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Spontaneity Training and Psychodrama With Alzheimer's Patients

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H. BROOKS MORSE
JOELLEN POPMA
SUSAN M. JONES

ABSTRACT. Alzheimer's patients are a difficult population with whom to work. Some nontraditional therapy approaches have proved effective, however. In the present study, psychodrama and spontaneity training were employed with an ongoing, daycare group of Alzheimer's patients for 16 weeks. The experiences of the four psychodramatists involved are related and examined. Based on these observations, recommendations for working with similar groups in the future are provided.

ALZHEIMER'S DISEASE, particularly in its later stages, produces severe dementia. Because of the nature of the disease, the effects on memory are most notable but not entirely predictable, depending on the areas of the cortex most involved. Usually, short-term memory capacity diminishes first; long-term recall for early life events or use of noneffected capacities—singing, for example—may remain intact for some time. Nonetheless, reduced ability to communicate orally causes frustration for both patients and caretakers.

Although a relatively recent area of concern, a number of studies have focused on working with Alzheimer's patients. The most consistently positive results have been reported by therapists employing music therapy (Clair & Bernstein, 1990; Geula, 1986; Olderog-Millard & Smith, 1989; Smith, 1986; Smith, 1990) and art therapy (Kornreich, 1988; Wald, 1983), both nontraditional approaches. Dramatic enactment, another nontraditional therapeutic form, has also proved to be a useful tool with Alzheimer's patients (Gray, 1986).

Although not employed in the context of Alzheimer's disease, psychodrama has been shown to be an effective aid in reclaiming memory (Remer, 1987). In addition, as an action therapy, including a large nonverbal component, psychodrama provides an expanded vehicle for expression. Given the

challenging aspects of working with this population and the need for and lack of consistently effective interventions, we wondered whether psychodrama might prove helpful with these patients.

Considering the factors mentioned, we felt that psychodramatically oriented interventions might prove productive in dealing with Alzheimer's patients. This article relates the outcome of an attempt to use psychodrama with an ongoing Alzheimer's support group, called the Helping Hand Program, run by the Alzheimer's Association in conjunction with the Sanders-Brown Center on Aging at the University of Kentucky in Lexington.

To give a varied and more comprehensive view, each of us provides a brief report, prefaced by some personal background. We then draw some general conclusions and make suggestions for those wishing to work with this growing population.

The Helping Hand Program

Helping Hand, established in 1984, is an outpatient support service offered to families of those afflicted with Alzheimer's disease. Space is provided at a local church. Alzheimer's patients are dropped off either in the morning at 9:00 for the full day or at 12:00 for the half day and stay until 4:00 when someone calls for them. The group meets daily except Sundays. Although there are a small number of full-day, daily attenders, the majority of patients come for a few afternoons each week.

Activities in which the patients engage are both consistent in form and varied in content. Consistency is ensured by adhering to a structured daily schedule; content is adjusted according to the time of year and current events. Topics and activities are planned in advance, taking the patients' capacities and needs into account, being as proactive/preventive as possible to minimize both patient and caretaker frustrations. Consistency, a requisite in dealing with this population, is further guaranteed by a program staff of four who run the week's sessions.

The most unique aspect of Helping Hand is the use of volunteer "buddies" for each of the patients. The volunteers range in age from 18 to 85, are male and female, and come from all walks of life. Each volunteer, paired with a particular patient, learns as much as possible about the patient's background from information provided by the family. The relationship between the two, patient and buddy, is strong, not only ensuring more stability but also engendering a telic bond.

Perspective 1

I am a 46-year-old male. As an associate professor of counseling psychology at the University of Kentucky, I have been teaching psychodrama for 18

years. I was first introduced to the approach as a doctoral student at the University of Colorado in 1971. At present, I am working on a certification in gerontology. My involvement in the Helping Hand Program is one result of that pursuit; it is also an extension of a similar group I ran for the Salvation Army in Denver during a psychodrama training internship done on sabbatical leave in 1985.

Working at Helping Hand has been both eye-opening and uplifting. Most of the patients are grateful for the attention shown them, if not always entirely enthusiastic about the new activities. Telic bond seems to be the key. Once patients become familiar with you and what you are attempting to do, they are willing, and sometimes even eager, to participate, within the limits of their capacities.

A humbling influence comes from encountering the limitations, both the patients' and one's own. The 16 sessions in which I have been involved at Helping Hand during the trial period have run the gamut from rave review to total flops. Fortunately, the successes give evidence of some consistencies that may provide guidelines for the future.

Primarily, what I have learned is to adjust my expectations continually to match the circumstances. Although this is not a new lesson, it is one whose impact is both more relevant and more direct when dealing with Alzheimer's patients. Acceptance of their restrictions and your own is essential.

The best results have been obtained from highly structured interventions, well anchored in past memories and with a positive, even humorous, ambience. Fairy tale and nursery rhyme enactments have gone over well. Reminiscent, constructive ventures—scene setting relying on the patients, life review enactments—have been much less effective. The operative differences are often hard to pin down, and thus to correct. Whether breakdowns occur as a result of lack of recall, poor attention span, or inadequate ability to communicate (or some combination of the three) is impossible to tell. The impact of unpleasant content (e.g., references to death) have also been impossible to judge.

The experience overall has been very edifying for me, if not as successful as I had originally hoped it would be. Although I have often felt pressure to be prepared with a new and energizing activity to engender a spontaneous reaction, I realized that spontaneity for those who cannot recall what they did an hour ago is quite different from that of healthy people. It is not judged nearly as stringently, at least along the novelty dimensions, as it is for the rest of us. For most Alzheimer's patients, what happens happens and is adequate, immediate, creative, within the parameters of the situation, and always spontaneous. That "freeing" realization helped make activities such as enacting the "Twelve Days of Christmas" and "A Christmas Carol" fun for all, even if the enactments were done a few times with some of the group overlapping. Some

of the most affirmative moments resulted from the vicarious enjoyment of the most severely afflicted patient audience, a joy shared not only by the therapists and severe patients but also by the buddies and other patients.

Perspective 2

I am a 26-year-old Caucasian female. This fall semester at the University of Kentucky, I took a course in psychodrama, my first introduction to psychodrama techniques and enactments. My participation in the Helping Hand Program has been a direct result of this class, where volunteers were recruited to help with the project.

My experiences at the Helping Hand sessions consisted of approximately an hour and a half period at each of three sessions. During these visits, I engaged in such activities as making clay figures, exercising, singing, and memory exercises. The patients enjoyed these activities at varying levels, with the higher functioning individuals participating more.

For the most part, the patients seem to be cooperative and interested in the activities going on around them. I found the patients to be mostly women, with only a handful of men. Because I am interested in women's issues, I have often pondered the reason for this: Women may be more willing to participate in such groups; women from this generation may be more easily recruited into such endeavors; or caretakers of these individuals may believe that the behavior of women in such groups would be easier for the group leaders to handle than men's behavior. In any case, it does seem to me that the women are more willing to try a larger variety of activities than are the men.

I found this to be true of our psychodramatic endeavors. When we tried to enact nursery rhymes and fairy tales, the women seemed to be more willing to try the roles assigned to them. Overall, getting individuals to participate was difficult. Often, they did not seem to understand what was happening or what was expected of them. When individuals did participate, however, they did so in the spirit of fun and childlike exuberance. This was most true of the higher functioning individuals. Those individuals who did not seem to notice what was happening about them did not appear to get much out of the enactments. When they were able, however, these individuals would participate.

