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The Place of Catharsis in Psychodrama

Peter Felix Kellermann

A brief historical survey of catharsis is given, and then the concept and curative value are discussed within the framework of psychodrama and of current thinking in psychotherapy. Catharsis is defined as an experience of release that occurs when a longstanding state of inner mobilization finds its outlet in action. Emotional, cognitive, and actional manifestations, as well as common experiences of catharsis, are described as they appear within psychodrama. It is concluded that catharsis in itself is not curative. It can only effect a change in combination with other factors, for example, sharing with a sympathetic group. Considering that catharsis is not the single or even the most curative factor in psychodrama, it seems to be overvalued by many psychodramatists. With regard to emotions, the overall aim of psychodrama should be not only catharsis but integration and ordering.

One of the more controversial issues in the literature on psychotherapy concerns the comparative advantages and disadvantages of catharsis. Unfortunately, the arguments for and against are often more impassioned than impressive, and we are provided with little systematic treatment of this subject from either a theoretical or an empirical perspective. The object of this paper is to review the concept and the curative value of catharsis and to reassess its status within the framework of psychodrama and of current thinking in psychotherapy.

Historical Development

Catharsis has played an important role in psychotherapy for almost one hundred years. However, a long time before it was used in psychotherapy, Aristotle, in his *Poetics*, used the term to describe the release of feelings in spectators who watched a tragedy. He believed that tragedy functioned "through the arousal of pity and terror to achieve a proper *catharsis*, or purification, of these same emotions" (Aristotle, 1941, p. 1460). This view of catharsis was interpreted in different ways. The accepted modern opinion is that catharsis is a medical term signifying an emotional purge in a patient. But Aristotle said very little about catharsis, and it is probable that this medical interpretation assumes a cleansing *from* emotions, as if they were noxious things to be gotten rid of. For centuries after Aristotle, patients were cleansed of evil spirits, demons, and other detrimental powers by priests, exorcists, mesmerists, and hypnotists, all of whom believed that something evil or unclean was influencing the person from within and that this had to be driven out.

The medical interpretation was powerfully reinforced in the late nineteenth century by Freud. Having studied hypnotism with Charcot, Freud (1894) provoked an emotional crisis in his hysterical patients and then guided the discharge of what he first re-conceptualized as repressed memories, and later, as "blocked libido."

In the early twentieth century, Moreno adapted the cathartic principles of Aristotle and the religious rituals of the Near East to the drama theories of Diderot, Lessing, and Goethe, to create the method of spontaneous drama—psychodrama—in which protagonists were given opportunities to liberate themselves from "conserved" roles and written manuscripts.

As time passed, many cathartic psychotherapies developed. For example, Character Analysis or Orgone Therapy (Reich, 1929); Narcoanalysis (Horsley, 1943); Gestalt Therapy (Perls, 1969); Primal Therapy (Janov, 1970); Bioenergetic Analysis (Lowen, 1975). The techniques differed, but the principles remained the same: to induce patients to purge themselves mentally from whatever morbid content was stored inside them. Common to these psychotherapies was the assumption that if not expressed emotions "build up" in a reservoir, like steam in a pressure cooker. This buildup causes internal pressure, or tension, which results in psychological malfunctioning. To regain a state of well-being, the patient must drain off the emotional residue by expressing ("catharting") it. This theory is sometimes called the "hydraulic" model.

A review of the literature makes it clear that there are a confusing and overlapping mass of related terms to describe catharsis, such as

"abreaction," "primal scream," or the Reichian type of complete orgasm, total climax. Each therapeutic approach uses its own terminology, together with various rituals, to allow its patients "to get things off their chest," "to cry themselves out," or "to blow off steam." Further, some of the different but somehow related phenomena—like acting out, peak experience, act completion, closure, happiness, ecstacy, AHA experience, confession, salvation, regression, need satisfaction—which are sometimes designated as catharsis should not be designated as such. For catharsis refers, specifically and exclusively, to release of stored up content through affective expression (observable surface changes in face, body, voice, and/or behavior). Consequently, catharsis is the particular experience of release that occurs when a longstanding state of inner mobilization (warming up) finds its outlet in action. What are the characteristics of this release?

Manifestations

To examine the characteristics of catharsis, let us begin with a common example: Imagine that you are the protagonist of a psychodrama and that you re-enact a scene in which you are unjustly accused of having done something bad. In spite of your protests and explanations, your antagonist begins to insult and denigrate you. We may assume that it will take only a few seconds before a wave of anger overcomes you—your heart begins to pound, your face flushes, your breathing gets heavy, your muscles tense, and your fists clench. Your memory will immediately offer up a complete list of all the former occasions when you were treated similarly. One of these memories will then evoke an emotional storm in you. Suddenly you re-experience a specific scene from your childhood. You feel like shouting: "I didn't do it! I didn't do it!" But instead you struggle to "keep cool," not to lose control. Nevertheless, despite your efforts to prevent an affectional outburst, you will find yourself in the midst of a furious scream. You will suddenly feel that old, dammed-up rage bubbling forth, and start to yell and hit and cry. It is as if something was "breaking through" within your body, something which you feel has been there for a long time. Something warm and soothing oozes out from your body. You will then know that you have discovered a secret. It was so simple, and yet, until now, you were unable to put your discovery into words, or even into thoughts; but your body always knew it. You feel a warm, tingling feeling of relief and begin to cry like a baby, a cheerful baby.

If this represents a typical catharsis, what may we learn from it?

First, catharsis is an *emotional release* encompassing a wide range of changes in physiological systems (cardiovascular, respiratory, muscu-

loskeletal, gastrointestinal, etc.), as well as in psychological systems (memory, imagination, perception, communication, judgment, etc.). "Emotion" is here taken literally—from the Latin *e-movere* meaning outward motion—conveying the idea of an outward expression of something inside. As with all affective expression, catharsis happens without voluntary control, spontaneously, "on the spur of the moment," as an automatic response to a specific inner or outer stimulus. But catharsis differs from other affective expressions in its intensity, rawness, and primitivity, as well as in its time-place distortion (of subjective reality), where here-and-now is mistaken for there-and-then. For example, bursting into tears after a long period of withholding may be regarded as catharsis, while weeping as a reaction to a recent loss is a normal grief reaction. Noncathartic expressions of emotions (for example, sadness) also include the resistive sobbing of somebody who covers up anger, the manipulative weeping of somebody who wants to arouse attention, and the symptomatic crying of somebody who is chronically depressed.

Second, catharsis is the *cognitive release* of an idea from the unconscious. As such, the affective expression is preceded, accompanied, or followed by a cognitive illumination where "a spotlight is switched on, psychic content of the patient, thus far hidden in the dark appears in the limelight of his consciousness" (Buxbaum, 1972, p. 161). For example, a sudden expression of grief may be connected to the memory of an earlier separation. Catharsis experienced in full consciousness will facilitate the experiential remembering that may lead to emotional insight. "Whenever something clicks, falls into place, each time a gestalt closes, there is the 'Aha!' click, the shock of recognition" (Perls, 1969, p. 236).

Third, catharsis is an *actional release* in which earlier events and their emotional residues are repeated in action via a direct motor expression of intrapsychic processes, where inner tensions are transformed into overt behavior. Such repetition provides a possibility of gaining action-insight. A complete catharsis, according to Breuer and Freud (1893) "depends on whether there has been an energetic reaction to the event that provokes an affect. By 'reaction' we here understand the whole class of voluntary and involuntary reflexes—from tears to acts of revenge —in which, as experience shows, the affects are discharged" (p. 8).

Whether focusing on the emotional expression, the cognitive awareness, or the actional re-living, it is assumed that something closed in, with a natural tendency to get out, is then let out. All three aspects together are necessary components of a complete cathartic process.

While this description gives an idea of the manifestations of catharsis, it does not help us understand the subjective experience of catharsis.

The Experience of Catharsis

From interviews with a number of psychodramatists, and from my own acquaintance with the phenomenon, I have learned the following about the experience of catharsis.

Catharsis differs from individual to individual in both quality and quantity. The intensity of liberation is highly relative and must be appreciated, not from an objective perspective, but from the perspective of each person's own experiential world. "A seemingly mute expression of emotion may, for a highly constricted individual, represent an event of considerable intensity, while an emotional storm for an impulsive individual may be a day-to-day regularity" (Yalom, 1975, p. 84).

Catharsis may be a sudden tidal wave of illumination, an explosion of energies finding an outlet since the purpose for which they have been mobilized no longer exists, or an inward unfolding of a kind of "oceanic feeling" where small ripples of release are experienced over a long period of time. In the words of Koestler (1969):

> One is the triumphant explosion of tension which has suddenly become redundant since the problem is solved—so you jump out of your bath and run through the streets laughing and shouting Eureka! In the second place there is the slowly fading after-glow, the gradual catharsis of the self-transcending emotions—a quiet, contemplative delight in the truth which the discovery revealed, closely related to the artist's experience of beauty. (p. 88)

Three authoritative psychodramatists perceived the experience of catharsis as "A relief after an extreme state of tension, or an emotional culmination where resistances are gone" (Schützenberger, 1966); "An upheaval, a breaking up of constricted emotions and stiff structures" (Leutz, 1974); and "The feeling that we are as we would like to be in our imagination" (Z. T. Moreno, 1971).

