reconditioning of phobic sufferers. His work facilitated the treatment of an individual by exposing him to 10 to 12 images, graded for anxiety-provoking potential, designed by the therapist. The person would become conditioned to these 10 or 12 constructs and then would be free of the phobic symptoms. In his pioneering work, Moreno (1946) pointed up the great benefits of enhanced activity on the part of the patient, his responsibility for his own growth, and the possibilities of treatment of people in groups.

The existing treatments for phobia are based on a medical model that focuses on removal of the symptom. This appears needlessly limiting. It is desirable to go beyond the previous level of integration. A person who might have been immobilized by fear of open spaces would be able not only to go out in the open spaces, but would also develop a genuine enjoyment of them. Benefits could then transcend the mere amelioration of symptoms.

Procedure

The following procedure for the treatment of phobic conditions lends itself to the simultaneous treatment of groups of sufferers in which they exercise control over their rate of recovery and the treatment process it-

self. The group serves to diminish feelings of uniqueness and isolation and enables greater numbers of people to receive help. Furthermore, the more responsibility individuals assume during the course of their treatment, the greater are their feelings of self-confidence and self-esteem.

A group of 10 phobic patients received training in a relaxation, or stress reduction, technique. This was accomplished in the following manner: The patients were asked to fixate on some spot on the ceiling, visualize the number 3, and repeat silently *three* to themselves three times. They were next asked to visualize the number 2 and repeat *two* to themselves three times. They were then asked to visualize the number 1 and repeat *one* to themselves three times. After that, they were asked to recall a place and a time in their lives when they had experienced inner peace. Using their imaginations, they were asked to recreate the place. Next, they were asked to imagine themselves in this surrounding and to recall and recreate their good feelings there. The director suggested they visualize themselves in this surrounding for approximately 3 minutes and remember the feeling state of that time and that place. Then the director suggested they allow themselves to develop deep relaxation by breathing while he counted slowly backward from 10 to 1. They were encouraged to consider that each exhalation would relieve them of residual stress. The therapist's pleasant and soothing tone facilitated each participant's relaxation, peace, and contentment. He told them that progress was in their own hands; the fear state had been learned; it was not genetic and therefore could be discarded if they used their minds in new and creative ways.

The director asked the group to recreate in their imagination precursors to the phobic state. For example, an agoraphobic whose job involved driving through large tracts of underdeveloped areas would be asked to reconstruct the various steps in getting ready to leave for work that day. He should picture the settings involved—the bathroom, the kitchen, the hallway, the garage, the car, as well as the various participants who shared his life space. In retracing these events, the instant the person experienced stress, he was instructed to stop his imagined progression immediately and go back to an earlier stage when he was completely relaxed. If, for instance, he experienced anxiety in starting his car, he could imagine himself in his kitchen finishing his morning coffee. Then he would imagine his procedure—putting down his empty coffee cup, standing up, putting on his jacket, bidding his family farewell, and walking out the front door toward the garage. The instant anxiety made itself evident, he was to go back to an earlier state, relax completely, and proceed with the events leading to the onset of the phobia. In this manner, the memory of the relaxed state would serve as a replacement for fear.

Discussion

One young man whose agoraphobia resulted in an inability to cross bridges found his career threatened. His work as a sales representative necessitated his crossing a bridge with an enormous open span. Unable to do this, he felt incapacitated, depressed, and agitated. During the group session, he imagined the sequence previous to the last attack—getting up in the morning, preparing for work, sipping his coffee, during which he started to feel twinges of anxiety related to his projected trip. He then regressed to his relatively calm state of mind while shaving. From that point, he tried to advance again through his activities leading to the bridge crossing. This time he was able to finish his coffee and reach for his jacket before the anxiety reasserted itself. After seven trials, he was able to picture himself at the entrance of the bridge without anxiety. Another six trials and he was able to cross the bridge without undue affect. Five trials more and he found himself enjoying the beauty of the bridge, the exhilaration of the view about him, and the loveliness of the surroundings. This was accomplished during four 2-hour, covert, psychodramatic sessions using his imagination and fantasy. It is not surprising that he was able to translate this into reality. His enthusiasm for his work and travel subsequently earned him a number of promotions.