Spontaneity training and psychodrama with Alzheimer's patients can have some positive effects. Those individuals who can participate either actively or vicariously experienced much joy and socialization. Also, the enacting of nursery rhymes and fairy tales seems to stimulate patients' memories from the past. The patients actually remembered the story or remembered people they associated with the story. Although there appeared to be positive progress during the sessions, I feel that, because of the nature of the disease, this was necessarily small and of limited duration.

Perspective 3

I am a doctoral student in counseling psychology at the University of Kentucky. I was introduced to psychodrama by my major professor, Dr. Pamela Remer, and fell in love with the action method of therapy, which fit in well with my beliefs and theory about counseling.

In my first experience at Helping Hand, I noticed how much energy the facilitator was putting into the exercise. The focus was definitely on her as she tried to energize the different members of Helping Hand. As she complimented a member for doing well, that person seemed to come alive, enter into the discussion, and come into some of the spotlight.

The other two times I have gone to Helping Hand we attempted psychodrama. The members did not seem to want to participate in roleplaying the parts in a baseball game. However, they appeared to enjoy watching others play the parts. I am not sure whether their inability to be active was due more to having a hard time moving because of their age, the possible embarrassment, or their confusion at the purpose of their being active in a psychodrama.

I noticed that with practice they warmed up to doing psychodrama. For example, the first time I tried the world series psychodrama the patients did not want to be very active. Yet, the second time I noticed that although staying in their chairs, the patients used body posture and nonverbal communication to be active in the roles. The Helping Hand staff also helped them warm up by role modeling many of the action methods.

I recognized the amount of energy a facilitator needs to put into a drama with Alzheimer's patients. The patients seem to respond to the energy of the leader and helpers. This appears very important in keeping the patients' attention and in role modeling the behaviors needed. Thus, if a patient has forgotten from the beginning of an action drama to the middle what he or she is doing, all that person has to do is look around at others to pick up the theme again. For this reason, I believe that action methods can be very helpful to these patients. If they are drawn to the energy but have memory capacity deficits, doing energetic action can cue their memory. For example, if one is acting out a fairy tale and portrays the wicked witch with a grimace, the patient is less apt to forget what he or she is doing.

Second, I learned that Alzheimer's patients need a slow warm-up to the process of psychodrama and very clear yet concise directions. On the same note, if patients are confused about psychodrama, having them start the action, rather than talking more about it, may help them understand. In addition, the director needs to be very flexible with this population and not maintain classical psychodrama as the optimum goal.

Third, as a feminist therapist, I had some conflict in working with this population. I found that having a collaborative relationship in which the patients

contract for the therapy is nearly impossible. I often felt I was doing this to them, rather than with them. The power is definitely with the director. Thus, I suggest the need for particular care for, and sensitivity to, the rights of this population.

Perspective 4

I am in my second year of the counseling psychology doctoral program at the University of Kentucky. The Helping Hand Program has provided me with my first experience working with people with Alzheimer's disease and with an opportunity to expand my skills in psychodrama techniques.

One of the most challenging aspects of doing psychodrama with this group, which varies in size, is that the lucidity of the individuals is always variable. One day, the therapist will be able to encourage an individual to participate actively in the drama, and, on another day, the therapist will be unable to hold the patient's attention.

The patients who come to Helping Hand are at all stages of the disease. Therefore, planning psychodrama warm-ups and scenes represents spontaneity at its best. The helper and patient develop tele from their close interactions in the program. Tele is very valuable and serves to help the volunteer "fill in" for memory lapses of the patient. The patients were able to see and hear their helper in action, which enhanced memory. Patients who were limited in movement and/or verbal abilities needed to rely more heavily on their helper volunteers because they are incapable of much physical action. Essentially, the helpers doubled for the patients, acting out the scene and giving them the words they lacked.

Theme maintenance to the topic chosen for the day by the program staff enabled the director and assistants to learn about the individual patient's personal background and experience with the topic. Knowledge of this personal data provided material that could then be used in choosing warm-ups or developing scenes for enactment.

In my critique of the psychodrama experiment with Alzheimer's patients, I would add a few suggestions. Although psychodrama has traditionally been accomplished in large groups, the Alzheimer's group should be limited to about four patient-helper pairs. This would enable the director to maximize action among all group members, important because of limited attention spans in this population. In the large group setting, some patients found it difficult to see and hear the action being played out.

I would also suggest grouping according to the level of functioning, which could provide important data for further research. Would lower functioning patients benefit from being in groups with higher functioning patients? Can psychodrama techniques be adapted to benefit limited mobility, low-

functioning patients for whom action is greatly restricted? Is it realistic to divide groups according to functioning levels, and what benefits would accrue?

Conclusions and Recommendations

Originally, we hoped to be able to work gradually into doing more customary psychodramatic interventions with the Alzheimer's patients in the Helping Hand Program. Although the possibility of accomplishing more than we have been able to do still exists, our expectations have had to be modified significantly. This is not to say that our experiment has been a failure; quite the contrary. On both a professional and personal level, the experience has been beneficial and has had a strong impact. We have learned a great deal that will be useful, not only in working with Alzheimer's patients in the future, but also with many other populations.

Our primary aim, however, was to be able to convey to others some indications of how to help Alzheimer's patients. The following suggestions and observations are offered with that goal in mind.

1. Remember always to adjust your expectations to the immediate circumstances of those with whom you are interacting.
2. Keep the work short, not more than 45 minutes, including both warm-up and closure.
3. Employ dual auxiliaries, a patient and a buddy.
4. Keep the work as concrete as possible, employ props (Mayers & Griffin, 1990) whenever possible. When imagination is required, rely on the professional auxiliaries and buddies.
5. Focus work on well-anchored past memorabilia or concrete stimulus materials.
6. Avoid unpleasant material, anticipating problem areas as much as possible, reframing the material or moving off quickly when a problem does occur.
7. Repeat instructions and statements, both your own and others, as much as necessary without making an issue of it.
8. Strongly encourage participation without forcing some to be involved if doing so would make them uncomfortable.
9. Give the patients time to act because they are not able to move quickly.
10. Encourage participation through physical contact; for example, take someone by the hand and help or lead them into the action.
11. Try to keep enactments interactive, rather than solo.
12. Stay primarily in the area of spontaneity training rather than in more customary psychodramatic enactments.
13. Allow yourself to flow, relax, and enjoy the interaction—work on your own spontaneity in the situation.

14. Reinforce the patient's involvement.

15. Provide role modeling, either your own demonstration or that of auxiliaries.

16. Keep the group size to between 8–10 patients.

17. Do not underestimate the capacities of the patients. They often can and do surprise you with how actively involved they can be.

Although this is only a beginning and hardly definitive effort, our work has been very encouraging. At this point, we do not know how much more can be done, and only further exploration can tell. What we do know, however, is that psychodramatic enactments have been and can continue to be an effective intervention with Alzheimer's patients.

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Psychodrama and Reminiscence for the Geriatric Psychiatric Patient

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

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

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

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

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

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

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

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

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

Method

Setting

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

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

Subjects

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

Procedure

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

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

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

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

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

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

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

Measures

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

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

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

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

Results

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

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

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

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

Comparison of high- and low-action groups

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

NOTES

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

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The Roots of Enactment—The Process in Psychodrama, Family Therapy, and Psychoanalysis

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ABSTRACT. The term *enactment* is used to describe therapeutic processes in family therapy, psychodrama, and psychoanalysis. An enactment in family therapy involves an encounter between family members in their here-and-now reality, whereas an enactment in psychoanalysis, if it occurs in the transference, is dominated by the intrapsychic reality of the patient, which is, to a large extent, governed by experiences in childhood. In this article, I argue that these two very different types of enactment both occur in psychodrama sessions and that each has a different psychological significance for the participants. I present a clinical example of therapeutic work with a family in mourning in which both of these two types of enactment are involved.