While many psychodramatists stress the experience of being "overwhelmed" by feelings, others find the cognitive experience—insight through perceptual restructuring—more evident. For example, one participant has said: "I reached catharsis when I had a new concept, when something changed in my mind. Like in one of my psychodramas when I suddenly saw my mother in a real, complete new light. I felt this was catharsis. I didn't scream or throw chairs or 'blow up' in any way. I just saw everything differently."

Catharsis may also be enjoyed as a pleasurable experience, one of relief after having released pent-up emotions, or of sexual excitement which may occur as the by-product of emotional excitation. One woman exclaimed: "It is like an orgasm! If you had it, it is blessed, it is

a miracle!'' This experience is similar, also, to the comforting relief one may feel after a verbal confession: ''Now everything will be all right. It has all come out in the open and there is no need to cover up any more.''

Some participants experience catharsis as a progressive realization of the self, e.g.: ''I am myself. Catharsis makes me strong, gives me energy and courage. It is a moment of growth, a moment of opening up to experience.'' Others experience it as a regressive de-realization of the self: ''I loose myself, let go of consciousness, of control, of memory. I become a little child.''

It seems that the experience of catharsis is something different for every person, and that it is very difficult to determine who has had ''it'' and who has not. It is further noteworthy that most of us think of it as something positive, a precious moment, an ''ideal state of being.'' Thus, in the world of common sense, catharsis, or release in general, has a positive connotation. However, this in itself does not make it something curative.

The Curative Value of Catharsis

The curative value of catharsis remains a controversial issue. Advocates believe that catharsis, as such, can cure in a kind of automatic way; critics either dispute its benefits or deny it completely. Proponents argue that the immediate sense of well-being experienced after a powerful emotional release is enough proof of its validity; that is, holding in one's emotions leads to feeling ''bottled up,'' while letting out leads to relief. Opponents argue that the relief is only temporary; that tension tends to reappear after a period of time; and that general emotional expression does not automatically reduce that emotion. (For example, crying does not always reduce sadness.) They also question whether emotional expression can, by itself, provide therapeutic change; for example, whether the expression of anger solves any problems.

Before continuing this discussion, we must define what we mean by ''cure'' and ''mental health'' and also try to differentiate among the various personality types who may benefit from catharsis.

The simplistic view of mental health as ''purity of the soul'' and mental illness as ''pollution of the soul,'' with catharsis as the intermediate agent of cleansing, is, of course, outdated. But current conceptions are not that different. A catharsis cure is still understood in terms of ''getting something out,'' as the liberation of something imprisoned. In psychodrama, for example, a healthy individual is seen as one who is able to give free and spontaneous expression to emotions, thoughts, and actions. However, this conception implies a constant process of change and further transformations.

Catharsis has traditionally been believed to be curative in cases of post-traumatic stress disorders, "in which what has happened is only that the reaction to traumatic stimuli has failed to occur" (Freud, 1894, p. 47). It is also considered valuable in the treatment of schizoid, avoidant, obsessive-compulsive, or passive-aggressive personality disorders in which affect is inhibited, and in the treatment of some somatoform disorders in which affect is repressed and somatized. But most patients, whether neurotic or psychotic, ego-strong or ego-weak, inhibited or impulse-ridden, are believed to have stored up "content" and are therefore believed to benefit from catharsis in some stage of their treatment.

Empirical research on the value of catharsis has focused, mainly, on the frustration-aggression hypothesis, as exposed by Dollard et al. (1939) who suggest that aggressive behavior reduces the instigation to aggression (is cathartic in effect). Early research, for example by Berkowitz et al. (1962), Feshbach (1956), Hokanson (1970), Kahn (1966), and Mallick and McCandless (1966), found little support for this theory, as have the more recent studies by Bohart (1980), Tavris (1982), and Warren and Kurlychek (1981). All these researchers found that the expression of anger, whether verbal or physical, does not automatically reduce anger. They did, however, conclude that interpersonal, behavioral, and/or cognitive factors were crucially related to whether catharsis was anger-reducing or not.

Theoretical studies within the framework of psychoanalytic thinking are also critical of the original catharsis hypothesis. For example, Kris (1952) said: "We are no longer satisfied with the notion that repressed emotions lose their hold over our mental life when an outlet for them has been found" (p. 45). And Binstock (1973) maintained that "the role of catharsis in human affairs is a most restricted and humble one" (p. 504). From a technical point of view, Bibring (1954), Dewald (1964), and Greenson (1967) view catharsis as an adjunct to therapy. They emphasize its rather insignificant curative role in psychoanalysis but do say that it can give the patient a feeling of conviction regarding the reality of unconscious processes.

Within the field of group psychotherapy, Yalom (1975), in his comparative study of curative factors, concludes that "the open expression of affect is without question vital to the group therapeutic process; in its absence a group would degenerate into a sterile academic exercise. Yet, it is only a partial process and must be complemented by other factors" (p. 84). His data are supported by the studies of Berzon et al. (1963) and Lieberman et al. (1972), who found that pure ventilation, without the acquisition of skills for the future, was of no curative value.

Slavson (1951) pointed out that "the value of catharsis lies in the fact that it induces regression to stages in emotional development where arrest or fixation occurred" (p. 39).

Advocates of catharsis as the single curative factor argue that what the critics repudiate is not "real" catharsis but "pseudo-catharsis." They maintain that patients who experience "real" catharsis, for example, a "primal scream," can be cured. Rose (1976) says that critics fail to get curative results with catharsis "because what they have identified as feeling is simply not sufficiently intense" (p. 80). Similarly, Scheff (1979) holds that it is the critics' failure to follow a procedure of repeated emotional discharge during a properly distanced re-experiencing of a traumatic scene that accounts for most of the difficulties they encountered, and not a lack of validity of cathartic therapy. Empirical evidence is given by Janov (1970), Karle et al. (1973), Nichols (1974), Nichols and Zax (1977), and Scheff (1979). Within the framework of human potential encounter, Heider (1974) believes that "catharsis is the most frequent and valued tool for entry into transcendental realms of experience" (p. 30).

If we want to know more about how patients change as a result of catharsis we must look for effective variables and curative factors in the patient, in the therapist, and in the treatment. Without a specification of the when, where, why, by whom and to whom, facets of catharsis, the more general question seems to be impossible to answer.

In their review of catharsis in religious and magic healing rites, psychoanalysis, clinical hypnotherapy, group therapy, behavior therapy, the social psychology of aggression and in the treatment of war neuroses, Nichols and Zax (1977) found that catharsis, alone, was never enough to promote a psychotherapeutic cure.

A common sense approach to the value of catharsis would seem to take into account Gendlin's (1964) observation that "major personality change involves some sort of intense feeling process occurring in the individual" (p. 105), the notion that tension reduction may lead to relief, and the idea that the benefits derived from catharsis depend on the response persons receive when they release pent-up content. When the expression of anger is met with retaliation, the experience may result in a new frustration rather than in relief. Thus giving expression to what one has heretofore kept in, *in the right environment*, can make a person more ready to listen to others and to reconstruct the perception of a total situation. Psychodrama provides the right environment.

One of the firmly noted assumptions in psychodrama is that the development of catharsis on the part of the protagonists is a major curative factor in the therapeutic endeavor, worth promoting for itself.

It is considered a greatly prized moment, a "magic" phenomenon, and a necessity for a successful session. As one participant said: "I feel I need it, both as a director and as a protagonist."

The Role of Catharsis in Psychodrama

The catharsis may occur in the beginning of the session, during the warm-up phase; in the middle of the session, during the action phase; at the end of the session, during the closure phase; or after the session, during the sharing phase. But, regardless of when it happens, it is always regarded as the "peak" or culmination of the session. It is sometimes even viewed as the single most significant event in a person's development. According to Ginn (1973), "the entire arsenal of dramatic weaponry is marshalled for the achievement and maximization of the cathartic moment" (p. 16). Polansky and Harkins (1969) were so impressed by the positive use of psychodrama for affect discharge that they "began to think of psychodrama as perhaps *the* specific for treating affect inhibition" (p. 79).

However, when the difficulty in determining the role of catharsis in personality change is taken into account, it seems monstrously overvalued in psychodrama. While catharsis may have a substantial value in certain contexts it should not, then, become so cherished and romanticized that it achieves functional autonomy, thereby becoming an end in itself rather than a means to an end. While emotional, cognitive, and actional release are central to the psychotherapeutic process, they are curative only in combination with other factors. As such, catharsis may set the stage for the change process by loosening up fixated positions; but sooner or later, the conflicts underlying these fixations must be dealt with, either with the outer world or in terms of one's own feelings.