A young woman experienced enormous shame about her compulsion to look at men's flies. As receptionist for a large advertising firm, she sat at a desk that faced a bank of elevators. Her eye level was in line with the zippers on the crowds of men leaving the elevators. After several hours at work, she was so exhausted and debilitated that she could barely get to the restroom to take her tranquilizing pills. As a result of covert psychodramatic reconditioning, she was able to do her work without feeling impelled to stare at the taboo region. With some additional reconditioning trials, she was able to glance at a man's fly without guilt or anxiety. Freed from her symptoms, she was enabled to progress to a better job within the company.

The pragmatism and impatience in our nation today serve to reinforce the popular acceptance of therapeutic methods that yield concrete results and accomplish them within a short time. The treatment of phobic and other fear-inducing types of disturbances appears to be a highly effective procedure leading to demonstrable change in a relatively short period.

In general, six to eight sessions of 2 hours duration seem to be sufficient to allow the sufferer to function normally in areas that were previously fraught with stress and anxiety. A few additional sessions can usually help the person to a level of enjoyment in the situation that previously caused pain and suffering. An agoraphobic could visualize enjoy-

ment of open spaces while driving through the attractive landscape. A person terror stricken with groups of people would not only learn to relax in that context, but also develop enjoyment of new relationships and associations.

The treatment modality can be conducted by a psychodramatist with some background in relaxation technique. It is desirable for the practitioner to have a grounding in psychodynamics as well. Most graduate programs today provide this training.

Results

After the eight sessions, all members reported themselves symptom free. They were able to accomplish activities that had been precluded on the basis of incapacitating anxiety. This improvement was sustained by 8 of the 10 subjects 7 months later. The remaining 2, although reporting some continued benefit, did regress to a level where the original symptoms were reasserted.

Research Implications

While the preceding was developed for the amelioration of phobic conditions, it might well have application for other aversive states. People limit their ambits, many times needlessly, due to a dislike or even a fear of certain others and situations. Most of these dislikes can be thought of as prejudicial in character. Prejudices, like phobias, are learned. The covert treatment outlined here appears appropriate for research in other aversive conditions harmful to the individual.

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Stimulus Activities for Family Communication

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MARY ANN GRAY

ABSTRACT. This article suggests four family communication stimulus activities that can be used in educational or group settings. The four exercises are (1) The Family as a System, (2) Communication Networks, (3) Draw a Family Tree, and (4) Fictional Families. By experiencing these exercises, participants can gain insight into family dynamics and their own behaviors as family members. These exercises can be used in a variety of settings and by facilitators with little or no training in psychodrama. While some of these exercises could be adapted for psychodramatic warm ups, others, such as the fictional-family technique, can be utilized as a long-term activity.

ALL OF US ARE born into a family and our family patterns follow us for the rest of our lives. We are each simultaneously experts in family communication, yet we are also very limited in our understandings of family dynamics. We are experts because we have spent several decades within a family setting; we are limited because each of us has experienced only one or two types of families. A variety of family experiences are available in our society. In the 1980s, in fact, the term family can mean single-parent, traditional, divorced, blended, or extended.

Family communication issues are of great concern to everyone. We need only look at divorce and remarriage statistics to see how many families are struggling. Single-parent families pose new problems for children (Satir, 1972)—current research suggests that 4 out of 10 children will be raised by a single parent for part of their childhood (Galvin & Brommel, 1986a). Family communication patterns can be constructive and supportive of healthy growth and development of individuals, or these patterns can be destructive and limit individual development.

The growing number of university courses in family communication demonstrates an expanding awareness of its significance. The authors

(having taught family communication courses and workshops) are convinced that family communication cannot be taught from a textbook. It can only be experienced. Thus, role-playing and action techniques are essential approaches for effective integration of the material.

In this paper, we would like to share four communication exercises that have proved effective in getting people thinking about their family styles. We believe these exercises can be used in a variety of settings by facilitators with little or no training in psychodrama. They can be adapted for use outside the university classroom. They could be used in group work or as psychodramatic warm ups. Wherever family communication issues are being dealt with, these exercises could be useful.