THE DRAMA OF HUMAN INTERACTIONS is a feature of all forms of psychotherapy. It may be very apparent, as in treatments such as psychodrama and family therapy, or, as is the case with the more physically static psychoanalytic therapies, the drama may be a subtle but nonetheless powerful quality.

Enactment, which is a feature of drama, is considered to be an essential feature of both psychodrama (Blatner 1973, 1988; Kipper, 1985) and family therapy (Guldner, 1983; Minuchin & Fishman, 1981). In these therapies, enactment is a process that uses not only the verbal and nonverbal communications common to all psychotherapy but also, at times, dramatic actions and physical movement.

Psychoanalytic therapists, however, tend to be very cautious about using overt action, and especially acting out, in the treatment, seeing it as potentially counterproductive to the therapeutic process (Greenson, 1967; Sandler, Dare, & Holder, 1973). They prefer the therapeutic drama to be in the transference and to be confined to verbal communications between patient and therapist.

This theoretical position has resulted in the psychological processes of the active therapies being seen by some as very different from those that occur in psychoanalysis (Williams, 1988).

This view tends to miss the point that drama and emotional action are also a feature of individual and group psychoanalytic psychotherapy. Indeed, the British psychoanalyst, Patrick Casement, has used the term *enactment* to describe the process that occurs in the transference (Casement, 1987).

It cannot be denied that there is drama in the psychoanalytic process, albeit more reserved than in some other therapies. The psychoanalyst, S. H. Foulkes, after experimenting with psychodrama in the 1940s, wrote:

> I find that in the analytic group there is sufficient dramatic action going on between people on deep emotional grounds, and [I] have found "action" unnecessary. (Foulkes, 1975, p. 9)

Enactment in Psychodrama

A distinction can be made between the enactments in a session of structural family therapy in which, to a large extent, no illusions exist and the illusory enactments in the transference experienced in psychoanalysis.

I contend that these two types of enactment can both be observed in a psychodrama session. Each has its roots in a different psychological process that does not have the same significance for the participants.

The first type of enactment, which has also been called encounter, is related to the enactment described by family therapists. In an encounter, two people meet in their common shared space in which, as far as is possible, they treat each other as real. Their relationship can be thought of as being symmetrical.

When encounters occur within a psychodrama group, the participants' interactions and communications are modulated by tele, which, in Moreno's terms, is a process involving the reciprocity of attraction, rejection, excitation, or indifference (Fox, 1987, p. 4). In such enactments, reality predominates over illusion.

The other type of enactment in psychodrama is associated with the use of role reversals, doubling, and the employment of auxiliary egos. In these circumstances, there is a suspension of reality testing. I believe that these enactments are more akin to the processes that occur in transference in psychoanalysis.

Enactment in Family Therapy

Salvador Minuchin described enactment thus:

> [W]hen the therapist gets the family members to interact with each other, transacting some of the problems that they consider dysfunctional and negotiating

> disagreements, as in trying to establish control over a disobedient child, he unleashes sequences beyond the family's control. The accustomed rules take over, and transactional components manifest themselves with an intensity similar to that manifest in these transactions outside of the therapy session. (Minuchin & Fishman, 1981, pp.78–79)

This here-and-now interaction of family members in the therapeutic session is a crucial feature of most family therapy processes, in which the emphasis is on the systemic relationships between people. As Minuchin so graphically described, in the process of enactment, the "therapist asks the family to dance in his presence" (Minuchin & Fishman, 1981). Salvador Minuchin's style of structural family therapy has been highly influential (Minuchin, 1967, 1974; Minuchin & Fishman, 1981; Guldner, 1983). However, many other styles and schools of family therapy also employ the same types of enactment in their therapeutic sessions.

Enactment in Psychoanalysis: The Transference

In psychoanalysis, the relationship between patient and therapist involves both participants in thoughts and feelings and sometimes in actions. To this extent, it is a horizontal relationship in the here-and-now. This relationship, however, is not symmetrical because the emphasis is placed on the patient's reactions and feelings toward the therapist as if he or she were an important figure from childhood. These feelings are experienced in the present. Roles are involved, for example, those of father, mother, or son. Together the therapist and patient are involved in the drama (Greenson, 1967; Sandler, Dare, & Holder, 1973).

Psychoanalytic therapists are expected to acknowledge and react to the everyday reality of their patients. During the therapy session, they will obviously have many feelings toward or about their patients. These responses have been called the countertransference and are considered to be an essential component of modern psychoanalysis (see Greenson, 1967; Sandler, Dare, & Holder, 1973). Some of their reactions will be reality (or tele) based, whereas others will be the result of the therapists' own unconscious inner world and neurotic conflicts (Holmes, 1992; Racker, 1968).

The psychoanalytic process involves an enactment in the consulting room in which the patient is involved in reexperiencing a long lost drama from childhood (Casement 1987). Although the process of psychoanalysis is physically fairly static, with the participants either sitting or lying, there is usually tension and drama in the air. Indeed, the psychoanalyst Ralph Greenson states that the transference manifests itself by the patient's "intense emotional reaction to the analyst" that differentiates this response from a relationship based more in reality (Greenson, 1967, p. 157).

The psychoanalyst John Klauber describes the transference situation as "therapeutic madness." He wrote:

> Perhaps illusion would be a more suitable word than madness, especially if you will accept a tentative definition of illusion as a false belief accompanied by uncertainty as to whether to give it credence. An illusion is produced by the breakthrough of unconscious emotion without consciousness surrendering to it completely. An illusion is a waking dream but somewhat less convicting. (Klauber, 1987, p. 6)

In the same book, Patrick Casement wrote:

> [Klauber] says of this horizontal dimension in the analytic relationship: "What had been experienced in the past was also being enacted in a relationship between two people in the present." This enactment, in some measure, involves the analyst as well as the patient. (Casement 1987, p. 80)

The patient is experiencing the therapist as if the therapist were his or her father or mother from childhood. This therapeutic illusion involves the externalization or projection of aspects of, or objects from, the patient's inner psychological world onto the therapist (Sandler, 1988). It is the interpretation and resolution of the transference that is a crucial process in the therapeutic power of psychoanalytic therapy.

The Use of Psychodrama Techniques with Families

To further our discussion of these issues, we shall consider the times in psychotherapy when the methods normally associated either with psychodrama or family therapy are used together in the same therapeutic session.

The use of family therapy as a method of psychological treatment is often seen as a postwar development, with many of the seminal books on the subject written as recently as the 1970s (Guldner & Tummon, 1983; Will & Wrate, 1985).

J. L. Moreno was, however, working with couples and families in New York in the 1930s, using his psychodramatic method (Moreno, 1969). From his published accounts, it appears to me that he was directing psychodramas, using the two different kinds of enactment.

As part of the therapeutic process, Moreno staged encounters between people, in which people met and interacted in their own realities. For example, in 1939, he directed a couple, Frank and Ann Mason, in a psychodrama of a marriage. He said to them, "Don't report what happened, don't tell a story of what you said to each other, but relive the situation as it actually occurred" (Moreno, 1969, p. 85).