Directors who provoke release for its own sake, without paying enough attention to resistance analysis, working through, and integration, may be compared to the early "id-analysts" in psychoanalysis who put all their efforts into uncovering the unconscious. Just so later ego-psychologists took ego-functions such as reality testing, adaptation, object relations, defenses, and integration into consideration. Directors who strive for both release (id) and integration (ego), will be more effective than those who emphasize release alone. This view is congruent with that of Weiner (1974) who changed Freud's dictum: "Where id is, there shall ego be," into "Where mind is, there shall body-mind be" (p. 48).

It was Moreno (1923, 1940, 1946, 1953, 1971) who enlarged the original etymological meaning of catharsis to include not only release

and relief of emotions, but also integration and ordering; not only intense reliving of the past, but also intense living in the here-and-now; not only a passive, verbal reflection, but also an active, nonverbal enactment; not only a private ritual, but also a communal, shared rite of healing; not only an intrapsychic tension reduction, but also an interpersonal conflict resolution; not only a medical purification, but also a religious and aesthetic experience. While this definition of catharsis reflects a considerable extension of that presented above, it conveys a profound understanding of the needs for ego-integration. Further, as this broad and inclusive definition of catharsis covers almost all essential aspects of psychodrama (which makes it difficult to study), it presents, implicitly, a two-phase process of psychodrama: (1) release and relief (catharsis), and (2) integration and ordering (working through). In the words of Z. T. Moreno (1965), "Restraint has to come after expression." The two phases of psychodrama will be further described below.

The first phase of psychodrama includes both resistance analysis (Kellermann, 1983) and catharsis. Protagonists are not manipulated into expression, but helped to overcome those resistances which block their spontaneity. Catharsis is neither induced nor inhibited, but allowed to emerge in its own time. Only when communication is open and feelings flow are protagonists encouraged to maximize their expression, in order to "let it *all* out!" The specific function of catharsis in psychodrama is to facilitate self-expression and enhance spontaneity. Self-expression is more than mere affective liberation; it includes communication of perceived inner and outer reality, of self- and object-representations, of values, defenses, body images, etc. Protagonists are encouraged to express themselves as broadly as possible, from their unique subjective perspective, in an atmosphere free of disapproval or retaliation. But, as Cornyetz (1947) pointed out, "the psychodramatist does not satisfy himself that the release took place, for here is the starting point of the task of psychotherapy and not the finishing-point" (p. 62).

The second phase of psychodrama includes integration and ordering of feelings. Whatever has been released must be integrated in order to prevent it from "going up in smoke." This integration involves restoring order in the internal emotional chaos, new learning of coping strategies, working through of interpersonal relations, identification and differentiation of feelings, reconciliation between opposing feelings, transformation of "partial" feelings to "complete" feelings, and assisting the protagonist's ego to find the best way of controlling unadaptive affects and regulating the enactment of the many and diverse affects that strive to take over behavior, perception, and communication.

Conclusion

The overall aim of psychodrama with regard to emotions is not only catharsis, but also the consequent integration and ordering. By reviving the original traumatic experiences, the constricted emotions and their corresponding ideas can proceed in their interrupted course of development to reach optimal degrees of spontaneity. In the words of Noy (1982):

> The cathartic effect of therapy can never be regarded as the goal, but only as the necessary means, for ordering the affect. Because only the person who is fully experiencing his affects—identifying, verbalizing, acknowledging, and responding to them appropriately—can succeed in ordering them and finding the best way for their enactment without anxiety, guilt, or remorse. (p. 82)

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Using Psychodrama to Reduce "Burnout" or Role Fatigue in the Helping Professions

JoAnn Kerr Thacker

Psychodrama has great potential for relief of burnout, or role fatigue, in the helping professions. It is useful for prevention and for remediation since it is an effective intervention strategy at all stages of the burnout cycle. Psychodrama provides a promising structure for the staff support groups which researchers of burnout agree are essential to its control. It has the advantage of being adaptable for role training, as well as being a highly supportive method of group psychotherapy. When presented as a means of improving job-handling skills, it is less likely to encounter staff resistance than a more unstructured group therapy method. The author describes her experience conducting a staff support group, using psychodrama, for counselors working in a county jail. She also suggests psychodramatic procedures which she has found particularly useful for reducing staff burnout.

A review of recent journals confirms that the concept of "burnout" has captured the imagination of human services workers—teachers, nurses, psychotherapists, police, correctional officers, and others. It is apparent that many workers recognize themselves in Maslach's (1976) description of burnout as an occupational hazard for "people who work intensively with troubled people," those in the so-called helping professions. Ideally, such professionals retain emotional distance and objec-

tivity without losing their concern for their clients. Maslach defined burnout as the loss of concern which can occur when they are unable to cope with the continual emotional stress of their jobs, and which causes them to treat their clients in detached, dehumanized ways. Burnout plays a major role in the poor delivery of human services to those in need of them, and it is damaging to the worker as well as to the client, having high correlations with other indices of human stress, such as alcoholism, mental illness, marital conflict, and suicide (Maslach, 1976).

Remedies that have been proposed for reducing burnout are various and include regular vacations, physical exercise, conscious relaxation, support groups for sharing feelings with colleagues, and training in assertiveness, communication, and other interpersonal skills. The present author (1979) has recommended psychodrama as a particularly useful tool for preventing and reducing burnout and has used psychodrama over a five-year period to help correctional counselors to examine and resolve moments of difficulty that they have experienced in their jobs. Psychodrama provides an adaptive method for coping with occupational stress, which reduces the need for the maladaptive coping mechanism of burnout. It also reinforces for helping professionals the necessity of maintaining their own mental health in order to work effectively with their clients.

Background

Freudenberger (1974, 1975) saw burnout as a significant problem for workers in alternative institutions, such as free clinics. His approach to reducing burnout involved both prevention and remediation. *Prevention* included:

- Intensive inservice training, which encouraged burnout-prone workers to screen themselves out;
- Restructuring of the work itself through rotation of duties, limitation of hours, and required vacations;
- Staff support groups for sharing experiences and talking about feelings about work.

Remediation involved long rest and supportive psychotherapy. Freudenberger emphasized that confrontation as a form of therapy was inappropriate for the burned out, because of the focus of blame on the individual rather than on the work. He also stated that, since there are various stages of burnout, any of the preventive measures can be helpful for "the person who is in the process of burning out but not yet burned out completely."

Maslach's research (1976, 1978a, 1978b) showed that burnout rates

are lower for those professionals who actively express, analyze, and share their personal feelings about their work with colleagues. She found that self-blaming, like client-blaming, was part of the general tendency of burned out workers to make person-centered evaluations. Most workers felt that they were "the only one who can't take it," and they attempted to cope with burnout through withdrawal, intellectualization, and physical distancing from the problem. When given the opportunity to share reactions to job stress and coping mechanisms with other staff in a confidential atmosphere, workers experienced reduced feelings of failure. Maslach also pointed out that the personal relevance of client problems often caused increased emotional stress for staff, since the problems of some clients were "too close for psychological comfort" for some staff.

Kahn (1978) recognized role conflict as a primary cause of burnout and recommended increasing the social support of helping professionals by expression of positive affect and recognition of the strenuous nature of their work. Hall et al. (1979) cited earlier research with physician drug abusers to demonstrate that persons entering the health professions often have high needs for approval. When these needs are frustrated, confidence decreases, exhaustion dampens interest, and efficiency declines. Staff training, support groups, and development of a team approach were recommended as appropriate organizational responses to burnout in health settings.

A review of a presentation by Dr. Carol Boggs ("Burnout," 1980) focused on role conflict and role ambiguity as causes of burnout and recommended emphasis on prevention, "since burned out individuals typically do not have the energy to remediate." Suggestions for prevention included: (1) Peer support groups (not encounter groups); (2) training programs to increase job-handling skills; and (3) decompression time after work, during which employees are encouraged to ventilate about the day's problems, in order to avoid taking them home where they may negatively affect family life.

Cherniss (1980) defined burnout as a psychological withdrawal from work in response to excessive stress or dissatisfaction and described the process as having three stages:

- Stress: perception of an imbalance between resources and demand;
- Strain: an immediate, short-term emotional response to this imbalance, characterized by feelings of anxiety, tension, fatigue, and exhaustion;
- Defensive coping: the tendency to treat clients in a detached and

mechanical fashion or a cynical preoccupation with gratification of one's own needs.

Cherniss also discussed the role of learned helplessness in burnout, "the belief that one has no control over the course of events." He recommended social support and increased staff interaction for remediation.

