TRAINING MENTAL HEALTH PROFESSIONALS THROUGH PSYCHODRAMA TECHNIQUES: BASIC ELEMENTS*

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The educational bias which places high priority on linear learning and low priority on behavior/attitude learning encumbers the training of most mental health professionals. Traditional education has long prized linear learning—the written or spoken word—and the reasons are logical. Results are measurable and words are part of our daily life. We read a book and go from line to line. We think in linear patterns as the mind rhythmically abstracts concrete objects, catalogues them, and stores them as pieces of information. The learning of behavior and attitude has been deposed by an ever increasing body of professional knowledge. It is as though the price of attaining a professional role is at the expense rather than with the help of behavior and attitude learning.

Beyond an occasional instance, mental health training programs labor beneath endless lectures, note-taking, and recall of factual information. But the linear influence runs deeper. Most psychotherapies rely on a linear process. Clients, whether individuals or groups, sit down and produce words, ideas, thoughts, and memories in a linear sequence. The ultimate goal is enlightenment on the part of the client who transforms knowledge into behavior once he leaves the therapy environment. The linear process is reinforced continually throughout professional training both in ends and means. Minimal attention is given to the behavior and attitude dimensions of professional development. Little wonder that aspirants to the mental health field find it difficult to change from a linear mode of thinking to a behavioral mode of helping.

One ballast for this dilemma is to extend the use of psychodrama in training mental health professionals. The indication is clear. Clinical practitioners intervene on a behavior/attitude level as well as on an intellectual level. Doctors, social workers, nurses, psychologists, and mental health technicians are distinct from those who function on a fixed amount of linear knowledge such as engineers, accountants, and chemists. Practitioners exercise additional role prescriptions which frequently affect the outcome of service. Meaningful intervention depends on more than amassing factual

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knowledge as clinicians are aware. What we need is to give greater attention to behavior and attitude as a component of training mental health professionals.

The following material offers some basic elements for including psychodrama as an adjunct to the mental health training experience. The conceptual design is meant to assist instructors who train mental health aspirants in daily interactions within the clinical setting. It is particularly geared to the practicum instructor who is disposed, but somewhat reluctant, to try action methods due to a lack of extensive background in psychodrama.

Psychodrama is a form of learning in its own right. It reverses the linear approach and begins with behavior/attitude aspects of human experience. As a therapeutic method or learning style, psychodrama relies on the action principle that when people convene, they behave rather than simply talk. The feelings, words, voice intonations, and movement dimensions of participants are made present in such a way that alternate responses to new or old situations can emerge. The psychodrama experience uniquely explores behavior, attitude, and intellect simultaneously within a learning environment. Learning has no time lapse and behavior rehearsal need not be postponed. Participants in psychodrama experience a fuller or cosmic dimension of their own conflict reality as it is felt as well as understood. Learning through psychodrama transcends the single linear dimension.

The founder of psychodrama, J. L. Moreno, took great care to develop a technical procedure for eliciting these dimensions of behavior and attitude. His method sharply contrasts with the psychoanalytic school and their views on persons they purport to help. "Historically, psychodrama represents the chief turning point away from the treatment of the individual in isolation, to the treatment of the individual in groups; from the treatment of the individual by verbal methods to the treatment by action methods."[1] Moreno's subject matter—human conflict—is still the guidepost of those who employ psychodrama. Whether a pure modality or ancillary to other action approaches, his methods have great popularity among mental health professionals. Clients typically deal with interactional or intrapersonal conflicts which may be precipitated by a change of social status or the acquisition of new role demands. Practitioners continually find treatment applications within hospital settings, probation departments, rehabilitation programs, industry, research and education.

