

## SERIAL PSYCHODRAMA WITH ALCOHOLICS

MARGARET VAN MEULENBROUCK

*Fort Logan Mental Health Center, Denver, Colorado*

Spurred by my own intense psychodrama experience at Beacon, I returned to my duties as psychiatric consultant with hopes of beefing up psychodrama on our Alcoholism Division. Allied with my intentions was a climate of familiarity with psychodrama on the Division. However, in actual practice, for various and sundry reasons, full and regular psychodramas were being used less and less. As a consequence, many staff members felt rusty and insecure in psychodrama techniques. Sporadic psychodramas often were incomplete and ineffectual. Both staff and patients lost confidence in its effectiveness. Thus a vicious cycle was set up.

Luckily, the Division Chief and his assistant were both psychodrama enthusiasts and were receptive to my enthusiasm. Also, a social worker gave her whole-hearted support and in fact was my most effective ally. Result: a small core of staff agreed to do daily psychodrama for two weeks with our readmit patients, who are the most chronic. We followed, as closely as possible, the format I had been so favorably impressed with at Beacon. We committed ourselves to two psychodramas a day for two weeks. We minimized warm-ups, encouraging patients to volunteer as protagonists and then select the director of his choice. The group was not strictly closed but had a core of about twenty consistent patients. Staff consistency was not 100%, but close.

Initial reaction, when our intention was announced to patients, was strong resistance, fear and negativism. One patient succinctly summed it up that of all the techniques and approaches listed on an admission questionnaire psychodrama was the one and only technique he said he wanted **NOTHING TO DO WITH!** Staff resistance, for the most part, was more indirect but almost as intense and dogmatic!

As our psychodrama experiment progressed, patients by day two or three had reversed from resistance, negativism and indifference to endorsement. Invariably, at each new session, some patients were already assembled around the stage when we arrived. Staff went along with unstructured warm-up and volunteer protagonist who then chose his director. However, some were anxious or uncomfortable with the arrangement throughout the entire two weeks. My reason for preferring this arrangement remains that it allows the patient to select a director he trusts and needs most at that time and this combination favors a more productive working relationship. With the frequency of dramas, patients were quickly exposed to styles of various directors and this aided them

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in selection. This was seen initially by some staff as competition or a popularity contest. However, as the pace picked up and we all felt we were contributing and working pretty much at peak level, selection of a colleague as director was viewed with relief rather than jealousy. Staff team work and morale increased.

The tendency of some staff to rescue patients from painful situations almost sabotaged the model on several occasions. This was especially critical after the first "heavy" session. Patients at the next session attempted to deflect further heavy sessions with bids to listen to music or go to the O. T. Shop. The protagonist of the previous session felt compelled to apologize for getting into some morbid material, especially just before Christmas. Nevertheless, he couldn't resist telling the group, rather defiantly, that he for one felt much better after his heavy session. During this critical warm-up, staff supported the norm of catharsis. I used the analogy of incision and drainage of an abscess, letting out pus under pressure and the tremendous sense of relief. I likened psychological hurts to the pus and psychodramatic catharsis to the physical relief when abscess is incised and drained. We also referred to the grief model which is presented weekly, reiterating that alcoholics frequently bypass hurt, anger and guilt associated with a loss by using alcohol to anesthetize it, rather than experiencing it and working through it. As the resistance began to abate, we half jokingly designated one wall as the "wailing wall" and another wall as the "chair-throwing wall." We invited patients to use them between sessions if impelled. The session that followed proved to be another heavy one with hardly a dry eye by terminus. But, this time, no one fled in disgrace or embarrassment. In fact, the director skillfully used a sobbing observer to play the role on stage.

Another norm we attempted to set up was to have patients get themselves "psyched-up" to work on something and attempt beforehand to focus in on one particular area, loss, person, crisis, trait, etc. Indeed, quite a few demonstrated that they attempted this outside of the psychodrama theater. Some reflected in solitude. More often they seemed to put things together in long rap sessions at the halfway house where most were residing.

A final norm which I suggested on the first day was that, especially as sessions got heavier, people recognize that they may be preoccupied and accident-prone immediately after a drama and in these states, avoid driving, working with power tools, etc. (Some were on day care and returned home evenings to their families or hobbies.) Confidentiality was an unstated norm until the final session when the last and most reluctant protagonist asked for it to be verbally agreed upon. In respect for this norm, this article contains no personal content from any of the psychodrama sessions.

Results? At this time, the only things that can be evaluated are group process and patient's testimonials. It is too soon to have any evaluation of impact criteria such as job or family stability, sobriety, etc. The group rather quickly became tight-knit and cohesive with a high level of trust and sharing.

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In my opinion, these were more genuine and solid than what occurs in our usual daily group therapy sessions with this readmit group. There were cumulative effects which triggered and facilitated dramas as we went along, e.g., scenes portrayed, comments in sharing often stimulated others until we had a steadily growing, rich sociometric network. As tele increased, auxiliaries were selected more spontaneously and needed less warming up. Reactions within the dramas became fuller. Staff also noted a patient who had not come full circle in his own drama finishing out in a subsequent drama in an auxiliary role. Another patient attempted new behavior (right out of her own surplus reality scene) in a critical conjoint interview with her husband and a staff member after hours one day. In other words, patients were trying out new behavior which had been explored or suggested by their own dramas! A staff bonus emerged in that, because of the frequency of the dramas, staff had more opportunity to expand skills. Those who ordinarily direct (and were scarce) had chances to enjoy auxiliary work. Conversely, a social worker who had done competent auxiliary work for years but had always been intimidated by directing was requested by a volunteer protagonist, responded and did a commendable job. Staff rehashes followed each session. Staff who previously had been hesitant but curious became involved and gained new skills through experience and tutelage.

Another auxiliary benefit, possibly, is that patients who were unmotivated to work on their problems quickly drifted out of the hospital. As our Division is frequently flooded with unmotivated patients committed by the courts or by patients merely seeking stabilization but no therapy (e.g., snow bunnies), intensive psychodrama tended to deflect these people to more appropriate places. It appeared to me that we did get a few unmotivated patients hooked on psychodrama and redirected into therapy.

Disadvantages were two in number. Number one was the emotional draining on the staff. This may become less the more we are exposed to psychodrama and the more facile we become. Staff has already embarked on a psychodrama training workshop once a week; in addition, we have agreed on continuing the two-week intensive psychodrama format with two weeks on, two weeks off. This allows patients to integrate some of their learning in regular group sessions. It also will allow staff to recoup and catch up on neglected chores. Number two disadvantage: day care patients felt it was too intense. Perhaps in the future, we can carry all of these patients on 24-hour care during their intensive psychodrama experience.

Granted that patient's testimonials are not an accurate indication of prognosis. Nevertheless, for the sake of completion, I would like to include some mention of them. For the most part the patients felt this was the most therapeutic experience they had ever had. Many had been here and elsewhere in alcoholism programs six or more times. One patient stated that this had been the most meaningful of 22 hospitalizations!

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I would like to conclude with a brief word about dynamics. My observation through five years as consultant on our Alcoholism Division is that one of the strongest common denominators in many alcoholics is passivity. Another, as many attest, is denial. The psychodrama provides an ideal vehicle for reversing both of these. Another dynamic is the tremendous opportunity in psychodrama for the alcoholic to work through unfinished grief, both with catharsis and concretizing techniques.