Edelwich and Brodsky (1980) also stated that the sensation of powerlessness was a key element in burnout, which they defined as a progressive loss of idealism, energy and purpose, experienced by people in the helping professions as a result of conditions of their work. They identified a burnout cycle, consisting of four stages, and for each stage they recommended a corresponding intervention strategy:

Burnout stages	*Intervention strategy*
1. Enthusiasm	Teach realism
2. Stagnation	Promote movement
3. Frustration	Mobilize the energy of discontent to build satisfaction
4. Apathy	Turn the feeling of disappointment into involvement

Edelwich and Brodsky cautioned against attempts to resolve the problem of burnout by prevention methods alone. They considered prevention impossible and regarded burnout as a phenomenon which will happen, perhaps repeatedly, in the careers of many helping professionals. They recommended intervention on an ongoing basis, which assesses the individual professional's stage in the burnout cycle and prescribes remediation accordingly.

Burnout and Role Theory

J. L. Moreno (1962) stated that role playing is prior to the emergence of self and that the self emerges from roles rather than roles emerging from self. The role of worker is one of the most important roles from which the self emerges. This is especially true for professionals, who have invested considerable time, money, and energy into preparing themselves for the work roles that they have chosen. Thus, burnout leads to the erosion, not only of the worker role, but of the self-concept.

Barbour and Z. T. Moreno (1980) suggested conceptualization of the syndrome known popularly as "burnout" in terms of role theory. They pointed out that the role is a bridge between self and others and

that role evolution passes through stages of perception and enactment. Self-concepts are tied to the roles we take in life and to our evaluations of how well we perform them. When we come to value our roles less, we value ourselves less. Because of approach-avoidance conflicts, one may persist while becoming increasingly disenchanted and experience "role fatigue" and "role burnout," resulting from the role's eroded value. There is less energy available and consequently role ambivalence.

This fatigue applies not only to job-related roles but also to social, familial, and religious roles, and it is possible to "burn out" in these areas as well.

> It is important that the person become aware that he or she is repeatedly performing a role which is no longer productive to others or satisfying to him or herself. Frequently people in these circumstances are blocked, immobilized, or in [J. L.] Moreno's term, "conserved." They may be cognizant of a need to "take charge" of their own lives but depressed due to an apparent lack of alternatives. . . . Assuming that role fatigue emerges from altered perception of unfulfilling role performance, perhaps concentrating on role perception and correction of such perception would be important to any later decision-making or goal-setting. Therapy for role fatigue would include:
>
> 1. Redefining what is seen.
> 2. Exploring the role psychodramatically in different ways and from the perspective of the significant other(s) through role reversal.
> 3. Expanding or reducing or eliminating the role, as indicated.
> 4. Re-assessing role expectations.
> 5. Re-evaluating role performance.
> 6. Considering alternative roles.
> 7. Training for alternative roles. (Barbour & Z. T. Moreno, 1980)

Burnout and Psychodrama

Garfield (1973) pointed out the usefulness of role playing for increasing skills in role enactment and promoting flexibility in dealing with life's problems by expanding one's role repertoire. Role-playing techniques afford a high degree of freedom in experimenting with and learning new role behavior. Role training provides the repetitive rehearsal of various roles in a diversity of situations, thus enabling an individual to perform more adequately in roles with which he has difficulty.

Rosenfield and Peltz (1978) examined the emotional responses of helping professionals during crisis intervention and concluded that the helper often experienced a "microcrisis," becoming momentarily

overwhelmed and undergoing a rise in tension. Because of the active nature of the helping role, the recognition of these microcrisis reactions was often blocked from awareness. Awareness of this dynamic was fostered through psychodramatic work with helpers.

VanderMay and Peake (1980) analyzed psychodrama as a group supervision method for therapists and found it especially helpful for work on countertransference. They saw the "here and now" focus, action orientation, spontaneity, sharing, group catharsis, and protagonist focus as aspects of psychodrama that contributed to its usefulness for this purpose. But the main strengths of psychodrama were considered to be in promoting and developing an understanding of the trainee's emotive response and in trying out therapeutic approaches and techniques.

Virtually all writers on burnout have stressed the importance of ongoing staff support groups for its prevention and/or remediation. What makes psychodrama a method of preference for such groups? Psychodrama is effective for interpersonal skills training as well as for psychotherapy, and by placing emphasis on the former, it can be made less threatening to staff than traditional group therapy would be. Action techniques are most effective for warming up a group and result in reduction of feelings of powerlessness and promotion of group interaction and team building.

While it is protagonist centered and focuses on the problems of the individual, psychodrama emphasizes commonality of problems through sharing. Thus it reduces alienation, eliminates "I'm the only one that can't handle it" thinking, and promotes building support groups for sharing in one's larger life. It is a supportive method which strives to leave the protagonist in a good place, therefore meeting basic approval needs of helping professionals and building their self-esteem. It also enhances positive self-image building by providing staff with opportunities to use their skills in auxiliary roles and in role training. It is nonjudgmental, in that it does not allow the group to place blame on the protagonist; members are encouraged to share related problems directly rather than projecting them.

Psychodrama is an effective method of intervention at all stages of the burnout cycle. Since all participants in a psychodrama can be helped by it, there is learning for staff whether in auxiliary roles or as audience, even if the protagonist role is usually taken by the most troubled. For new staff, feelings of enthusiasm and idealism are brought into contact with reality as they experience directly the effects of work pressures on fellow staff members. Movement is encouraged in the stagnated by the focus on problems and on "moments of difficulty." Catharsis allows ventilation and decompression for the

stressed or frustrated, and somatic symptoms usually associated with strain can be explored psychodramatically. The apathy and defensive coping associated with the final stage of burnout respond to the spontaneity of psychodrama, which: (1) Breaks through role conserves with fresh thought and action; (2) allows the re-emergence of long-blocked feelings; and (3) emphasizes flexibility and creativity by showing that there are many effective ways to resolve problems.

Psychodrama is especially effective for working with countertransference, those client problems which cause anxiety because they are "too close for psychological comfort." The effectiveness lies in its ability to concretize metaphor and to allow the separation of the interfering problems from the client's own problem. Its emphasis on working on problems as they occur makes it appropriate for the ongoing intervention that seems to be necessary for reducing burnout. Its grounding in role theory is also helpful; conceptualizing burnout as role fatigue encourages workers to be wary of the effects of dissatisfaction with their working roles on their self-concepts and larger lives. Also, the concept of role fatigue translates readily into action exploration, which, aside from being therapeutic, can lead to assessment of the group's need for training in skills related to the work role.

Useful Psychodramatic Procedures

While all of psychodrama is relevant to the phenomenon of burnout, certain procedures can be particularly germane and deserve special mention. The opening phase of a psychodrama group, the *warm up*, is critical during the first few meetings of a staff support group. The use of fairly structured warm-up techniques at this time can reduce the initial discomfort of group members and help them to begin to focus on work-related problems. Asking the group to sculpt an auxiliary to resemble "you in your work role" and then to reverse roles with that auxiliary and soliloquize is an example of an applicable warm-up technique. Another is having each member imagine a client in an empty chair and express concerns about helping to that client. If the mood of the group is angry, members can be encouraged to express feelings to an empty chair representing the administration. If the mood is depressed, a "one downmanship" warm up may be appropriate, in which members pair up, and each claims to be the poorer worker of the pair. This usually results in the group's laughing at itself for taking small failures too seriously. Structured warm ups such as these mobilize the group's energy, making members more comfortable with each other and with the task at hand, and allowing a protagonist to emerge.

When a staff support group has become established and the task of the group has become clear to its members, a go-round during which each member makes a *soliloquy* is usually adequate for warm up. Soliloquy is a here-and-now statement of one's feelings and preoccupations. Each member has come to the group from somewhere, and the opportunity to summarize where one has been allows one to be more fully in the present. It also allows members to warm up to each other's preoccupations and feelings. A group focus or concern frequently emerges from this process, and in a work group, the group concern is likely to be work-related. It remains only for the group to select a protagonist who seems most ready to work for the group on its common concern. Soliloquy is useful during the action phase of psychodrama as well as during warm up. Stopping to soliloquize during work on an interaction with a client gives the protagonist a chance to sort out personal feelings that was not available during the real-life interaction, because the focus was on the client's feelings. Allowing auxiliaries to soliloquize in role is often helpful in the staff support group psychodrama, since auxiliaries have usually had direct personal experience with the kind of roles they are playing.

Role playing moments of difficulty is an especially useful format for psychodrama in the staff support groups. Warner (1972) has described the use of this format for training auxiliaries. Members are asked to focus on moments of difficulty that they have experienced in their work. By role playing these situations and concentrating on the protagonist's feelings at the moment of difficulty, the director attempts to expose the block to effective functioning and to help the protagonist to overcome it. Closure should involve the protagonist role playing the original scene in a way that is personally more satisfactory. The director can model sensitivity to moments of difficulty by sharing with the group personal moments of difficulty in directing during the processing of psychodramas.