Psychodrama's distinct advantage for the mental health instructor is in being able to explore group conflicts around a common role aspiration. Davies summarizes: "If the method is modified so that social roles are

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[1] Moreno, Jacob L., *Psychodrama, Vol. I.* Beacon, New York: Beacon House, Fourth Edition, 1972, p. 10.

focused upon rather than individual personalities (the sociodramatic as opposed to the psychodramatic approach) it can be used to catalyze a social system without excessive disturbances to its equilibrium.[2] Professional role clarification is a dominant issue in mental health training since the reciprocal social roles of client and the reciprocal roles of client and staff are dependent on how the staff role functions in behavior and attitude. For instance, nurses are required to perform behaviors such as managing a certain patient type, supporting a particular patient through illness, and dealing with the social network of the treatment staff. The variations and consequences of behavior associated with the role of nurse are seldom tested beyond the actual situation. Nurse-patient problems, interactions which involve co-workers, supervisors, instructors, or relatives and friends of clients all need a degree of training if preparation for the professional nurse role is to be complete. Trainees from all disciplines should be familiar with some dimensions of role demands as well as a range of feelings on both sides of the role transaction. For the instructor, the focus is not how a personality can function in a professional clinical role, but what behavior and attitude ingredients constitute a specific clinical role.

A selected review of the literature on the use of psychodrama in professional training gives few conceptual guidelines for the instructor wishing to supplement instruction with action methods. The technical model outlined by Moreno often appears too complex for direct application by instructors. Consequently, a busy instructor familiar only with the mechanics of action techniques may find it difficult to conceptualize what action might be appropriate for his particular group. Situation replay is the usual outcome which may or may not resolve conflict issues. Without some model an instructor is limited in how he perceives the action.

The instructor who attempts action methods around issues of professional roles must do more than set scenes in motion. He must maintain an organized sense of where the group is for that moment in time while keeping to a theory framework. Regardless of the depth of action, his job is no less than that of director. As Weiner and Sacks advise of the director: "His job is divided partly into freeing the individual or individuals for action, partly to concentrate on some conceptual framework."[3] The instructor must do more than impart linear knowledge; he must allow behavior and attitude to develop. His goal is not therapeutic in the usual sense of the word, but

[2]Davies, Martin H., The Origins and Practice of Psychodrama. *British Journal of Psychiatry,* 1976, 129, p. 205.

[3]Weiner, Hannah B., and James M. Sacks. Warm-Up and Sum-Up. *Group Psychotherapy,* Vol. XXII, 1969, p. 85.

educational. He must guide his trainees to an action appreciation of their perception of a professional role.

An action model for clinical instruction can originate from many directions. One viable framework for training mental health professionals is the systems approach. A systems approach proposes a multiple causation and interrelatedness of forces to explain individual behaviors.[4] It is particularly useful since trainee groups bring before the instructor a degree of prearranged structure by their sharing a common goal. Moreno interprets this as a type of culture. By utilizing this prearranged structure or culture, an instructor can speculate on underlying sources of strain which influence the interactions.

Working within a systems framework, Moreno posits that in groups with a common role aspiration, the subject of conflict is not a person but the relatedness of a group. "It is therefore incidental who the individuals are, or of whom the group is composed, or how large the number is. But as the group is only a metaphor and does not exist in itself, its actual content are the interrelated persons composing it, not as private individuals but as representations of the same culture."[5] The interrelatedness of social roles is what the instructor investigates throughout the action. The convergence of the educational culture, the aspired professional culture, and the client culture generates the stress felt by trainees. The resultant conflicts in behavior and attitude arise from the impact of each culture upon each. This can be recreated when a trainee group convenes and what psychodrama is specifically designed to handle. Training groups all share the commonalities of meeting clients, dealing with superviors, and seeing others practice new roles.

To help an instructor interpret this multi-cultural impact, he must first analyze the structure of the social system and then interpret some possible origins of conflict. It is not unusual for common elements to arise when training groups discuss difficulties concerning their professional role relations. Smelser and Smelser[6] cite four areas of conflict with a social system which serve as an initial guide for instructors sorting out group conflicts. The list is by no means exhaustive. The conflict areas they associate with interaction are: (1) ambiguity in role expectation for both trainees and clients, (2) conflict among roles where behaviors are perceived as incompatible, (3) discrepancies between professed social values and actual situa-

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[4] For a discussion of behavior through systems analysis see: Chapter I, Systems and the Analysis of Functions. In John A. Seiler, *Systems Analysis In Organizational Behavior*. Homewood, Ill.; Dorsey Press, 1967, pp. 1-22.

[5] Moreno, p. 354.