Thus did Moreno direct this couple to enact an aspect of their relationship in the therapeutic session. Together they enacted a scene from their life that

had happened a week before in their home. I would suggest that the conversation they had about Mr. Mason's mistress, Ellen, in Moreno's theater was an important encounter or interaction for them in the here-and-now. In Minuchin's terms, they showed Moreno aspects of the tortured dance of their marital relationship. Their session resembled that which might occur these days in the clinical work of any family or marital therapist. The relationship of the couple was symmetrical and occurred in the here-and-now reality of the Masons, Moreno, and his staff.

Surplus Reality

Later in this session, when Moreno used an auxiliary ego to play Ellen, he moved the drama into the realm of surplus reality.

Psychodrama is much more than the encounter of individuals in a group session. Moreno created the concept of surplus reality and added the associated techniques of role reversal, doubling, and the use of auxiliary egos to the therapeutic repertoire (Blatner, 1973, 1988; Holmes, 1992; Leveton, 1977). He wrote:

> We do not practice such surplus reality techniques as role reversal in life itself; that is why we have started them in therapy. (Moreno 1966, in Fox 1987, p. 8)

As I will describe, Moreno used some of these techniques in his family therapy with Mr. and Mrs. Mason.

I believe that these aspects of psychodrama have a closer relationship to the enactment described in the transference of psychoanalysis than to the enactments that occur in the classical family therapies because reality testing is suspended and an illusion is created.

In his work with the Masons, Moreno created an illusion that Frank Mason's mistress, Ellen, was in the session. Ellen was played by a professional who was not a member of the family. This auxiliary ego joined the therapeutic dance, playing an absent member of the family drama. Moreno directed the session thus:

> Now I would like you to pick an auxiliary ego to represent Ellen. Ellen is not here, but we can provide you with someone who has been trained to do this, and she will take the role of Ellen. (Moreno, 1969, p. 88)

With his assistant, Miss Sheffield, in the role of Ellen, the enactment in the family session continued.

I would suggest that the process that occurred in the enactment in the early parts of Moreno's psychodrama with Mr. and Mrs. Mason was akin to the enactments of the classical family therapists. The Masons showed Moreno their own habitual "dance" and brought the everyday reality of their marriage into the session.

Later in the session, a different psychological process occurred when Moreno asked the auxiliary ego, Miss Sheffield, to play a role. The Ellen of the psychodrama was an illusion, accepted by Mr. and Mrs. Mason to assist the therapeutic process. Indeed, the Ellen created by Miss Sheffield was the product of Mr. Mason's memories and impressions of his mistress and, to this extent, reflected aspects of his own internal world. A less involved person or a video camera would perhaps have shown greater objectivity in the creation of Ellen. The real Ellen was elsewhere and did not attend the therapeutic session.

At that moment, the psychological significance of the drama for Mr. Mason was the same as that which occurs for a protagonist in classical psychodrama when the techniques of surplus reality, including the use of auxiliary egos, doubling, and role reversal, are employed. Mr. Mason and the others in the session agreed to accept the therapeutic madness of the illusion that Ellen was in the room with them.

In the same way, the individual psychotherapy patient's experience that the analyst is his or her father or mother is also an illusion fostered in the service of the treatment. Unless the patient is psychotic, he or she knows well that the real father is not there.

The Jones Family—A Case of Family Loss and Delayed Mourning

To continue my discussion of these two types of enactment, I present a clinical example from my work with one family.

The Jones family was referred to me for assessment and treatment. Lucy, the 17-year-old daughter, was refusing to go to school and showed various depressive and hysterical symptoms. She felt miserable and found it difficult to leave the house for fear of panic attacks that were associated with a sense of acute unreality. Until a year ago, she had been an excellent and popular scholar; her parents were proud of her. In our sessions, Lucy was bright, positive, and cooperative. Both her parents were now deeply worried about her difficulties.

Other problems soon became apparent in our sessions. There were serious marital tensions and disagreements. Moreover, the parents were worried about Lucy's older brother, who they feared was gay.

I learned in our early meetings that Lucy's problems had started soon after the death of her maternal grandmother. The death from cancer had been sudden and unexpected. Mrs. Jones described her intense but ambivalent relationship with her mother. She had been very upset by the death but soon gave all her energies to looking after her distressed daughter. In our sessions, Lucy was able to express her deep regret that the death had been so sudden and that she had been unable to say good-bye to her much loved grandmother. At other

times, however, she became preoccupied with her concerns about her sanity and health, worries that dominated both her mind and our sessions.

The Assessment

I formed the hypothesis that, along with other factors, the death of the grandmother still caused Lucy and her family deep grief. I suspected that the mourning process was, in part, inhibited because of the family dynamics that, as is often the case, involved difficult relationships across several generations. I also felt that Lucy was having trouble separating from her mother, a problem that could be conceived of both in psychoanalytic terms (see, for example, Margaret Mahler's 1975 concept of individuation) or in terms of the family system (see Skynner, 1976). Thus, the problems I was presented with could be conceptualized in different ways.

Lucy's behavior and symptoms could be seen as being the consequence of her own tumultuous inner world full of conflicts. Indeed, she reminded me of the hysterical young women in nineteenth-century Vienna whose treatment by Sigmund Freud and his associate, Joseph Breuer, led to the development of psychoanalysis (Freud & Breuer, 1893). I had no doubt that Lucy was an anxious, unhappy, and insecure girl whose long-standing conflicts, made worse by her recent loss, might well benefit from individual psychotherapy.

It was also obvious that the family as a whole had intense relationship difficulties, that Lucy had a special bond with her father, and that the difficulties in the marital relationship had their effect on Lucy. The Jones family had obvious structural and transgenerational problems (Minuchin, 1974); the family was a dysfunctional system (Gorrel Barnes, 1985; Skynner, 1976).

There was some pressure from Lucy's family that I see Lucy alone. However, I decided that, on the basis of my assessment, the situation and Lucy's problems might benefit initially from some sessions with the whole family. I have already discussed elsewhere the complex issues of assessment and the choice of treatment modality (Holmes, 1989).

The Treatment

The family agreed to a series of weekly sessions, each about 2 hours long. I saw them, in all, for about 3 months.

Using Structural Family Therapy Techniques

In many sessions, I used the techniques of classical structural family therapy (Minuchin & Fishman, 1981). I observed the close alliance Lucy had with her father, a relationship that excluded her mother. At other times, I saw that

Lucy sided with her mother "against the inconsiderate behavior of men." It was clear that Lucy had little experience of her father and mother as a couple working together at the task of parenting. The parents demonstrated their difficulty in listening to each other, and, as part of my therapeutic intervention, I encouraged them to discuss and negotiate their daughter's future and indeed the future of the marriage. The family enacted their styles of relationship in our sessions, and I used these family dramas, which occurred in the reality of our sessions, in my attempts to help them with their difficulties.

Using Psychodramatic Techniques

In several sessions, I also used methods that originate from the psychodramatic concept of surplus reality. As I will describe later, I directed the family into actions or dramas that had a closer relationship to each individual's internal psychic reality than to the here-and-now family system. Psychodramatically, we brought the dead grandmother back into the session—a therapeutic illusion that joined the shared external reality of the family with the unconscious inner worlds (psyches) of each member.

The psychological significance of their psychodramatic meeting with the dead grandmother may have been, for family members, conceptually closer to the dramatic enactment that occurs in the transference in psychoanalytic practice (Holmes, 1992) than to the styles of enactment described by Minuchin and many other family therapists. To a large extent, the drama enacted derived from the "inner object world" of the individuals.