Getting in touch with the protagonist's feelings during a moment of difficulty often leads to *exploring the past*. Several directorial leads are appropriate to determine whether a past scene needs to be done. One is the emotional bridge. When the protagonist experiences strong emotion in a present scene, the director says, "Close your eyes and stay with the feeling until another scene emerges." If the protagonist shows evidence of regression, the question, "How old do you feel?" often leads to a relevant past scene. When frustration with an antagonist is the theme, "Whom does this person remind you of?" or "Is this person like anyone else in your life?" may lead the protagonist to past work that needs to be done. When the protagonist returns to past

scenes with present resources, the results are usually experienced as successful, allowing a return to the present scene with greater insight and confidence. The protagonist also becomes aware of countertransference and is able to begin to separate personal issues from client issues and thus to become more available to the client.

Role reversal has several important functions in the staff support group. It encourages the protagonist to empathize with the antagonist, whether it be a client, supervisor, or co-worker. Additionally, when the antagonist is a supervisor or administrator, the protagonist may be given an opportunity to show "the right way to run things." When auxiliaries are skilled, role reversal provides a unique opportunity to see and hear oneself in one's work role from another's perspective. Soliloquies or asides in the antagonist's role can be used to maximize this insight. If the protagonist seems rigid, or scripted, and not open to insights, prolonging role reversal with the antagonist is likely to break down this mind set and increase spontaneity. Role reversal is also important as the process by which auxiliaries learn to play their roles in the way that will be most helpful to the protagonist.

The *double* is the auxiliary role of greatest importance in the staff support group. The double's job is to reflect the protagonist's inner feelings. Since group members are co-workers and presumably play similar work roles, the audience can be expected to experience much empathy with the protagonist, and doubling is one of the most effective ways for this empathy to be expressed. *Tandem doubling* gives everyone in the group an opportunity to double a protagonist's soliloquy; the protagonist can then choose as double the member whose statement best reflects inner feelings, thus assuring good tele. At "stuck" places in the drama, the director may request spontaneous doubling and allow any member who feels empathy to come onto the stage and make a doubling statement. The protagonist's reactions to the statements of several doubles will often clarify for the director where to go next. Besides reflecting feelings, the double can be used to embody resistances, to split ambivalences (i.e., one double becomes the angry part of the protagonist and another the depressed part), and to separate out emotional reactions generated by countertransference. The latter technique might use a developmental double to represent the hurt child who is interfering with the protagonist's adult work. By nurturing and attempting to meet the child's needs, the protagonist can become free of the interference. Reversing roles with one's double is a technique that can lead to deeper levels of insight, especially as group members become experienced and adept at doubling.

In the moment of difficulty drama, *mirroring* helps the protagonist to

gain emotional distance from the moment of difficulty and to use professional skills to resolve it. The director asks the double or some other group member to stand in for the protagonist, while the protagonist becomes an outside observer of the action. The protagonist can be asked to comment on the scene as observer (e.g., "What's happening here?" or "What do you see him doing?"). If aware of what needs to be done, the protagonist can be encouraged to use professional skills to help the auxiliary standing in, by the direction, "Be a teacher to the teacher [or a counselor to the counselor, or whatever professional identity is appropriate] and help him to resolve his moment of difficulty." Having done this, the protagonist is reversed back into the action, so as to experience a mentor providing the self-prescribed help. This technique moves from subjective experience to objective analyis, then back to subjective experience for correction re-enactment.

Role training may be appropriate in the moment of difficulty psychodrama if the protagonist seems unable to generate alternatives for more effective work role behaviors. The director can call on the pooled professional skills of the staff support group for role training by inviting group members to "show how you would do it." The protagonist can then be reversed into the antagonist's role in order to experience the helping styles of various group members first hand. When all members wishing to try the role have been given a chance, then the protagonist is reversed back and told to "use whatever you can use of what you've learned to play your role better." Two important lessons come from this technique. One is that there are many satisfactory ways to resolve a problem situation, if one remains spontaneous and avoids a rigid approach. The other is that the skills and knowledge necessary for resolving virtually any work-related problem exist within the group and are available to any member willing to ask for support and assistance.

Surplus reality techniques are invaluable for facilitating catharsis in staff support groups by going beyond reality. One of the great frustrations of the helping professions is that workers are expected to maintain professional detachment and good will, while clients are free to act out and express negative emotions. Psychodramatically, a teacher can literally "kick" a recalcitrant student out of the classroom, a therapist can "shake" sense into a slow-moving client, and a correctional officer can physically take on a verbally abusive inmate. The release of frustration and anger that accompanies such actions usually frees up the protagonist's spontaneity to help the client in a more creative manner. Surplus reality is also useful for closure with future projection scenes. For example, a nurse may be instructed to teach a class of student nurses how best to cope with that troublesome patient.

Sharing is the very essence of the staff support group, and the psychodramatic technique of sharing provides a framework within which members can help, support, and teach one another in a noncritical, nonjudgmental way. In sharing, members are encouraged to disclose personal experiences which a psychodrama brought to mind. Because members perform the same or similar work roles, sharing is likely to be extensive, and plenty of time should be allowed for it. It should be modeled carefully by the director and any trained auxiliaries. Sharing makes the protagonist feel heard and understood and promotes a sense of not being alone in one's concerns. It also gives members who have not yet warmed up to the protagonist's role an opportunity to reveal themselves to the group in a limited manner. Sharing from auxiliary roles one has played can also be helpful to the protagonist, since it is possible to learn from another group member's perspective how it feels to be one's client or one's supervisor. Professionals in most work settings fail to adequately share their strengths with each other, let alone even to begin to think of sharing their vulnerabilities. Ideally, sharing becomes a mode of supportive communication among co-workers, which begins in psychodrama but is ultimately carried into the larger community of the workplace.

Implementation

For the past five years, the author has conducted a staff support group, using psychodrama, for counselors working in a county jail. The objectives of this group have been, in order of priority: (1) To work on pressing personal issues of members which might interfere with our proficiency as counselors were they left unresolved; (2) to work on moments of difficulty experienced in our counselor roles; and (3) to learn more about psychodrama. Preventing or reducing burnout was never a stated group goal, but we found ourselves, after a time, feeling more comfortable with our jail work than with our counseling experiences in other settings (clinics, universities, private practice). This was clearly not a function of the environment, since for most of us the jail was the most stressful setting within which we had functioned as counselors. The support that we provided one another in our group seemed to make the difference. When we terminated it for a while because of scheduling conflicts, we found ourselves more tense, more fatigued, and prone to feelings of hopelessness in our work with our inmate clients. We have since given the group higher priority in our professional lives.

Researchers of burnout agree that staff support groups are essential for both the prevention and remediation of this all too prevalent mal-

ady. And psychodrama provides such groups with a promising structure. While an unstructured group therapy procedure is likely to encounter staff resistance, psychodrama proves to be more acceptable as a means of improving job-handling skills. It has the advantage of being well adapted to role training, as well as a highly supportive method of group psychotherapy.

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RESEARCH AWARD

The Federation of Trainers and Training Programs in Psychodrama is sponsoring an award for the most significant research project in psychodrama, sociometry or group psychotherapy conducted during a calendar year. The award consists of a certificate and a cash prize. Nominations are now open for the year 1984 and will close on December 31. Nominations may be sent to Alton Barbour, University of Denver, Denver, Colorado 80208.

Rebirthing through Psychodrama

Arden G. Thompson

I felt like an unwanted puppy cowering in a morning-damp gutter awaiting the next kick. And the next. I was trembling all over. Most of the others in our psychodrama class had already come back to the big rug and were eager to share what they had experienced in the crib scene. I only wanted to forget. To sit in the sun and somehow get warm again. To forget. Oh, what a fool I had been.

I had been one of the assistants that morning helping Dr. Doris Twitchell Allen ease the others back into their early years. "And so the Mother comes and loves the baby. . . ." I had cradled their heads, and held and rocked their shoulders helping them to re-experience the warmth and love that every child needs, or psychodramatically to experience that kind of supportive love for the first time if they previously lacked it.

I had not been afraid because I had had no intention of returning to that terrifying period of awful helplessness and terror. But when I had finished "mothering," Helen had put her arms around me and rocked me as she sang for the others, and I had forgotten my fear. It felt so good and warm—and so, finding an open space, I lay down to wait for Dr. Allen to finish the exercise and bring the others back from those early years.

Fool! Fool, will you never learn?

I didn't mean to go back myself, it just happened. Suddenly I was back before birth again. Trapped. All the wordless terror rising. Helpless again. . . .

Eventually I managed to creep back into the circle where the others were sharing their experiences of being cared for and loved. Friends, sensing that all was not well, reached over and hugged me, and gradually the trembling ceased.

My birth had been very long and difficult, and as a consequence I was born with a head so pointed that I was kept away from my mother for the first two days of my life while the nurses tried to knead my head back down into some semblance of normal shape. My mother thought I was dead. And maybe something in me had died during that long struggle, or perhaps had never been born—it's hard to be rejected before you've even begun.