[6] Smelser, Neil J., and William T. Smelser, (Eds.). *Personality and Social Systems*. New York: John Wiley and Sons, Inc., Second Edition, 1970, p. 10.

tions, (4) widespread conflicts of values in a system. An instructor may see any of these conflicts within his group either singly or concurrently. Once an instructor senses role struggle within the group, he should focus the core conflict rather than a tangential concern. Action themes may begin to emerge as the group brings their own particular content into discussion.

After the conflict area is isolated, an instructor's second task is to note the educational stage within which the students are immersed. This is rarely considered. Specifically, the instructor must know whether students are in the beginning, middle, or final stage of their clinical (practicum) experience since each has singular concerns.

All trainees aspiring to mental health professions seem to experience recurring role struggles at calculable stages. The struggles may be more a function of the education process and should be dealt with through this context. Regardless of the discipline, students feel apprehension around mobilizing unfamiliar behaviors prescribed by a professional role at specific stages.

It is suggested that four universal sources of strain are built into the practicum clinical experience which trainees from all disciplines encounter.[7] Briefly stated the sources include: (1) orientation and management of a new clinical setting or social system, (2) interviewing, (3) problems in direct service delivery, and (4) termination. The role conflicts outlined by Smelser and Smelser can predictably emerge when a trainee encounters each of these educational stages. (See Table I).

As students enter each stage there arises a kind of anxiety which Moreno describes as "a separation of the individual from the rest of the universe—the result of being cut off."[8] The feeling is shared throughout the group although the experiences are individual. As each expands professional role behaviors, each encounters a struggle. The instructor's preliminary to action is to locate the educational stage and relate the specific type of conflict. Students then have structural boundaries and are free to focus spontaneity on the central conflict.

The paradigm suggests the instructor be sensitive to the educational development of the students by anticipating developmental sources of strain. Together with the conflict areas outlined by Smelser, the instructor should

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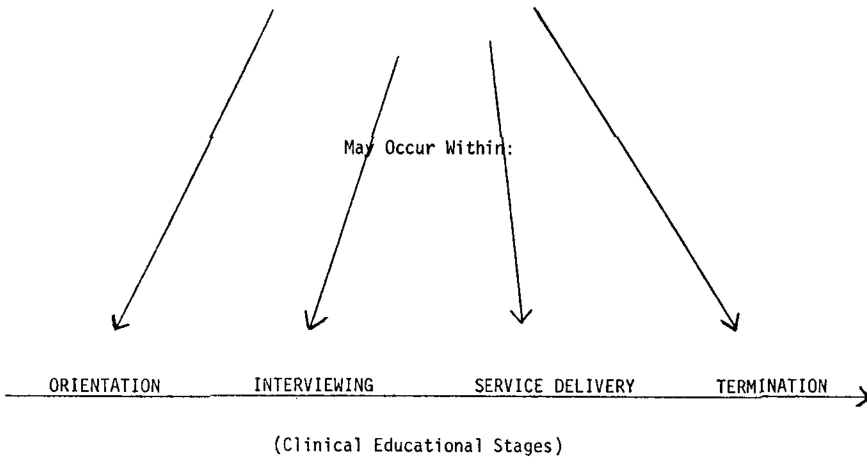
[7]This extends the work of John E. Mayer and Aaron Rosenblatt, Sources of Stress Among Student Practitioners in Social Work: A Sociological View. *Journal of Education for Social Work,* 1974, Vol. 10, No. 3, pp. 56-66.

[8]Moreno, Jacob L. Global Psychotherapy and Prospects of a Therapeutic World Order. In Jules H. Masserman and J. L. Moreno (Eds.), *Progress in Psychotherapy, Vol. II, Anxiety and Therapy.* New York: Grune and Stratton, 1957, p. 6.

Table I

TYPES OF CONFLICT IN A SYSTEM

1. Ambiguity in role expectation.
2. Conflict among roles perceived as incompatible.
3. Discrepancies between professed values and actual situations.
4. Conflicts of values in a system.



more accurately perceive an action theme.[9] The goal of action is to explore behaviors and attitudes of professional roles which the students feel are self-satisfying as well as adequate. Issues may repeatedly emerge, but the instructor simply guides the group through variations on the same theme while trying to help the group work towards a resolution.