The Family as a System

The first exercise is relatively simple and brief. It illustrates how the family social atom functions as a system and how each individual affects all the other members of the system (Hale, 1981). Ask for two volunteers. Have them sit on the floor in such a way that they are comfortable and yet touching each other. Then add a third person, who must be touching each of the previous two people. As you add members to the system, all the members of the system must be touching some part of every other member. Invite members to share their reactions. During the sharing process, focus on how the system had to change to fit in each new member. Ask each participant how it felt to rearrange the group each time a new member was added. After five or six members have joined the family, ask one specific member to leave. Note how the family must readjust itself to cover for the missing member. Then ask a second member to withdraw. Note the effect on the family. Process the exercise by drawing an analogy to a real family. How do the parents react to the birth of each new child? How do the children react to a new sibling? How does the absence of a family member due to death or divorce upset the family (Galvin & Brommel, 1986b)? Hale (1981) details other related exercises on the systemic nature of the social atom.

Communication Networks

A second exercise focuses on family communication networks (Bavalas, 1950). By networks we mean the channels or individuals through which messages flow from one family member to another. Three networks were selected for illustration purposes: the chain, the Y, and the wheel (see Figure 1). Prepare each of the above networks on large pieces of paper, using circles to indicate each individual in the network. Do not

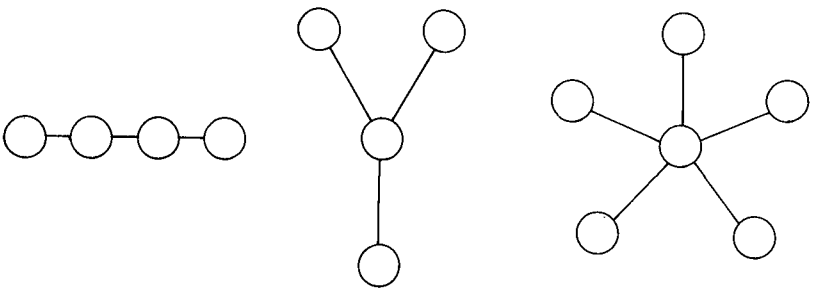

FIGURE 1. Family communication networks.

draw in the lines or arrows. Just draw the circles initially. Invite participants to fill in each of the circles by drawing a face. After the faces have been completed, the leader draws in the arrows and explains how each network functions. Participants are then invited to move to the network that most relates to their family experience. It can illustrate either their current family or their childhood family. Then cluster the participants into three groups, each group focusing on a particular network style. Each participant in the group now shares with group members how his or her family is depicted by that network. Each group eventually chooses one member's family to enact. That member provides an incident that can be role played, then chooses auxiliaries from the group to play each member of his or her real family. Role reversal is used. This can be a terminal exercise or a warm-up exercise that could branch off into a psychodrama. When processing this exercise, advantages and disadvantages of each network can be discussed, as well as advocating open communication among all family members.

Draw a Family Tree

The third exercise is an adaptation and extension of the Family Tree Theater technique developed by Claire Danielsson and modified by Joe

W. Hart (personal communication, May 1986). The goal is to get in touch through the family stories and accounts of family history told to children by their relatives. The intent is to discover underlying themes and messages and to gain insight into how they have affected each participant's personality.

Each group member is supplied with a blank sheet of paper and an assortment of colored markers and invited to draw a tree. Then participants are asked to label the tree with names of their relatives, past or present, making it into a family tree. Next, each person is asked to choose a partner and explain the drawing, sharing family stories that are invoked. The dyads are asked to join with another dyad and repeat the process. Then each group of four selects one member's stories to enact. Sociometric choice continues until a single person's stories are chosen by the entire group. The psychodramatic techniques used are the same as those for a dream psychodrama, meaning that the stories are literally enacted. Following the first enactment, the stories may be expanded, uncovering themes that continue to affect the participants today.

Fictional Families

In this exercise, participants create a fictional family. The family may be similar or very dissimilar from their actual family. They choose persons to play each role. They also explain what situation the family will be enacting. This provides the participants with a chance to experiment with roles or family situations that are not readily available in their everyday lives. For example, a child may have the opportunity to play a parent role.

As an expansion of this exercise, the facilitator may use a technique of briefly flicking the lights off and then on. The flicking of the lights is a cue to stop the action (as opposed to a blackout technique). The participants step out of their roles and become themselves again. This allows the facilitator to lead a 5-minute discussion with the participants, asking them to share from their roles. The facilitator determines when to stop the action and what type of processing questions will be most helpful. After a few moments, the facilitator flicks the lights again and the action continues.