As someone said after class, "You looked so like a puppy that had just been beaten." But I think I felt no anger, only that somehow the beating must have been justified.

Given the overwhelming terror of my rebirthing experiences up to this point, I am still amazed at what happened next. Yes, I was tired. We'd been living psychodrama for almost two weeks: mornings helping with the class at the university, afternoons continuing with the practicum at the hospital, and evenings debriefing. Finally I had gotten some much needed sleep, and I guess I was still half asleep when asked, "Do you want to try that birth again?"

No! I never wanted to experience it again, and said so. Yes, it would probably be for my highest good, but I really didn't want to go through it ever again—it was too soul-shaking.

Then I must have relaxed because the next thing I knew I was back there again being reborn. What an incredible difference it makes to be welcomed into the world! To have someone rejoice that you are arriving, that you are going to live, that you are you. To be helped into the world instead of being kept out of it.

Lynne didn't talk me through it, she lived me through it. It was like being awakened and welcomed from the top of my head to the tips of my toes—it was a wonderful awakening. It began just at the point where the previous terror had begun, at that point where I had probably almost died as an infant. At the point where I knew that I was totally helpless and that further struggle only meant more agonizing pain—no words, only my body knew. I couldn't get out without help. But this time, I didn't have to.

Lynne was there urging me to breathe, rejoicing when I did, and holding the former frightened puppy with reassuring gentleness and warmth. And, oh, the glorious welcome!

I argued with her as I never could have with my mother, and with the magic shuttle of psychodrama, she answered, and my whole view of the world shifted just like a kaleidoscope—only this time the little colored pieces were my perceptions of the world.

I was no longer rejected. It was okay for me to be me. I could live. They wanted me. I could be.

It has now been several months since all this happened, and things for me are different. I am different. I could always feel people before they spoke, especially their negative thoughts, but now I can feel their love and acceptance of me as well.

I ponder what made it all possible. J. L. Moreno, Dr. Allen, Lynne? Sound? Yes, it was good to have been able to confront terror verbally, but more than that, touch had been important: rhythmic motion and touch had somehow given me myself, my whole self, the self, perhaps, that had never before been born.

Now it is difficult to remember the old terror, for today when I think of birth, there is only that great wonder of a joyous welcome. Love is timeless, and now at last I had entered time with love.

Mindset

Being rejected hurts,
hurts way back down through
the spiraling hall of years,
past all the doors
I wouldn't try for fear
that they'd be locked
because I was me,
and remembered waking,
ready somehow to do and be,
then agony:
pushing, hard, hard.
No way out.
Can't go back. Trapped!
Twisting, pushing through
trumpeting pain: We
don't want you;
you can't be.
Then weaker and weaker
like water soaking back
into the Ground
of all being.
Almost gone.
No motion now,
nothing left
to want with,
to fight with,

to live with;
only Light,
and silence. . . .
Then exploding noise
and pain and darkness.
So my mind was set to be rejected
over and over again.

Magic Shuttle

Drowsy, words fluttering
off as feelings come.
Will you go back with me,
risk the pain, try again?
Come, time's an illusion,
freedom's waiting
to be won.

Drifting, dreaming, waking
ready somehow to do, to be,
then terror:
I can't. No, not again.
I'm too weak and helpless.
Only let me die;
let me cease
trying to be.
Child, beloved child, welcome!
We've waited for you so long.
Feel the motion of our longing
sing the movement of life's song
smoothly now together—
I, joyous with your coming,
you to love awakening . . .
But you couldn't
really want me;
you wouldn't even
let me out!

Oh child, forgive. Forgive me
for I did, but was too young
and frightened for myself
to show you how much
I yearned to see
and hold you. But now let me
touch you with love's joying,
welcome you with all my being
as the wind, and sun and stars,
all the creatures that there are
affirm with me Love's calling
to you to come, to be.
Welcome as you are!
Send the magic shuttle forward
and back to mend tomorrow's years.
Oh beloved child,
Love is timeless,
now with love be reborn
through a cleansing
flood of tears.

Arden Thompson is a teacher of gifted children (K–8), in the Wiscasset Middle School.

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Program Analysis of a Centralized Psychotherapy Service in a Large Mental Hospital

Dale Richard Buchanan

This paper documents a four-year program analysis of a centralized psychotherapy service within a large (1,900 inpatients) mental hospital. Surveys were distributed to all treatment units receiving psychodrama group services. Treatment team members were asked to evaluate both psychodrama staff and trainees' professional performance, the quality of the psychodrama sessions, and a quantitative analysis of the products produced by the therapists, e.g., progress notes, attendance at treatment team meetings. The study indicated that between delivery of services by trainees and staff there were no significant differences except on 4 of the 24 indices of treatment effectiveness or provider expertise. Both staff and trainees received high ratings of satisfaction with services and service delivery from the treatment teams. The advantages of conducting such evaluation surveys for feedback to staff, trainees, treatment units, and supervisory personnel is discussed. Further evidence is cited of the utility of such evaluations within hospital administration (budget, personnel, administrative offices).

Despite both admonitions and encouragements from the professional community (Karasu, 1981; Kipper, 1978; Luborsky, Singer & Luborsky, 1975; Wilderman, 1981), few evaluative or empirical studies have

been published on the effectiveness of either specific psychotherapies (the services provided) or their application within mental health delivery systems (the services providers). Empirical studies and program evaluation surveys are hindered by: (1) the almost insurmountable number of independent variables inherent within most treatment centers, (2) decreases in budgets with a concomitant increase in demand for clinical services, and (3) a notable lack of enthusiasm for research from clinical service providers.

The author recognized the need for an evaluation of both personnel and treatment resources upon becoming supervisor of a centralized psychotherapy service branch in 1979. The Psychodrama Section at Saint Elizabeths Hospital in Washington, D.C. was established in 1941 with its primary focus the delivery of clinical psychodrama group services to the inpatients and outpatients of the hospital (Buchanan & Enneis, 1981). Over the past four years, the Psychodrama Section has ranged from 4 to 7 clinical staff and 10 to 13 year-long stipended students (10 staff and 42 trainees were employed in this time period). The majority of the staff hold Ph.D. degrees in clinical psychology or M.S.W. degrees; all are certified by the American Board of Examiners in Psychodrama, Sociometry, and Group Psychotherapy. Trainees in the year-long stipended training program generally have the same academic degrees as the professional staff.

As manager of the Psychodrama Section, the author was called upon to justify budget expenditures and assignment of personnel to the various treatment units within the hospital. The author, with assistance from Kerry Paul Altman, Ph.D., devised a questionnaire to measure treatment units' perceptions about (a) the psychodrama service provider, (b) the usefulness of the therapy, and (c) the number of work products offered by the Section. Because this survey instrument proved useful such surveys were conducted again in 1980, 1981, and 1982. These document the changing patterns of the perceptions of the hospital staff concerning psychodrama staff and trainees, the psychodrama method, and the work products of the Section.

Data Collection

Surveys were sent to all treatment units receiving psychodrama services. Follow-up telephone calls were placed by the clerical staff to ensure completion of the questionnaire. Saint Elizabeths Hospital, which currently has 3,762 employees and 1,857 inpatients as well as 2,763 outpatients, has had an average of 66 treatment units per year. Treatment units are the functioning centers for a variety of clinical pro-

grams. Generally units range from 14 to 36 patients. Treatment units may be organized according to specific populations (e.g., alcoholic, geriatric, pediatric, adolescent), census tracts (e.g., all new admissions or readmissions from a specific area of the city), or a combination of both. Each treatment unit has at least one treatment team, but depending on its size may have an additional one. The treatment team is composed of a psychiatrist, psychologist, nursing staff person, social worker, and various adjunctive therapists. Therapists may include but are not limited to: recreational therapists, art therapists, dance therapists, clinical dietitians, speech audiologists/pathologists, occupational therapists, bibliotherapists, and industrial therapists. The surveys were sent to the treatment team leader. The treatment team leader was asked to complete the survey with input from the other treatment team members. Over the four years, the number of units receiving services has varied from a low of 30 in 1979 to a high of 43 in 1980. During the four years, 70 separate treatment units received services and 98 staff members completed the survey. One hundred percent compliance for the survey was achieved in 1979, 1981, and 1982; two of the 43 units did not respond in 1980. The respondents to the surveys were 150 persons, of whom 33% were professional nurses (R.N., M.S.N., Ph.D.), 22% clinical psychologists (Ph.D.), 20% psychiatrists, 15% social workers (M.S.W.), and 10% other mental health professionals (occupational therapists, mental health counselors, etc.).

Since the survey was conducted annually, the statements were intended to be a reflection of the psychodramatists' performance throughout that year. Because of substantial problems related to a previously attempted patient survey (Altman, 1978), no attempt was made to distribute the survey to the patients receiving the services. It was also felt that staff would be in a better position than patients to judge the merits of the group and its overall contributions to the total treatment program.