The instructor must carefully decide which stage the group is currently experiencing and what the group sees as its central conflict. At times the instructor may need to shift the frame of reference so students may rework a prior conflict. Likewise the group should not concentrate on a peripheral issue or anticipate an action situation appropriate to another educational stage. For example, social work trainees doing field training at a prison may be over-concerned with the conflicts involved in building a therapeutic rela-

[9] Reference is made to the approach developed by James Enneis at St. Elizabeth's. His quadradic psychodrama is a unique integration of the basic Morenean contributions of Role Theory, Sociometry, and Group Dynamics with Social Systems Theory.

tionship with individual offenders. The instructor may wish to expand an identified conflict area to a larger issue such as how a social work trainee functions when he and the client are part of a very closed and structured social system. Earlier issues should be dealt with in the first stages of the practicum. Advanced issues should not be dealt with prematurely even though it may appear more "spontaneous" to let the group go where it chooses. The method has been stated many times: "While the process activities are structured, the particular content considered at any session is completely unstructured and dependent upon the interest and readiness of the individuals involved."[10] The instructor should allow a productive winnowing process by letting each culture emerge through the behavior of the trainess within a "safe" action environment. The intent is to clarify student perceptions and assimilate those behaviors and attitudes which contribute to a helping style of intervention. The following material discusses how the educational paradigm can facilitate an instructor's guide to action.

(1) *Orientation to a new clinical setting or social system:* Even though this is the age of computers, inputs, outcomes, and feedback, the social system concept is difficult for a clinician to grasp and even more difficult to retain as part of practice. Yet the first phenomenon all mental health trainees encounter at the practicum level is the new social system or the interrelatedness of persons encultured within a specific hospital, correctional setting, institution, clinic, or agency. Two observations are often made by trainees after a brief time at the practicum setting. First, there appears a certain equilibrium to the social relations network regardless of the type of clinical setting, and secondly, the network operates smoothly without him. His role as trainee is the least defined within the system and usually commands a nebulous status. These observations are further compounded by the temporary nature of being a student which gives tenuous social anchorage within an already existing equilibrium. Unless the trainee's perception is challenged early in the clinical placement, his static view of the clinical setting will remain indefinitely.

Orientation is crucial to trainee perception. An illustration clarifies the point. A group of student nurses was midway through the first day of their psychiatric training in a large psychiatric hospital. On their way back from lunch, a patient approached one of the students and struck her in the face for no apparent reason. Whatever the cause, that incident could very well confirm the trainees' stereotyped perceptions of psychiatric hospitalized patients. It is extremely important that this incident and others

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[10] Fine, Leon J. Action Group Processes and Psychodrama In Residency Training. In G. Abroms and N. Greenfield (eds.), *The New Hospital Psychiatry.* New York: Academic Press, 1971, p. 123.

be managed by the instructor and student perceptions explored within the action setting.

Humans in general tend to think that effects have single causes; students in particular are products of the single cause method of learning. Orientation for student nurses and others should alert trainees to the movements of a social system. Instructors should guide action sessions toward a more dynamic appreciation of the causes and consequences of behavior within a social system. Initial anxiety felt by trainees is not an anomaly nor attributable to a sheer lack of linear knowledge. Rather, it is a function of role. The student needs a place to sort out initial perceptions, attitudes, behaviors, and anxieties. He needs to experience what unidentified sources generate strain within the social system. All of these will ultimately affect the nature and strategy of his future intervention.

Management of the clinical system is an ongoing source of strain as trainees interact with clients, friends and relatives of the clients, supervisors, staff personnel, and each other. Conflicts arise at all interaction levels given the nature of a social structure. Some typical concerns felt by students throughout the practicum experience which instructors may wish to focus include: How far can one try to enter a family or institutional system which appears closed? What may a patient be feeling? How may one respond to rejection? What attitude is involved in a commitment to human service and what experiences affect it? What behaviors should remain outside the professional role function? The instructor should pay careful attention to how the trainee perceives and manages his role in the assigned clinical setting. Behavior and attitude are most pliable during this early educational stage.

(2) *Interviewing:* Between all who work in mental health and clients served, a kind of synapse exists. This is where two persons stand face to face while services and needs are exchanged through behavior. The term "interviewing" describes any interaction within mental health services where roles are prescribed within a helping framework. For example, nursing assistants observing someone on suicidal precaution, a psychiatrist desensitizing someone with a phobia, or a counselor helping someone confront alcoholic behavior all fall under this use of the term interviewing since role behaviors are involved. The duration of interaction is of little consequence. The focus is that both trainee and client are thrust together at a particular moment and are expected to interact. A whole range or relationships can emerge during their face to face exchange.