In a classroom or on-going group setting, the concept of fictional families can be used on a more permanent basis. A group of five or six participants can jointly agree on a family description. Often, this gives individuals a chance to work out problems in a family similar to their own. But it can also give participants an understanding of family structures quite different from their own. For example, when the authors used this tech-

nique, one woman commented, "I've lived in a single-parent family, an extended family, and a blended family, but I've never experienced a traditional nuclear family. I'd like to see what that feels like."

When developing a family description, the group should determine the names, ages, and personalities of each family member. They should decide on a family name, on the jobs and income level of the family members. They should clarify how long each member of the family, stepparents or stepchildren, for example, has been present (Galvin & Brommel, 1986b).

Recognize that fictional families can be used as a short-term warm up to a psychodrama or as a long-term simulation experience. As a long-term simulation, members would return to the same family and remain in the same role in the family each week. In this permanent role, they would enact different situations as determined by the facilitator. The advantage of having a permanent role is that the person is given the opportunity to work on his or her relationships with other family members, trying different strategies to improve those relationships. As a learning tool, each member is also asked to keep a journal of weekly family interactions. After each role-play situation, members should respond in their journals to the following:

1. Describe what happened in your family today.
2. Describe how you felt about the interaction.
3. Which family member did you feel closest to? Why?
4. Which family member did you feel most distant from? Why?
5. Do you wish you had said or done anything differently? How could you have changed your behavior to improve the family interactions?

Family members are instructed not to share with each other their perceptions of how the family is functioning. They should not discuss their emotional reactions to playing their role. They are simply to write their reactions in the journal. After several weeks, the facilitator may allow them to share portions of what they have written in their journals. This creates a more realistic portrayal of family life. Most families rarely communicate openly about how they feel or how they view other family members. We usually keep our reactions to ourselves, being fearful of revealing too much to an intimate family member, who may be able to use that information against us.

We have discussed four exercises that can be used as warm ups: (1) The Family as a System, (2) Communication Networks, (3) Draw a Family Tree, and (4) Fictional Families. These exercises can also be adapted for

use by educators or therapists in a variety of settings. Any of these exercises can result in greater awareness of family dynamics. In this decade of divorce, remarriage, and single parenting, family dynamics are often difficult and unresolved. The ever-changing nature of the family leaves many of us unprepared to deal with new family forms (Paris, 1984). Most of us will encounter family structures different from our family of origin. Through exercises like the four discussed here, we can learn more about family dynamics, gain insight into our own behavior, and create more healthy family interactions.

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BRIEF REPORT

VAKTO, A Tool for Improving Directorial Skills

D. B. ESTES

Psychodrama is a complex tool to master; it can cause even the experienced director to have feelings of being at sea without an anchor to keep him/her in place. VAKTO, a simple mnemonic device, is designed to be a help in keeping the psychodramatist anchored. It can help the director organize him/herself in setting the scene for the psychodramatic action and may be especially helpful as a training device; it can be used for making feedback specific concerning the director's therapeutic utilization of the senses important to the protagonist's drama.

Visual, *auditory*, *kinesthetic*, *tactile*, and *olfactory* (VAKTO), all of the five senses, are utilized, at one time or another, to induce the protagonist to experience his/her scene in as realistic a fashion as possible. VAKTO is critical to action scene setting; these initials become an effective mnemonic device to anchor the overwhelmed director.

Psychodrama is therapy in action. The drama is produced in space, whether an actual stage designed specially for the purpose or a day room in a psychiatric unit. Within that space a setting is created by the protagonist, with the help of the director, which duplicates the protagonist's reality. Without adequate scene setting, the action could not occur in as enriching and psychologically forceful a manner. The senses are a vital part of the warm up and scene-setting processes that must not be overlooked. The exception that proves the rule is the already warmed up or hyper-warmed up protagonist. Sometimes scene setting can actually be used to slow down or, if necessary, redirect such a protagonist.

The protagonist must present his/her reality, and the director must be alert to the implications of verbal and nonverbal language. *Visual*: If there is a couch in the scene, what color or pattern is the material? What is seen? *Auditory*: In any scene there is sound or lack of it. Music, voices, a jack hammer on the street outside—what does the protagonist hear? *Kinesthetic*: If, as the scene unfolds, an auxiliary ego is called for, how does the protagonist stand or move while presenting the character? How does the protagonist hold his/her body or move as him/herself? *Tactile*:

How does the material on that already-positioned couch feel as the protagonist runs a hand over its surface? Is the texture pleasant? *Olfactory*: Perhaps there is the memory of the odor of a particular brand of alcohol or tobacco. What does the protagonist smell?