The reality of the drama was indeed an illusion and not reality (Klauber, 1989). Moreno said:

> . . . psychodrama provides the subject with a new and more extensive experience of reality, a "surplus" reality, a gain which at least in part justifies the sacrifice he made by working through a psychodramatic production. (Fox, 1987)

Surplus reality can be entered by the use of three basic techniques:

Role Reversal. In this technique, two individuals in the therapeutic drama change roles during the session. For example, in my therapy with the Jones family, I asked Lucy and her mother to reverse roles. This was done correctly in the session by telling them to change chairs and to adopt each others words, body position, and attitudes. Role reversal, be it in family or in group psychotherapy, allows the individual to enter actively the world of the other person, encouraging insight and an increase in what Moreno called role repertoire. With the Jones family, it allowed Lucy to gain, in an experiential way, knowledge about being not only a mother but also her mother.

Doubling. This is a technique in which one individual stands or sits behind another, and together they enact the single role. For example, when the mother became rather stuck and speechless in a session, I asked Lucy to double her and to speak those words (in the first person as mother) that she felt her mother could not say or perhaps even think.

Scenes in Surplus Reality. Such scenes involve having the director move the drama into areas that never occurred and indeed may never now be able to occur. With the Jones family, this involved each member of the family talking to the dead maternal grandmother and role reversing with this dead woman who (in a sense) was thus talking to her family from the grave.

I used the techniques of role reversal and doubling to help all the members of the family to gain insight and access to the roles of the other family members.

In my experience, these techniques, which may seem very strange and bizarre to a family, are best undertaken when the therapist is well accepted and trusted by all the family members. Instructions about the process must be given very clearly and firmly. The director/therapist may need to explain more than once what he or she wants. In the role reversal, it will be necessary to ensure that the patients sustain the reversal. For example, Mr. Jones must remain in role as his distressed daughter, and Lucy must maintain her enactment as her father. In such a role reversal, I initially request that the players change seats and roles, allowing the family members to use their creativity and spontaneity to talk from their new roles.

In protagonist-centered psychodrama or psychoanalysis, the illusion that someone important from the patient's real life is in the session involves another person (the auxiliary ego or the psychotherapist) who usually has no deep developmental family history with the patient. However, when techniques such as role reversal or doubling are used in family therapy sessions, the situation is more complex. In our case history, Lucy's mother is both a real person in the here-and-now and an internal object or role in Lucy's mind.

Object relations theory describes how the inner world, or psyche, of an individual is made up of the internalized objects of self and other in relationship (Holmes, 1992; Kernberg, 1976). These inner object relationships are the result of an individual's experience and relationships in the real world.

Thus, both Lucy and her mother have internal object relationships of "mother relates to daughter." Of course, in Lucy, the self-object is that of daughter and the other-object is that of mother, whereas in her mother, the self-object is that of mother. (Note that in this context, I use the term *self-object* in a different way from that adopted by Kohut [1977]. See Holmes [1992] for a more detailed development of these ideas.)

In terms of her relationships with the world or in the transference, should she be in psychoanalytic therapy, teenage Lucy will relate to others as a daughter. However, through her identification with her internal mother object, she will also be able to identify with both her own mother and the more general role of mother, a role, no doubt, that will become more central in her role repertoire when she to becomes a parent.

The use of role reversal in family therapy thus allows for the internal object relationship of both participants to be externalized and explored. Each person has the opportunity to enact his or her internal object, which is internalized as a result of one's experience of life, in relationship with the person from whom this object derives.

Doubling in family therapy also has a somewhat different significance from that which pertains in classical psychodrama. When Lucy doubled her mother, she was taking on a role that was already a major part of her own inner world. It might be expected that in individuals who have difficulty separating self from other, the experience of doubling the other might resemble a return to a physically fused (undifferentiated) state (Balint, 1968; Kernberg, 1976; Mahler, 1975).

Indeed, this was Lucy's initial experience when doubling her mother. Her sense of self and (m)other became confused. However, this regression to a more fused state seemed to help her, for when she ceased to double and reverted to her own role, she was able to differentiate more clearly those aspects of herself that were truly self and those identifications, with all the associated roles, feelings, and actions that, although part of her psyche, represented the other.

Once the family members have reversed back to their own roles, a process of discussion, sharing of experiences, and correction of misconceptions may occur. This is, of course, an essential aspect of the therapeutic task, the aim of which is to alter the family's habitual patterns of interaction. The use of role reversals increases each family member's understanding of each other's roles, helps correct inappropriate alliances, and assists the formation of generational boundaries (Minuchin, 1974).

The Process of Mourning Loss

In my assessment of this family, I had formed the hypothesis that Lucy's recent difficulties related, in part, to the family's, especially her mother's, unresolved grief for the dead grandmother. I felt that Mrs. Jones had been able to avoid her own grief and depression by her intense commitment to looking after her "sick" daughter. Lucy, too, avoided her grief and rage over the death of her grandmother by the unconscious adoption of the sick role in the family.

Freud (1917) discussed the psychopathology of loss in his work *Mourning and Melancholia*. He described the process of mourning as the "detachment of the libido" from the "lost object" or the dead person. This process is clearly intrapsychic and occurs in the inner world as the dead person no longer exists in the real external world. The nature of the inner object relationship must change in the face of the reality of the loss through death of the external person. It seems probable that this process involves a slow decathexation of the object, followed by an identification of the self with positive or good aspects of the lost person. The inner self-object is also able to relate, with less anxiety, to the inner other-object, allowing this object relationship to exist with less psyche tension or, indeed, torment.

This painful, but normal and essential process, takes time, at the end of which, according to Freud (1917), "the ego becomes free and uninhibited again." Freud recognized that a failure of normal mourning could lead to depression or other hysterical or somatic symptoms.

Clinical experience since Freud has clearly demonstrated that the existence of deeply ambivalent feelings held in life toward a person (in which love is suffused with anger or hate) may make the process of normal mourning for that person after death more difficult, leading to depression or other symptoms. It is as if the dead person cannot be released and must be clung to, against the objective reality of his or her departure. This clinging to the dead person may be seen in various ways, including hallucinations, maintaining his or her room unchanged, and other somatic and psychological symptoms.

Mourning with the Jones Family

I felt that each member of the Jones family had, in his or her own way, unresolved and unfinished business with Grandma that, in part, resulted in Lucy's and the family's problems. With their agreement, I directed a session in which we moved into surplus reality. We brought Grandma back, for a while, into the family. We reversed the process of death to give this family the opportunity for some resolution of its relationships.

To increase the drama, I turned the lights down in the room and provided a chair in the family circle for Grandma. I asked each member of the family to start by telling her a little of his or her life events in recent months. I then asked Mrs. Jones to role reverse with her mother by moving into the chair of the old lady (which was, of course, in reality empty). I then asked "Grandma" about herself and her life. One of the most magical features of role reversal is how completely any of us can become the other person. The illusion was very powerful and moving.

Next, I asked Mrs. Jones to reverse back to her own role. The family members were then able to talk to "Grandma"; to say things that had remained

unsaid, to unburden themselves of certain preoccupations and ruminations about her sudden death, to express their anger with her as well as their sense of loss. From time to time, I asked them each to role reverse with Grandma and, in role reverse, to talk to the family, to give advice, and to provide support as if from the grave. I was impressed with how healing and positive each family member was when playing the grandmother.

