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Culminating Project for Lindenwood 4

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The Following is the Written Portion

of the

Culminating Project

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Master of Arts Program

in

Psychology and Counseling

for

Sandi Janson

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Introduction

This paper is divided into two parts which cover the two major learning areas stated in my Program Overview, Psychodrama and Counseling.

The first section will speak to my learnings in Psychodrama. Briefly, I will relate the experience of directing a workshop for some of the Lindenwood 4 student body in the Washington, DC region, as I agreed to do in my Program Overview as a part of my final project. Further evidence of my growth in my skill as a psychodrama therapist will be shown in the second part of the section on Psychodrama entitled " Death, Burial, and Resurection."

The second section will demonstrate my learnings from my basic psychology and advanced psychopathology studies: and my supervision in counseling which comprised approximately a half of my work this year.

SECTION ONE

Action Drama of Culminating Project

&

Death, Burial, and Ressurection in the

Psychodrama Theater

Action Drama of Culminating Project

The following paragraphs consist of my learnings which I received during my project.

Audience. The group of students and faculty with which the workshop on psychodrama was held consisted of six women, one man and one nine-year-old girl. The common goal shared by all was to learn the basic techniques of psychodrama, while not going into deep personal, emotional depths in a psychodrama.

Director's Goal. My learning goal was consistent with my goals for the workshop. My learning goal was to respond only to what the group expressed that it wanted, and not to lead the group into any hidden emotional area.

My goals for the workshop were: (1) to describe basic psychodrama techniques, (2) to demonstrate experientially these techniques, and (3) to give an opportunity for a psychodrama to take place.

Evaluation and Means of Achieving Goals. The evaluation of the achievement of my goals rests on the responses of the participants. The summation of their responses was that they learned information about psychodrama and its techniques to enable them to describe intelligently what psychodrama is; and that they appreciated my asking what they wanted to do and my not pushing them into anything additional.

To achieve my learning goal, I asked each participant to state what each one wanted to get out of the session and what he/she was willing--and not willing--to give.

I remembered each response and did not go beyond the stated limits when the individuals were sharing their personal issues.

To achieve my goals for the session, I gave a brief history of the development of psychodrama as a therapy, and Jacob L. Moreno, the founder of psychodrama, and compared it to other approaches. I then described each part of psychodrama and various techniques and provided an opportunity for those who desired to participate, to do so.

During one of the basic warm-up techniques, a participant emerged a protagonist and experienced her reluctance to say "good bye" to some departed loved one.

To slow myself down in order to go the desired slow pace of the group, I remained aware and in control of the speed of my movements and breathing. The participants expressed appreciation for my respect of their privacy and desire to move slowly; and for my skill in being able to facilitate real personal growth within that framework.

Death, Burial and Resurrection in the Psychodrama Theater

Introduction

The word "psychodrama" is derived from the Greek words, "psyche" and "drama", meaning, having to do with the mind in action. The psychodramatic method of therapy is an exploration of the mind through action methods. It is a group-oriented process, facilitating the integration of the intellect, and the emotions into life experiences. The human potential is much greater than is ever realized in a life-time. Psychodrama nourishes this potential by providing a climate and a method for the understanding and awareness of one's self and others.

This process is one in which the protagonist--the star--or person identified as the main focus, has an opportunity to reenact or project into the future, issues of great personal, emotional importance on the psychodrama stage. The work done on the stage is performed by one person alone or in relationship to others who "stand in" and assist by representing people or objects in the protagonist's life. In this way, all the instruments necessary come into play, all working. These are as follows: the protagonist, the life space or stage, the Director, the auxiliary egos, and the audience. It is not possible to be in the room when a psychodrama is taking place and not in some way be a part of the process.

The experience of psychodrama has four distinct parts. The first is the "warm up," which is a getting-acquainted time. This time is spent in group discussion and often includes goals, time arrangements, limits, fees, roles, and the like. The Director has the responsibility to lead, at times, action exercises which will encourage spontanity, creativeness and trust. Out if the "warm-up" evolves a concentric theme

or individual issue which reflects the state of the group at that given time. One of the group members is selected, by the Director or group, as the protagonist. The protagonist will be the person to enact his/her own, or the group's, problem. When it is the group's problem, technically, a sociodrama and not a psychodrama is taking place.

The second part is the "action" phase. One method is that the problem is discussed on stage, and there redefined so as to be able to enact it. Another is to focus in on the present reality by exaggerating it. This technique is used in the psychodramas presented in this paper. The scene is played out with the aid of either professional auxiliaries or participant auxiliaries, as the Director senses the need. The action is kept in the "here and now" with interest in working through a difficult or perplexing issue by developing alternative behaviors that might be more fulfilling and/or increasing self-awareness and awareness of others.

The third part is the "closure". Here the protaganist is usually aided and encouraged to return to the reality of the psychodrama room and leave the "scene" in which he has just been. A part of this process is called "deroling." This is usually done to avoid the disorientation and lack of integration with reality that might occur if left in 'role.'