Research Design

The survey was initiated with the intention of ascertaining how a treatment unit perceived the psychodrama staff and trainee service providers, how the treatment teams perceived the service, and a measurement of the need for an increase or decrease in the work products produced by our personnel (e.g., treatment sessions, attendance at treatment team meetings).

The collection of accurate meaningful information from the treatment units in providing feedback to our clinicians and managers within

the institution overrode the need for a rigorous experimental design. The survey instrument was divided in four parts to meet the specific goals of the evaluation process. The first section of the survey consisted of 12 Likert-type questions regarding psychodrama therapy. The second section consisted of six Likert-type questions regarding the psychodramatist's performance vis-à-vis the delivery of the treatment. The third section was open ended and requested the unit to comment on the performance of the psychodrama therapist. The fourth and final section of the instrument was an evaluation of the need for more, the same, or less work products provided by the Psychodrama Section to the treatment unit. These questions were culled from a list of variables originally composed by selected staff and trainees of the hospital. This list was piloted on a sample group of treatment team members and questions were added, deleted, and edited to incorporate feedback from the pilot.

Hypothesis 1: That there are no significant differences between staff and trainee averages on behavioral indices of treatment or provision of treatment services.

Hypothesis 2: That treatment team units are highly satisfied with psychodrama services as provided by psychodrama staff and trainees.

The tables show that the treatment units rated the psychodrama sessions as being highly valued and useful within their treatment programs. As hypothesized, staff-led treatment sessions were not rated significantly higher than those led by trainees except on 2 of the 12 indices:

(1) The psychodrama group is a place where patients feel free to bring up almost any concerns. $t(144) = 2.38, p < .05$.

(2) The psychodrama group helps patients learn more appropriate behavior. $t(143.8) = 2.32, p < .05$.

The null hypothesis was rejected for two of the six measures of the treatment provider:

(1) Does the psychodramatist/psychodrama trainee on your ward maintain an appropriate therapeutic relationship with patients? $t(137.2) = 2.12, p < .05$.

(2) Does the psychodramatist/psychodrama trainee on your ward act professionally in interactions with other members of the treatment team? $t(120) = 2.09, p < .05$.

The staff mean (M) was 1.31 while the trainee M was 1.41 for all indices of treatment effectiveness (1 = Strongly Agree; 5 = Strongly Disagree). Averages for the treatment provider were M 1.94 for staff and M 1.98 for trainees.

Table 1—Evaluation of Treatment Sessions (1 = Strongly Agree; 2 = Agree; 3 = Neither Agree nor Disagree; 4 = Disagree; 5 = Strongly Disagree)

	Behavioral Indices		*Staff*		*Trainees*
Treatment Sessions					
1.	The psychodrama group is a place where patients feel free to bring up almost any concerns.	*M*	1.25	*M*	1.45
		SD	.50	*SD*	.57
		n	69	*n*	77
2.	The psychodrama group is an important part of the total treatment plan.	*M*	1.10	*M*	1.19
		SD	.30	*SD*	.48
		n	71	*n*	79
3.	The psychodrama group helps patients deal with problems they may have with one another.	*M*	1.23	*M*	1.23
		SD	.45	*SD*	.42
		n	71	*n*	79
4.	The psychodrama group is really helpful.	*M*	1.16	*M*	1.23
		SD	.63	*SD*	.66
		n	70	*n*	78
5.	The psychodrama group helps quiet patients express themselves.	*M*	1.50	*M*	1.57
		SD	.63	*SD*	.75
		n	70	*n*	79
6.	The psychodrama group deals directly with the patients' treatment goals.	*M*	1.45	*M*	1.55
		SD	.65	*SD*	.75
		n	71	*n*	78
7.	The psychodrama group provides therapy for the patients.	*M*	1.07	*M*	1.15
		SD	.26	*SD*	.36
		n	71	*n*	79
8.	The psychodrama group helps patients learn more appropriate behavior.	*M*	1.26	*M*	1.46
		SD	.47	*SD*	.60
		n	70	*n*	78
9.	The psychodrama group helps the patients more than it upsets them.	*M*	1.39	*M*	1.42
		SD	.71	*SD*	.78
		n	71	*n*	78
10.	The psychodrama group is something the patients enjoy.	*M*	1.65	*M*	1.87
		SD	.76	*SD*	.87
		n	71	*n*	79
11.	The psychodrama group gives staff an opportunity to interact with patients.	*M*	1.41	*M*	1.61
		SD	.69	*SD*	.75
		n	70	*n*	77
12.	The psychodrama group provides staff with important information about patients.	*M*	1.28	*M*	1.48
		SD	.48	*SD*	.68
		n	71	*n*	79

Table 2—Evaluation of the Provider of the Treatment (1 = Strongly Agree; 2 = Agree; 3 = Neither Agree nor Disagree; 4 = Disagree; 5 = Strongly Disagree)

	Behavioral Indices		*Staff*		*Trainees*
Treatment Provider					
1.	Does the psychodramatist/psychodrama trainee on your ward actively participate in treatment team meetings?	*M*	2.46	*M*	2.50
		SD	1.24	*SD*	1.25
		n	70	*n*	78
2.	Does the psychodramatist/psychodrama trainee on your ward maintain adequate and informative progress notes?	*M*	1.27	*M*	1.34
		SD	.56	*SD*	.60
		n	70	*n*	79
3.	Does the psychodramatist/psychodrama trainee on your ward participate in the formulation of treatment plans for the patients in the group?	*M*	2.21	*M*	2.46
		SD	1.20	*SD*	1.26
		n	70	*n*	79
4.	Does the psychodramatist/psychodrama trainee on your ward attend other meetings such as community meetings?	*M*	3.52	*M*	3.27
		SD	1.17	*SD*	1.19
		n	64	*n*	74
5.	Does the psychodramatist/psychodrama trainee on your ward maintain an appropriate therapeutic relationship with patients?	*M*	1.08	*M*	1.21
		SD	.28	*SD*	.41
		n	71	*n*	78
6.	Does the psychodramatist/psychodrama trainee on your ward act professionally in interactions with other members of the treatment team?	*M*	1.08	*M*	1.11
		SD	.17	*SD*	.32
		n	71	*n*	79

There were no significant differences between staff and trainees on any measure of work products. The staff *M* was 1.65 and trainee *M* was 1.69 (1 = More; 2 = Same; 3 = Less).

The units provided informative written comments concerning staff and trainees. All comments were appended to the final report. Comments were of the same positive nature as results from the other sections. All respondents requested continuation of psychodrama services.

Discussion

The study yielded evidence insufficient for the acceptance of the hypothesis regarding the differences between staff and trainees' averages on treatment sessions or provision of treatment. It should be noted though that of the six behavioral indices regarding the treatment provider, four were quantitative in orientation (attends meetings, writes notes, etc.) while two were qualitative (professional interaction with patients and with other staff members). The null hypotheses were

Table 3—Evalution of the Work Products (1 = More; 2 = Same; 3 = Less)

	Behavioral Indices	*Staff*		*Trainees*	
Work Products					
1.	Number of patients treated	*M*	1.64	*M*	1.67
		SD	.48	*SD*	.50
		n	69	*n*	76
2.	Number of treatment sessions provided	*M*	1.64	*M*	1.75
		SD	.48	*SD*	.44
		n	70	*n*	76
3.	Participation in treatment team meetings	*M*	1.53	*M*	1.53
		SD	.53	*SD*	.50
		n	70	*n*	76
4.	Documentation	*M*	1.91	*M*	1.93
		SD	.33	*SD*	.30
		n	69	*n*	75
5.	Attending community meetings	*M*	1.67	*M*	1.63
		SD	.51	*SD*	.49
		n	58	*n*	73
6.	Attending ward staff meetings	*M*	1.53	*M*	1.64
		SD	.50	*SD*	.58
		n	60	*n*	72
Continuation					
	Would you like psychodrama services continued on your treatment unit next year? Yes-No	100% Yes		100% Yes	

rejected for the two qualitative issues regarding treatment providers. This leads the author to speculate that there is a subtle difference in quality of services provided from a mature certified mental health professional and a trainee. While the null hypothesis regarding differences between staff and trainees was not accepted, the evaluation did not attempt to measure all levels of trainee versus staff personnel patterns. Staff traditionally are able to develop long-term relationships with both patients and other staff members which can significantly affect the therapeutic relationship. Trainees provide independent clinical services for only 9 of the 12 months. Thus, another problem in reliance upon trainees' services is the break in treatment for 3 months of each year. Trainees too must be given more supervision and training experiences than seasoned staff. Nevertheless this study is a potent argument for the justification of inclusion of trainees' services within hospital settings as a method of providing quality services.