Eliciting any of these sense memories often elicits complex emotions that are associated with the particular sense in the scene. It is the task of the director to call forth as many or as few VAKTO memories as are necessary for the protagonist to reexperience action therapeutically in the here and now. Absence of any of these senses can also provide further grist for the therapeutic mill.

Psychodrama directors in training, or those others of us who want to further hone our skills, may wish to make a VAKTO checklist, either mental or written. After directing a psychodrama, we can then evaluate ourselves or discuss another's observation of our directing by using the VAKTO list as a basis for an enriching discussion on a direct observation of one element of the total complex of skills the director must master.

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Errata: On page 168 of the Winter 1987 issue, the second sentence in the second paragraph should read: The history of Beacon House, which was founded by J. L. Moreno . . ., is known to us all.

Book Review

TITLE: *Drama Therapy: Concepts and Practices*
AUTHOR: Robert J. Landy
PUBLICATION DATE: 1985
PUBLISHER: Charles C. Thomas
PRICE: $28.50

This book examines drama therapy, intending to synthesize material "into the parameters of a new discipline," according to the author.

It is divided into five parts: Drama Therapy in Context; The Conceptual Basis of Drama Therapy; The Techniques of Drama Therapy; The Populations and Settings for Drama Therapy; and Research in Drama Therapy.

Part 1 attempts to relate drama therapy to other psychotherapies and other fields such as education and recreation. This section defines drama therapy as a complex discipline with the general goal of helping individuals to "increase their repertory of roles and their ability to play a single role more effectively." Specific goals depend upon the "nature and needs of the client," Landy notes.

Part 2 examines the conceptual basis of drama therapy. Important concepts from fields as diverse as psychodrama, play therapy and "ritual, magic, and shamanism" are considered. Chapter 4 of this section presents the concepts that begin the theoretical mode of drama therapy and discusses the key concepts of self, role, other, role taking, imitation, identification, projection, transference, role playing, representation, distancing, catharsis, affective memory, spontaneity, and the unconscious.

Part 3 reviews some of the most practiced techniques of drama therapy and offers suggestions for the flexible structuring of this therapy. Among the suggestions are that the therapist needs to understand the nature of the client population, consider his/her own natural style of leadership, know specific institutional practices, know the "viability of his techniques in the context of work with a particular population in a particular setting," and consider therapeutic goals in context of the population and place.

Part 4 focuses on the populations and settings that are appropriate for drama therapy. These include school, community, and clinical settings.

Examples of applications include work with education of deaf, emotionally disturbed, and mentally retarded in school settings. Specific conditions—schizophrenic, affective and anxiety disorders—as well as populations such as the elderly are considered suitable for drama therapy treatment in a clinical setting. The author suggests that prisoners and the physically disabled are among those who can be treated in community settings.

The final section is titled "Research in Drama Therapy." One chapter gives an overview of theoretical models for research and notes several research methodologies; it includes two pages of data analysis and results. The final chapter suggests future directions in research, reconsidering theoretical models, research questions, methodologies, and analytical strategies.

This book may appeal to some persons in any of the helping professions, especially social work and counseling, and those who identify themselves as drama therapists.

Its major strength is that it brings attention to a developing therapeutic profession and attempts to examine drama therapy as a discipline.

The major weakness is that the book is so inordinately superficial and wide ranging that readers are apt to gain little substantial (and perhaps only distorted) information beyond a "feel" for an emerging profession. This weakness results in fragmented expression and a lack of continuity among parts and chapters. The general lack of readability may also be due to the experiential and emergent nature of drama therapy. The author's conclusions and inferences are often ambiguous and amorphous.

Beginning students in drama therapy or expressive therapy programs at the undergraduate and paraprofessional level may find this book useful, but they will find it must be supplemented with instructor clarification.