However, Moreno, at times, purposely did not "derole' his patients, whom he saw and treated almost daily,, in the hopes that if the patient were left in that particular role their needs would be met at present and they might sooner regain normalcy in their given culture. For example, he left a male patient, being treated at his Becean, N Y hospital, in the role of Jesus Christ for months, as shown in Volumne I of his book Psychodrama, which initiatied the patients' journey toward recovery.

The fourth and final part of a psychodrama session is the "sharing'. Here the individuals in the group share with the protagonist the feelings each experienced during the enactment that were realated to and involved with the protagonist's experience diring the psychodrama. There is an avoidance of intellectualizing. Supportive feedback is given to the protagonist by the group members. Inshights are shared. The protagonist usually feels less alone with his/her problem, and affirmed by the group.

The "sharing" may be followed by further discussion by the group and a "warm-up" for another psychodrama, or may be guided toward ending that session by the Director.

Psychodrama is a therapy that can be used alone or in conjunction with other therapies.

Preface

The idea for this paper began with my being intrigued by seeing the effects of a "mistake" which occurred in a psychodrama therapy session at a State Psychiatric Hospital Center with a group of patients. The "mistake" was that the Director neglected to perform the usual pro-cedure of taking the patients out of the roles they had been given and taken on in the session: "deroling" the patients. A question I raise for myself is as follows: What is the theraputic value of not "deroling" psychodrama therapy patients, who are seen only once a week, and when would that be appropriate, and for what type of patients.

Intent

This paper will show the sociometric dynamics of individual members of a group, the group's relationships with the ward staff, and the psychodrama staff, (Director and Auxiliary) after two specific and related psychodrama therapy sessions.

Setting

This group of patients was from an in-patient ward of a community Mental Health Clinic in an eastern suburban metropolitan area. This unit is on the grounds, but not connected administratively, to the Psychiatric Hospital Center. The staff working at this clinic is en-tirely separate from the hospital staff and is on a higher salary scale and has better working conditions, i.e., schedules, surroundings, patient-staff ratio, and access to the staff psychiatrist assigned to the ward. The staff make-up on this unit is the same as that in wards attached to the Hospital Center, consisting of a psychiatrist, psychologist, medical doctor, social workers, day and night nursing staff, dining room staff,

kitchen staff, and various students in training, as well as office staff. The difference is that this staff group has consistently good and open communication going among its members. The physical plant is bright, cleaner, and generally more pleasant than most buildings on the grounds. Patients at the clinic in-patient division have their own dressers for clothing and personal belongings, and share rooms with one or two other patients. There is no overcrowding here.

The patients meet as follows: (1) daily in community meetings for an hour; (2) once a week, for an hour-and-a-half, in a religious discussion group; (3) once a week, for two hours, in psychodrama group therapy, (all able patients); (4) on an informal basis for conversation, TV, walks on the grounds, and to the canteen; and (5) two or three times a week for non-sexually segregated occupational and recreational therapy activities.

This unit is for "acute" patients requiring intensive care; therefore the make-up of the patient group is in constant transition, with some patients leaving and others coming in to the group. There were, however, some patients who were present for the two specific and related sessions in question, and who had a history together, ranging from one to four months to several years. Specifically, there were fourteen patients present for both sessions.

Patient Background

The following outline form will describe the patients who were present for both sessions being discussed in this paper. Each patient will have noted following the pseudonym, his/her age, race, sex religion, education, marital status, number of times psychiatrically hospitalized (X represents the number of times), the diagnosis and admission date.

Ms. Grettel	36	w/f	Catholic	2 yrs. college	divorced
	3 X		Schizophrenic		8/76
Ms. Byrd	52	w/f	Presbyterian	11th grade	widow
	7 X		Schizophrenic		1/76
Ms. Bogart	32	w/f	Catholic	7th grade	married
	2 X		Schizophrenic		2/76
Ms. Day	45	w/f	Presbyterian	9th grade	widow
	11 X		Schizophrenic		3/75
Ms. Barton	44	b/f	Baptist	8th grade	married
	2 X		Schizophrenic		9/75
Mr. Roade	37	w/m	Catholic	10th grade	single
	2 X		Schizophrenic		4/74
Ms. Juliet	67	w/f	Catholic	8th grade	married
	2 X		Phychotic depressive reaction		1/76
Ms. Brae	27	w/f	Baptist	10th grade	married
	1 X		OBS due to brain surgery		10/75
Ms. Fay	45	w/f	Methodist	9th grade	married
	2 X		Schizophrenic		6/75
Ms. Mills	65	w/f	Episcopalian	8th grade	widow
	3 X		Schizophrenic		8/75
Ms. Gladstone	53	b/f	Baptist	6th grade	widow
	10 X		Schizophrenic		8/75
Ms. Wicker	30	w/f	Catholic	11th grade	separated
	11 X		Schizophrenic		6/75
Mr. Hart	62	w/m	none	12th grade	separated
	1 X		Reactional depression		1/76
Mr. Schibe	65	w/m	Catholic	12th grade	married
	1 X		Alcoholic		1/76

The consistent patient group was made up of eleven women and three men. All were members of the Christian faith except one man who professed connection to no faith. The age range was from 27-67 years, with four patients in the 30-40 range, three in the mid-forties, two in the early fifties, and four in the sixty to seventy range. Two female patients were black with the remainder of the group being white. The average education

level achieved was slightly above the tenth year. Marital status was as follows: one single, six married, one divorced, four widowed, and two separated. Only two of the patients were being treated as in-patients for the first time. The others had more than one admission for psychiatric care. The diagnosis for ten of the patients was Schizophrenia, two were diagnosed as Depressive reactives, one as an alcoholic, and one as Organic Brain Syndrome.