Hypothesis two was accepted because of the average scores which both staff and trainees received from the treatment teams. On a scale of 1 to 5, treatment sessions averaged 1.36 which is a very high level of satisfaction with the psychodrama treatment sessions. Psychodrama providers fared less well with an overall rating of 1.96; however, on the issue of quality the *M* for staff were 1.08 (therapeutic relationship with patient) and 1.08 (acts professionally with staff) whereas trainees received the *M* of 1.21 and 1.11. The overall rating was affected by lower ratings indicating that psychodramatists do not attend other meetings such as community meetings ($M = 3.38$), average ratings for participation in treatment team meetings ($M = 2.47$), and formulating patient treatment plans ($M = 2.34$).

The evaluation model presented above proved extremely useful to both management and clinical personnel of the Psychodrama Section and the greater hospital community. As a result of the yearly survey some modifications in policy were made, according to the units' suggestions. Psychodrama attendance at treatment meetings was made a higher priority than attendance at community ward meetings. Important information was provided to the staff and trainees regarding their performance in the delivery of therapy services.

The surveys also helped with budget planning. Services provided by both staff and trainees were considered excellent. Although services delivered by trainees were rated slightly lower than services provided by staff, in some cases trainees actually received higher ratings. This tended to dispel the theory that trainees' services are grossly inferior to services provided by staff. For the management of the section, a ratio of two trainees per one staff person has been found to be highly cost effective in the provision of psychotherapy services.

Summary

In conclusion, the evaluation provided little empirical evidence that staff services or providers are significantly different from the trainee equivalents. Only four measures indicated significant differences: the two regarding the patients' ability to bring up concerns and learn more appropriate behavior, and the two regarding the staff/trainees' ability to maintain an appropriate therapeutic relationship with patients and other members of the treatment team. Trainee services are judged, under certain supervisory conditions, to be cost effective and function at high levels. An area of limitation regarding trainee service delivery not addressed by an empirical study is the disruption of services between the time when one class of trainees is terminated and the new

class is able independently to deliver clinical services. The model presented here is relatively easy to implement and other disciplines and methodologies could easily substitute their terms (i.e., dance therapy, art therapy, transactional analysis group) or personnel (e.g., psychologist, group therapists). The model can serve as an important feedback mechanism between a centralized therapy program and the units it serves, and also between such other components of hospital administration as budget and personnel.

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These findings are based on research conducted at Saint Elizabeths Hospital where Dale Buchanan coordinates the training program in psychodrama and is chief of that section.

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BRIEF REPORT

Bibliotherapy: An Approach to Helping Young People with Problems

John T. Pardeck
Jean A. Pardeck

Bibliotherapy is a process of dynamic interaction between the personality of the reader and literature (Russell and Shrodes, 1950). When this interaction is guided by a skilled helper, therapeutic change can occur.

This process consists of four stages: In *identification* the reader finds that a character in the book is experiencing a problem similar to his own. *Projection* leads him to grasp the meaning of the story and the helper guides him in applying this meaning to his own problem. When *abreaction and catharsis* follow, it is imperative that the therapist guide and support the client through the experience of emotional release. In a satisfying conclusion to the process, the client gains new *insight*, which he utilizes through *integration* of possible solutions into his own life situation.

As a practical application of these principles, the following books may be used by a bibliotherapist in working with a young person dealing with parents' divorce. It is important to select books appropriate to a young person's interest level and reading ability. The subject of separation and divorce should be handled realistically, avoiding the infrequent happy ending where parents reunite, and also placing the blame on any one character. The most helpful books are those which explore the feelings that children and young people experience at this time, their positive and negative reactions to their new familial situation, and also some of the trauma experienced by the divorcing parents.

Like Ned and his little brother in *Mommy and Daddy are Divorced* (Perry and Lynch, 1978), children hearing this story may have eagerly anticipated spending the day with their father and later become upset when he brings them home again. They may be helped to discuss their disappointment and to accept their feelings.

When Joey, the main character in *My Dad Lives in a Downtown Hotel* (Mann, 1973), promises to be good in an effort to get his father to come back home, young readers recognize themselves.

An appropriate follow-up to reading *It's Not the End of the World* (Blume, 1972) is to discuss, perhaps in a group, some of the changes the readers too have gone through.

A young person who has developed behavioral problems at school following the parents' divorce may react quite strongly to the turmoil of Lorraine in *Something to Count on* (Moore, 1980). An experienced guide can facilitate the positive expression of emotions, channeling them into a constructive purpose. Role playing a scene from such a book as *The Divorce Express* (Danziger, 1982) may help a young person to deal with confused feelings, for instance, about a parent's dating.

In a very realistic book, *How Does it Feel When Your Parents Get Divorced?* (Berger, 1977), a girl gains perspective on her own progess toward self-reliance during the two years since her parents' divorce.

Bibliotherapy is most effective when used in conjunction with other therapies, lest a reader seek by reading a refuge in the world of ideas and fail to make the necessary adjustments in life. With the guidance of a wise counselor, the pain of parents' separation and divorce may indeed be transmuted into a valuable growth experience.

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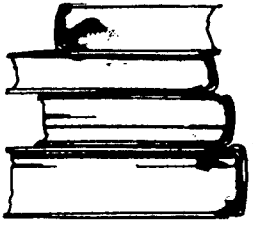

Book Review

J. L. Moreno. *The Theatre of Spontaneity* (3rd edition). Beacon, NY: Beacon House, 1983 ($10 hardback, $8 paperback).

It is difficult to trace what the impact of this book has been since its original German publication in 1923. Most students of theater would not know of Moreno. Yet Moreno had contact with the Group Theater and the Civic Repertory Theater when he was first in New York. More recently Eric Bentley, in his collection of essays on the experimental theater entitled *Theatre and War* (1972), devotes a whole chapter to Moreno's work. And it is interesting that the Summer 1983 issue of the *Drama Review*, which is devoted to "grass roots" theater, should feature two theater companies influenced by Moreno's ideas: Playback Theater and Ecotheater, an Appalachian Mountain theater whose director, Marat Lee, was influenced by Moreno in New York in the 1950s.

In fact, it is remarkable how much spontaneity theater has been on the upswing in the past quarter century. The theatrical tradition of improvisation has been enlarged by work in the experimental (avant garde) theater, educational theater, and therapeutic theater. This latter category did not even exist ten years ago. Today, however, theater companies whose purpose is therapeutic and service oriented are to be found in many quarters. An example is Problem Solving Theater, directed by Meg Givnish, who is also now editor-in-chief of Beacon House, publisher of this new edition of *Theatre of Spontaneity*.

Ms. Givnish and her colleagues are to be congratulated for reissuing a book that has been out of print and in demand. It is lamentable, however, that they did not take the opportunity to write a critical introduction. This is an important book. It shows the extent to which Moreno, early in the century, was grappling with ideas which are only now becoming widely accepted. It deserves both to be placed among the literature of theater and psychology and to be evaluated seriously in its own right.

While the book is uneven and fragmented, it contains much of interest. Moreno rightly focuses on the preoccupation of the legitimate theater with repetition and insists that the "reproductive process of learning must move into second place" in favor of a "spontaneous-creative process." There is nothing on sociometry and frustratingly little on catharsis—detailed writing about these important areas of Moreno's contribution must be found in later works.

What Moreno does emphasize in *Theatre of Spontaneity*, perhaps more than in his other books, is the importance of community to his world view. For Moreno, psychodrama was not just for a ring of patients, but for the community at large. This sense inspired him to found theater companies both in Vienna and in New York, and later to establish a tradition of public session psychodramas. Moreno's vision was for a theater of families and neighbors, of social and working groups; for a theater that recaptured the spirit of the storyteller, and of that young man who told fairy tales to children in a park, with them creating an "act" and an "atmosphere."

Jonathan Fox

Jonathan Fox is on the faculty of the Maritime College of the State University of New York, and Artistic and Executive Director of Playback Theater. Playback Theater, in Poughkeepsie, New York, is an artistic and therapeutic form of communication based on the idea of playing back, in mime, music, and spoken improvisation, the personal experiences of members of the audience. He may be reached at 47 N. Manheim Boulevard, New Paltz, NY 12561.

Selected Abstracts of Outcome Research in the Action Methods

by

Thomas G. Schramski, Ph.D.
Clyde A. Feldman, B.A.

A thorough introduction to experimental and descriptive outcome studies in the psychodramatic methods. This compilation includes abstracts of 200 outcome studies with salient evaluation characteristics and outcome measures identified. An index of the studies accompanies the collection.

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The pioneering membership organization in group psychotherapy, the American Society of Group Psychotherapy and Psychodrama, founded by J.L. Moreno, M.D., in April 1942, has been the source and inspiration of the later developments in this field. It sponsored and made possible the organization of the International Association on Group Psychotherapy in Paris, France, in 1951, whence has since developed the International Council of Group Psychotherapy. It also made possible a number of International congresses of group psychotherapy. Membership includes subscription to *The Journal of Group Psychotherapy, Psychodrama & Sociometry* founded in 1947, by J.L. Moreno, the first journal devoted to group psychotherapy in all its forms.

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