As students exercise their role behaviors in an interview, the resulting relationship may be very threatening. The conflict felt by all trainees in relationship is closeness and distance. The anxiety around how close to

become to the client, and vice versa, may appear in an assortment of ways. How much of my personal life should I reveal? What if he walks out? Does the family trust me? Does he know I care? What if he misinterprets what I say?

This issue of closeness and distance routinely emerges after a period of orientation and needs to find expression and resolution. This can be a most productive area for group interaction. Each has experienced closeness and distance in his personal life and action themes should be relatively easy for the instructor once a role conflict is identified. A trainee group shares similar role concerns and can supply numerous alternatives from their personal perspective. The whole purpose of mental health training is to establish alternative avenues for offering help. Although threatening, students are usually quite receptive to action around the notion of interviewing.

(3) *Problems in direct service delivery:* Closely related to the interviewing stage in educational development is how a student can help a person in need when the student cannot fully identify with the professional role. Establishing a positive relationship is the first step, but most mental health workers are expected to provide something more. The student may feel somewhat frightened when giving service since the specifics are often unspecified. Mayer and Rosenblatt focus the problem. "Students worry over the fact that troubled persons are depending on them for help, and they question their ability to supply it. Moreover, their anxieties are compounded by the fact that their performances are under the constant surveillance of their supervisors—who can substantially influence their future."[11] The conflict is unique in that some service is expected to be rendered through the relationship. This sharply focuses the helper/helpee roles. Students often have difficulty deciding what service they are expected to give and how to go about effectively giving it.

Services to clients can be given either in a custodial or humanistic fashion. The contrast is best seen through action. Whether supporting a schizophrenic patient through an acute episode, interpreting psychological test results, contracting for long-range therapy, or locating money to pay utilities due that day, a service should accompany the professional clinical relationship. Students should have little trouble selecting typical or unusual conflicts for action as they learn the behaviors which accompany rendering service through a clinical role.

(4) *Termination:* Termination has special significance for the mental health trainee due to his unique social status. The student may vacillate between gladness that another training phase is complete, and sadness that

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[11] Mayer and Rosenblatt, p. 56.

no one will continue his individual kind of service. Fact to face encounters should have taken on new dimensions which the student must now break. The literature is replete with issues around ending face to face engagements. Essentially, termination is the final "letting go" in a relation in which a student has invested a great deal of time, skill, and personal concern. This educational stage is unique as students leave practicum training, but the process will repeat itself as long as they assume the professional role. Instructors often minimize this stage, since so much energy is spent on the previous stages.

The issues in termination crystallize what has occurred in earlier stages. Intimacy, a recurring theme, is felt by all but differently by each. When termination moves into action, the instructor should allow individuals to find their own resolution to intimacy as they feel it. Remember they are working for the entire group. Rehearsing prior to actual termination is often very helpful to trainees and not utilized enough. Termination for the trainees often contains different elements than will be experienced as a professional. Adequate closure for individuals in the group should complement the period of orientation.

SUMMARY

Linear learning prepares mental health trainees with intellectual skills; it does not teach sensitivity and role behavior. Both are essential to a clinician's intervention arsenal. Practitioners need training in the behavior/attitude dimensions of human problems. Psychodrama provides a combination of linear and behavior learning in a creative environment.

Most instructors who train mental health professionals are committed to extending both linear and behavior knowledge. The theoretical framework presented above can assist instructors familiar with the psychodramatic or action approach. The education process is similar in all trainee groups and once the process is identified by the instructor, the challenge role conflict resolution through action is made easier.

All training groups are not alike, but the process of professional socialization contains common elements. Human interaction has defined and predictable patterns, and in this sense is not unique. Repetition is part of the human condition. But the process can be creative in discovery, and each person makes it creative through his individuality. This is the essence of spontaneity. Psychodrama offers trainees a creative experience which can enhance professional training. The development of sensitivity is the anticipated fruit of the experience. Hopefully this fruit will become a wellspring for helping others.

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