Jerold D. Bozarth

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NIH Observes Centennial

DURING THE 1930s, Public Health Service leaders debated whether NIH, still a small organization, should support research scientists whose work might not have immediate practical value in preventing and treating disease. The Surgeon General of the Public Health Service, Hugh S. Cummings, contended that such support was necessary. He had in mind the work of Dr. Claude Hudson of NIH. "I do not know of any possible connection Professor Hudson's work on sugars will have to public health," Surgeon General Cummings said. "Yet you can never tell." Dr. Hudson's discoveries about the structure of carbohydrates later became a major landmark in organic chemistry, and NIH established, early on, its policy of supporting research in the basic sciences while always encouraging its practical applications.

During the past century, NIH has grown from a one-room laboratory in the attic of the Marine Health Service Hospital on Staten Island to one of the world's largest biomedical research institutions. Investigators in that attic lab studied the epidemic and killing diseases of the day: yellow fever, cholera, and tuberculosis. In 1891, the Laboratory of Hygiene, as it was known, moved to Washington, D.C. Congress renamed the Laboratory the National Institute of Health in 1930, and broadened its mission to "ascertaining the cause, prevention, and cure of disease." In 1938, the Institute relocated to Bethesda, Maryland, and, in 1948, was renamed the National Institutes of Health in recognition of its major constituents, the already-established National Cancer Institute and the newly created National Heart Institute.

Today NIH is staffed by some 12,000 employees, including more than 3,200 scientists (about 1,250 with medical degrees and 1,800 with Ph.D.s). Its budget, which exceeds $6 billion, supports far more than the buildings, laboratories, and people on the Bethesda "campus." More than 80 percent of the NIH budget funds the projects of nearly 20,000 scientists in 1,300 universities, medical schools, hospitals, and other research institutions throughout the United States and abroad. NIH-supported scientists pursue their own scientific ideas through extramural research grants. These and other programs, including the training of young scientists, have proven to be powerful mechanisms for fostering scientific discovery.

One proof of the success of this approach lies in the list of Nobel Prize winners. Since 1945, NIH has supported two thirds or 41 of the 58 American Nobel Laureates in medicine or physiology before they won the award. Of 28 American scientists awarded the Nobel Prize in chemistry, well over half either worked at NIH or were supported by NIH prior to receiving the prize.

The research programs of the NIH have generated discoveries that have led to lower death rates from heart disease, cancer, stroke, and respiratory distress syndrome in newborns. Research scientists who are supported by NIH, or who work in its laboratories in Bethesda and elsewhere, have developed improved vaccines against influenza, pneumococcal pneumonia, rubella, rabies, hepatitis, and other infectious diseases that once caused handicapping illness and death. NIH has conducted or supported studies that led to the first successful liver transplantation, the synthesis of human insulin, the first discovery of a human infection caused by a slow virus, and significant reductions in the incidence of dental caries in the United States. Scientists at NIH also have played a major role in the discovery of the AIDS virus.

Indeed, the goal of the Centennial observance is to educate the public about health benefits resulting from biomedical research accomplishments over the past 100 years, and about the roles that NIH, academia, the private sector, and voluntary and professional organizations have played in these accomplishments. A second objective of the Centennial observance is to stimulate the interest of young people in biomedical research careers so that progress will continue during the next 100 years.

The theme of the Centennial, "A Century of Science for Health," illustrates the accomplishments of NIH after its first 100 years. October 16, 1987, will mark the end of a year of celebration of far more than an institutional birthday. The year-long observance is an occasion for deepening public understanding of biomedical research and of its many gifts to people throughout the world.

Information for Authors

The *Journal of Group Psychotherapy, Psychodrama and Sociometry* publishes manuscripts that deal with the application of group psychotherapy, psychodrama, sociometry, role playing, life skills training, and other action methods to the fields of psychotherapy, counseling, and education. Preference will be given to articles dealing with experimental research and empirical studies. The journal will continue to publish reviews of the literature, case reports, and action techniques. Theoretical articles will be published if they have practical application. Theme issues will be published from time to time.

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3. The *Publication Manual of the American Psychological Association*, 3rd edition, the American Psychological Association, 1983, should be used as a style reference in preparation of manuscripts. Special attention should be directed to *references*. Only articles and books specifically cited in the text of the article should be listed in the references.
4. Reproductions of figures (graphs and charts) may be submitted for review purposes, but the originals must be supplied if the manuscript is accepted for publication. Tables should be prepared and captioned exactly as they are to appear in the journal.
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