Clearly, in this session, the drama enacted was an externalization of the painful and conflicting object relationships that formed part of each family member's psychic self. These inner worlds could also be described as the family's memories of the grandmother.

As director, I then told the family that the time was coming when Grandma must die again, to leave the family once more to go back to her grave. I encouraged them to say good-bye, to let her go more fully and peacefully, to remain loved in their memories and hearts, but not to cling to anxiety and distress. I began to feel the gradual easing of tensions. Tears associated with deep calm filled the room as the individuals prepared once more to say good-bye.

Lucy, however, seemed to find it difficult to let Grandma go. I asked her to role reverse once more. As Grandma, she had no difficulty saying that she had to go and that she hoped that Lucy would remember her with love while getting on with her life as a healthy, happy teenager. Once role reversed back to her own chair, Lucy was calmer and able to let go of her grandmother. In psychoanalytic terms, she was now more able to reduce the libidinal cathexis to the dead person, allowing her grandmother to become incorporated as an inner object associated with less ambivalence.

To end the session, I once more increased the level of the light in the room, and we all shared our very moving experiences of the recent drama enacted in surplus reality.

This was not our final session, and in subsequent meetings, we continued to explore the family's dynamics, usually using more classical family therapy techniques (enactments in reality). After a time, Lucy was able to separate more from her parents and returned to school a more relaxed, mature young person.

Mrs. Jones had become more aware of her need to face her own depression and to work on her own difficulties with her mother in further therapy. If she were to choose analytic psychotherapy, one might expect that she would re-experience through the medium of the illusion of transference her relationship with her mother and thus be able to continue to work on this difficult relationship. If instead she chose to join a psychodrama group, she would no doubt enact dramas in which an auxiliary ego would take the role of her mother.

Conclusion

In this article, I have described a session in which I, as therapist, encouraged family members into two psychologically different types of enactment. In the first, they encountered each other in their shared here-and-now; their confrontations were mainly based on a shared reality. They also said farewell psychodramatically to their dead grandmother. This second type of enactment was driven, in part, by each family member's unconscious inner world.

I have endeavored to demonstrate that in important ways, many enactments in psychodrama have a similar psychological significance to the process of the transference in psychoanalysis. These types of enactment must be differentiated from "encounters in reality" that occur in family therapy and in psychodrama at times.

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Group vs. Individual Counseling: Treatment Mode and the Client's Perception of the Treatment Environment

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ABSTRACT. The impact of treatment mode (group versus individual counseling) on the client's perception of the treatment environment was examined with a sample of institutionalized female delinquent offenders. The delinquents' perceptions of the treatment environment were measured by the Correctional Institutions Environment Scale (CIES). This instrument measures the client's perceptions of three environmental dimensions: (1) the treatment program, (2) the degree of interpersonal relationships, and (3) the emphasis on institutional order and control within the correctional environment. The findings indicate significant differences between the consensual ratings of the treatment environment by the delinquents in group treatment and those in individual treatment. The consensual ratings of those in group counseling units were significantly higher and more positive on two environmental ratings: perceptions of interpersonal relationships and perceptions of the treatment program.

ONE COMPONENT OF COUNSELING EFFECTIVENESS that has been identified by research is the client's perception of the treatment milieu. A positive perception of the therapeutic relationship and climate has been found to relate to more successful treatment outcome (Moos, 1970; Wenk & Halatyn, 1973; Truax, 1971). Many studies on the effectiveness of therapeutic interventions have focused on personality variables, but few studies have focused on environmental variables such as the client's perception of the treatment milieu (Moos, 1970; Wenk & Halatyn, 1973). Carl Rogers (1957) stressed the importance of the client's accurate perception of the therapeutic relationship as an integral component of treatment effectiveness. With institutionalized clients (mental patients, penal inmates, in-patient alcoholics, and institutionalized delinquents) the accuracy of their perceptions of the therapeutic environment may be questioned. In studying the relationship between perceived therapeutic conditions and therapeutic outcome, Truax (1971) focused on two institutionalized populations: mental patients and juvenile delinquents. A

strong positive relationship was found between the perceived therapeutic environment of the delinquents and successful treatment outcome. There was no such relevant relationship with the mental patients. This finding suggests that the delinquent group was capable of assessing the therapeutic environment and responding with successful behavioral change. Jesness (1975) found that institutionalized male delinquents who had positive perceptions of the treatment staff's involvement and fairness showed greater improvement in psychological and behavioral variables. Using the Correctional Institutions Environment Scale (CIES), Moos (1970) found that boys in units that were rated high on CIES dimensions of relationship and treatment program showed more positive change on withdrawal and social anxiety variables.

Research on effective offender treatment is particularly needed because of the controversy regarding the value of traditional treatment methods with offender populations. Martinson's (1974) evaluation of the effectiveness of offender treatment and his resulting conclusion that "nothing works" was tempered with the cautionary probability that correctional programs may be ineffective because they were not "yet good enough." Later research indicates that "appropriate" offender treatment is effective in reducing recidivism. Andrews et al. (1990) defined appropriate offender treatment by listing three elements that are necessary in matching offender to treatment. These three elements of appropriate offender treatment include adequate needs assessment, targeting of service delivery to high risk offenders, and the match between treatment, client need, and client learning style.

Regarding the match between treatment and client, some studies indicate that group counseling is related to lower recidivism rates (Truax, Wargo, & Volksdorf, 1970) and the commission of less serious offenses (Taylor, 1967). Yet, other research reports that certain types of offenders (males psychopaths) who were treated by group therapy committed twice as many offenses upon release as did a matched group who received individual therapy (Craft, Stephenson, & Granger, 1964). The conflicting research findings suggest that there may be more sophisticated interactions of variables that determine the potential effectiveness of any one treatment mode. Studies need to examine the interaction of several variables that may affect treatment effectiveness. Factors such as offender type and personality, congruence of therapy group members, and counselor skills may influence the client's perception of the treatment environment and treatment outcome.

The study reported in this article examined the bivariate relationship of treatment mode and the client's perception of the therapeutic environment at a state institution for female delinquent offenders. The independent variable, treatment mode, was defined by the dominant form of therapy (either group or individual counseling) used in the contained cottage units. The dependent variable, clients' perception of the treatment environment, was based on con-

sensual ratings of environmental factors. The research question asked whether there were significant differences in the environmental perception ratings of those assigned to group counseling and those assigned to individual counseling.

Method

Subjects

The subjects were 96 institutionalized female delinquents. The age range of the girls was from 13 to 18 years, with a mean of 15.4 years and a mode of 16 years. There were 63 (65.6%) Whites and 33 (34.4%) Blacks in the sample. The range of IQ scores of the sample was 73 points, with a minimum score of 54 and a maximum score of 127. The mean IQ score was 96.6 with a mode of 100 and standard deviation of 14.5 points. The distribution of IQ scores of the sample conforms to the normal distribution of IQ scores in the general population. The range of educational levels (defined as last grade completed) was between Grade 6 and Grade 12. Most subjects (73.9%) were placed in Grades 9 through 11 at the time of the study. The subjects' length of time in counseling ranged from 1 month to 11 months, with a mean time in counseling of 4.77 months.

Treatment Environment

The youth institution was organized by contained cottage units. Nine cottage units participated in the study, but two of these cottages had fewer than 35% of their client population completing the research instrument. It was decided that the small percentage of residents completing the instrument in the two cottages did not constitute representative samples from those units. Therefore, Cottage 4 and Cottage 6 were excluded from the analysis of differences between cottage groups. The client environmental ratings of the other seven cottages were analyzed. The population of each cottage (and thus the cell size of the multiple analysis of variance) was roughly equivalent with a minimum of 13 and a maximum of 16 girls in each cottage living unit.

Of the seven cottages that participated in the study, five employed individual therapy as a primary mode of treatment and two used group therapy. In group counseling cottages, there were two groups, with six to eight girls assigned to each group. The groups were open groups, meaning that discharge of a group member from the institution resulted in replacement with a girl who had newly arrived at the institution into the group vacancy.

Group counseling was labeled positive peer culture (PPC) and adhered to a guided group interaction model. The girls used the PPC designation for their

assigned treatment group, and there is reason to believe that the label may, in itself, have had an effect of shaping the expectations and perceptions of both those assigned to the group counseling cottages as well as those assigned to individual counseling cottages. This possible limitation is considered at greater length in the discussion section.

A fundamental precept of guided group interaction is that group members have the responsibility for therapeutic change. The group uses peer pressure and attacks on defense mechanisms that inhibit the change and growth of the group members. The group leader sets the boundaries of group behaviors and attitudes but otherwise adopts a nonauthoritarian role and allows the group members to be the change agents (Lester & Braswell, 1987).

The basic commonality of individual counseling was the one-on-one therapeutic relationship between counselor and client. Although treatment approaches in individual therapy included psychoanalytic, person-centered, and cognitive approaches, the study focused not on these variations but rather on the dyadic therapeutic relationship in individual counseling versus the multiple therapeutic relationships in group counseling. There was one counselor assigned to each cottage unit.

Cottage assignment was based on the available bedspace when the girl was admitted to the institution. Cottage assignment was a variable that the researcher was unable to control because of the practical limitations of the study. Even though cottage assignment based on available bedspace is not random assignment of subjects to treatment, time of admittance that mandated cottage assignment is a chance variable. The girls' demographic factors of age, race, IQ, educational level, and length of time in counseling were statistically treated as covariates to control for any initial differences that may have occurred between the girls assigned to group counseling cottages and those assigned to individual counseling cottages.

The only girls selected out of either group or individual counseling cottages were those judged to be too emotionally disturbed or mentally disabled to benefit from these counseling approaches. The girls who were selected into this exclusionary set comprised less than 10% of the total population at the institution. They were assigned to a self-contained cottage that employed behavior modification therapy and became part of one of the two cottage units that were excluded from the study.

Instrumentation

The Correctional Institutions Environment Scale (CIES) (Moos, 1974) was used to assess the clients' perceptions of the treatment environment. This instrument is divided into three dimensions that describe the environment of a correctional institution: (1) the relationship dimension scale, which measures

the degree of involvement, support, and expressiveness within the environment; (2) the program dimension scale, which measures the degree of autonomy, practical orientation, and personal problem orientation of the treatment environment; and (3) the system-maintenance dimension scale, which measures the degree of order and organization, clarity, and staff control within the institutional environment. The CIES is a 90-item questionnaire in true-false format. Content and criterion-related validity have been assessed, and test-retest reliability values range from .65 to .80.

Data Collection

The researcher met with each individual cottage unit and administered the CIES. The researcher informed the subjects that the purpose of the study was to examine their views about the institutional environment and the treatment services provided in the institution. Both the girls and counselors were told that the results of the study would be used in the correctional treatment staff's ongoing efforts to measure treatment impact.

As previously explained, there was one counselor assigned to each of the six cottage units. Each of the six counselors was present when the purpose of the study was explained to their cottage unit, and the counselors remained in the cottage during the administration of the research instrument. The girls and counselors were assured that feedback on the consensual ratings would be presented to them at the completion of the study. To insure confidentiality, instruments were coded by cottage units, and the girls were instructed to give no identifying information on the test instrument.

Data Analysis

First, Pearson correlation analysis was used to examine the bivariate relationships between the clients' perceptions of the treatment environment and the demographic variables of age, race, IQ, length of time in counseling, and educational level. Next, I used analysis of variance to assess the differences between the consensual ratings of the relationship, program, and system-maintenance dimensions of the treatment environment. Consensual data were analyzed according to groupings of the two treatment types. Because of the linear hypothesis approach underlying analysis of variance, the analysis can appropriately handle the unequal cell sizes that were characteristic of the population studied (Ferguson, 1976). Analysis of covariance was used to assess the extraneous variation of environmental ratings that could be due to the client's IQ, age, educational level, race, and the length of time in counseling. Analysis of covariance helped to insure that reasonable departure from assumed homogeneity and normality of the variance between groups might oc-

cur without serious impact on the findings of the study and the validity of the conclusions (Ferguson, 1976). The pattern of differences between the two treatment types was assessed by multiple classification analysis.

Results

Pearson correlation analysis indicated three significant relationships between the girls' demographic characteristics (age, educational level, IQ, race, and length of time in counseling) and their perceptions of the treatment environment (Table 1). The client's race related to the clients' perceptions of the program and system-maintenance dimensions of the treatment environment. The negative correlation (−.242) between race and perception of the program dimension was significant at the .009 level of confidence. There was also a negative correlation between race and perception of the system-maintenance dimension (−.219). The race of the client was coded as a dichotomous variable, with White = 1 and Black = 2. The negative relationship means that the White clients had higher ratings of the program and system-maintenance dimensions of the treatment environment. There was also a significant negative relationship between length of time in the treatment environment and rat-

TABLE 1
Pearson Correlation of Demographic Variables and the Clients' Perception of the Treatment Environment

	AGECL	IQ	RACECL	CLIETIME	EDCL
RELATION (CIES I)					
r	−.044	.027	−.112	−.108	.065
p	.34	.39	.14	.15	.26
PROGRAM (CIES II)					
r	.027	.116	−.242	−.102	.160
p	.40	.13	.009	.16	.06
SYSTEM (CIES III)					
r	−.132	.156	−.219	−.241	−.065
p	.09	.06	.02	.00	.26

Note. Control variables: AGECL = age of client; IQ = IQ or client; RACECL = race of client; CLIETIME = client's length of time in counseling; EDCL = educational level of client.

ings of the system-maintenance dimension. The inverse relationship means that those with shorter lengths of stay in the institution rated the system-maintenance dimension higher than those who had resided in the institution longer.

The analysis of variance of the clients' perceptions of the treatment environment indicated significant differences between the ratings of clients in individual counseling cottages and group counseling cottages on two dimensions, the relationship dimension and the program dimension. There was no significant difference between the two groups in their ratings of the perceptions of the system-maintenance dimension.

With an F of 12.86, the variation of the ratings of the relationship dimension between group and individual counseling cottages was significant at the .001 level of confidence. With an F of 10.55, the variation between the two cottage types on the program dimension was significant at the .002 level of confidence. Multiple classification analysis was then used to indicate the pattern of the consensual ratings. The effects of the covariates—client's IQ, age, educational level, race, and length of time in the treatment environment were controlled for in the multiple classification analysis. On the program dimension, the group counseling units scored 1.86 points above the grand mean, and the individual counseling units averaged .77 of a point below the grand mean. With the effects of the covariates adjusted for, the mean score of the group counseling units increased to 2.04 points above the grand mean. The individual counseling units mean increased in a negative direction, to $-.84$ from the grand mean.

Higher scores on the CIES program dimension indicate that the residents perceive a higher degree of autonomy, practical orientation, and personal problem orientation in the treatment environment. Lower scores indicate a lesser degree of the aforementioned environmental components. The findings indicate that the girls involved in group counseling had more positive perceptions of the elements that related to the treatment program.

Multiple classification analysis of the relationship dimension indicated that group counseling cottages scored 1.94 points above the grand mean, and individual counseling cottages averaged .80 of a point below the grand mean. When the effects of the covariates were adjusted for, the mean score of the group counseling units increased to 2.55 points above the grand mean, and the mean score of individual counseling units increased in a negative direction to 1.05 from the grand mean.

Higher scores on the CIES relationship dimension indicate that clients' perceive a higher degree of involvement, support, and open expression within their environments. Lower scores on the relationship dimension indicate a lesser degree of the aforementioned environmental components.

TABLE 2
Analysis of Variance by Cottage Unit of Clients' Perceptions of the Relationship, Program, and System Maintenance Dimensions of Treatment Environment

Source of variation	*SS*	*df*	*MS*	*F*	Signif. of *F*
		Relationship dimension			
Covariates	43.77	5	8.75	0.58	.71
IQ	4.26	1	4.26	0.28	.59
AGECL	4.71	1	4.71	0.31	.58
CLIETIME	12.55	1	12.55	0.84	.36
EDCL	4.32	1	4.32	0.29	.59
RACECL	16.22	1	16.22	1.08	.30
Cottage	346.64	6	57.77	3.85	.002
Explained	390.40	11	35.49	2.36	.01
Residual	1261.32	84	15.02		
Total	1651.72	95	17.39		
		Program dimension			
Covariates	95.20	5	19.04	1.55	.18
IQ	0.04	1	0.04	0.00	.96
AGECL	0.05	1	0.05	0.00	.95
CLIETIME	5.30	1	5.30	0.43	.51
EDCL	9.99	1	9.99	0.82	.37
RACECL	47.44	1	47.44	3.87	.05
Cottage	193.27	6	32.21	2.63	.02
Explained	288.47	11	26.23	2.14	.02
Residual	1029.35	84	12.25		
Total	1317.82	95	13.87		
		System-maintenance dimension			
Covariates	158.42	5	31.68	2.88	.02
IQ	5.79	1	5.79	0.53	.47
AGECL	4.96	1	4.96	0.45	.50
CLIETIME	49.60	1	49.60	4.51	.04
EDCL	24.23	1	24.23	2.20	.14
RACECL	44.12	1	44.12	4.01	.05
Cottage	178.22	6	29.70	2.70	.02
Explained	336.64	11	30.60	2.78	.004
Residual	923.34	84	10.99		
Total	1259.98	95	13.26		

Note. Covariates: IQ = IQ of client; AGECL = age of client; CLIETIME = client's length of time in counseling; EDCL = educational level of client; RACECL = race of client.

Discussion and Conclusions

Previous research findings have indicated that positive perceptions of the treatment environment relate to successful treatment outcome, improved psychological and behavioral indices, greater satisfaction measures, and less hostility. This study did not examine the summative measure of treatment outcome but rather focused on the intermediate and formative level concerning perceptions of the treatment environment and the impact of treatment mode on these perceptions. Therefore, it is speculative, at best, to conjecture that treatment outcomes are enhanced by positive perceptions of the treatment environment. A subsequent study is recommended to examine the relationship between the client's perception of the treatment environment and summative measures of treatment outcome.

The study's several limitations need to be addressed. The inability to assign subjects randomly to treatment mode, although controlled for statistically by analysis of covariance, presented a methodological limitation. The narrow demographic slice of subjects (female adolescents), although important because of the sparse amount of literature on female delinquents, limited generalizability of the findings to other populations. The adolescent age cohort, with its natural affinity toward overemphasis on peer relations, may have also skewed the results in favor of group treatment.

Another possible contaminant of the study was the label used for the group counseling mode (positive peer culture). The name implies positive demand characteristics that may well have affected the perceptions of all of the institutionalized delinquents in a favorable direction for group counseling.

TABLE 3
Multiple Classification Analysis of the Clients' Perceptions of the Program and Treatment Dimensions of the Therapeutic Environment by Treatment Mode

		Program dimension (grand mean = 16.21)		Relationship dimension (grand mean = 15.89)	
	n	Unadjusted deviation ETA	Adjusted for covariates	Unadjusted deviation ETA	Adjusted for covariates[a]
Group counseling	28	1.86	2.04	1.94	2.55
Individual counseling	68	−.77	−.84	−.80	−1.05

[a]Covariates = client's IQ, age, race, educational level, and length of time in treatment.

The significant differences in clients' perceptions of group counseling versus individual counseling environments raise interesting questions. One may question whether the girls in the group counseling units differed substantially from girls in individual counseling units and whether the differences in environmental ratings were a result of this initial difference. Yet, with the effects of the client's race, age, educational level, IQ, and length of time in the treatment environment controlled for with analysis of covariance, the differences between group counseling clients and individual counseling clients remained highly significant.

One might question the qualities of the group treatment mode that may have contributed to the higher ratings. The advantages of group therapy over individual therapy, as described by Lester and Braswell (1987), include information sharing, role modeling, recognition of similarities with others, reciprocal helping and being helped, support for emotional catharsis, and intimate connection with a family substitute. With the leadership of a competent group counselor, the social learning and bonding that occurs within the group counseling setting may have a positive effect on the girl's perception of reality. The combined advantages of group support, modeling, and socialization may result in a higher degree of involvement, connectedness, and expressiveness (as measured by the CIES relationship dimension). The sense of belonging that is promoted in a counseling group and the feelings of worth that one realizes when able to help others may have positive consequences on the self-esteems, attitudes, and positive outlooks of group members.

The significant relationship between the client's race and perceptions of the program and system-maintenance dimensions of the treatment environment also raises interesting questions. A third of the clients and a third of the counselors were Black, and there was no disproportionate pairing of Black clients with Black counselors (or vice versa). There is no immediate explanation of why White clients have significantly higher ratings of the degree of autonomy, practical orientation, and personal problem orientation that are measured by the program dimension subscale. Neither is it readily apparent why White clients view the institutional environment as having more order, clarity, and staff control, as measured in the system-maintenance subscale. It is recommended that further research examine the impact of race, as well as other demographic variables, on perception and effectiveness of treatment. The other significant relationship between length of time in the institutional setting and perception of the system-maintenance dimension seems more apparent. After the initial adjustment period, institutionalized delinquents probably see the environment as more malleable and informal than they conclude it to be at first blush.

The outcome of this study will, I hope, encourage others to examine more complex interactions between treatment modes, personal factors, and envi-

ronmental factors as they relate to treatment effectiveness. Treatment modes such as social-learning therapies (behavior modification, social skills, and assertion training, etc.) have been found to be effective with some institutionalized youth (Stumphauzer, 1986) and warrant further investigation. These and other treatment approaches need to be compared with individual and group counseling in future studies that evaluate differences in clients' perceptions of the treatment environment and also differences in postrelease outcomes. Interactive studies of independent variables (e.g., the interaction of offender type and treatment mode) on dependent variables such as recidivism, severity of offense patterns, absconding rates, and frequency of delinquent behavior are needed to guide treatment planning. Interactive studies that assess multivariables may have a profound impact on future correctional rehabilitation of delinquent offenders and thus improve the record of correctional treatment that is "not yet good enough."

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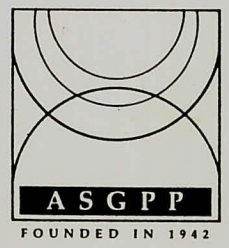

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