Variables and Non-variables

The medication remained the same during this period. The staff remained constant on the ward unit and in the psychodrama staff during the eight weeks prior to and eight weeks after the two specific sessions, except for the addition of a clinical psychologist. The location for the therapy remained the same for the two sessions being discussed.

Some patients left here who had been present for sessions prior to the two specific ones being examined. (Ms. Day, Ms. Wicker, Ms. Barton, Ms. Gladstone, and Mr. Schibe left the clinic following the second specific session. They were discharged or left at varying times which will be noted below.)

Another factor which adds complexity to the issue of the effect of lack of the "deroling" of the patients is that of the Director taking the initiative of developing a scene out of his fantasy rather than that of the patients. This further becomes a point to note when we consider that a consistently passive group may well be playing the helpless role and looking for a saviour.

Description of the Psychodramas and the Sequence of Events

Death and Burial Session

This patient group had been meeting for four months in regular weekly sessions. With a high degree of consistency they had remained very passive, sharing little of themselves and aiding one another not at all when one patient would choose to start a little work on his/her own issues. The group, as a whole, was waiting for the Director and the Auxiliary to do the work and make them well again.

This day the group members were quiet, many looking at the floor, there was little eye contact. One or two patients complained that the group "was boring and didn't do anything. Psychodrama is a waste of time, you (the Director) didn't to anything for us." The complaining patients were Ms. Grettel and Ms. Day. Other patients looked up and nodded their heads in agreement. The group then fell silent again. The Director said nothing, looking about the room at the individual patients and waiting for more. After waiting for a few minutes in silence, the Director said: "This group really feels heavy. Seems that no one wants to do anything. It's a struggle to move. My fantasy is that you're all dead." The Director then waited for a response. There was none, verbally. There was some moving about in chairs by Mr. Roade and Ms. Mills, indicating some anxiety. The Director then continued, "I see a hearse coming. It looks like a funeral." Mr. Roade said, "I'm not dead, Jack." The Director invited him, and anyone else who wasn't dead, to come up on the psychodrama stage with him to participate in the funeral services of all the people who were dead. No one spoke, only Mr. Roade came up to the stage. The Auxiliary assisted by verbally reflecting the group's seeming "deadness." One patient, Ms. Mills, whispered to the Auxiliary the statement, "I'm not dead. I don't like this." The Auxiliary suggested to her that the Director was the one to be told, since he was conducting the burial. Ms. Mills said nothing more and was "buried" along with the others, never having taken responsibility for herself, and focusing and directing her anger directly where it actually belonged.

"Burial" services consisted of the Director walking over to each member of the group, where he or she was sitting and saying a brief paragraph about each person. He mentioned what each person had given in

the group psychodrama sessions and what the possibilities had been for him or her. Following each eulogy, the Director and his patient auxiliary, Mr. Roade, placed an imaginary cross over each of the patients, who was then "buried." Not a single word was spoken by any group member except for Mr. Roade who aided in the funeral service. At the end of the service, the Director sang a hymn. Ms. Barton sang softly along with the Director although she, too, had been "buried." Silence followed for several minutes. The Director then moved from the position of the "funeral" director to the psychodrama Director and shared with the group what he had done and why. He asked for the members of the group to tell what their feelings were as they were being "buried." No one voiced a response. The group sat silently. Several minutes later, when the session time was over, the Director said that it was time to go and that he hoped to see them next week. The members of the group quietly, one by one, left their chairs and walked out of the room without speaking. They took their usual bus back to the ward.

In the post-group evaluation session, the staff observations included that the scene was appropriate to where the group actually was from a psychodrama view. It was thought that being pronounced dead might well be what was needed to help the patients experience and realize the psychological position they put themselves in constantly.

The following week's session was observably more lively than any session had been in a long time. Almost all the patients said that they didn't want to come to the psychodrama therapy session that day, and didn't want to come any more at all. The patients who did not speak were Ms. Juliet, Ms. Gladstone, Ms. Mills. Despite the anti-psychodrama therapy statements, Ms. Day and Ms. Bogart initiated some issues

and emerged the protagonists. Other members of the group were helpful to the protagonists by participating as patient auxiliaries and/or providing verbal encouragement during the "action" phase.

The unit staff reported to the psychodrama staff that between the first psychodrama, (the burial), and next session, the patients were hostile on the ward. The unit staff told the Director that the patients were uncooperative, hostile, and very resistive to any suggestion made by any staff member. The patients were refusing to attend meetings, meals, and argued with some of the most influential of the nursing staff. Some patients would not get out of bed; those who would often refused to clean their rooms, take medication, or participate in community or ward meetings. The staff informed the Director that it had been necessary to lock the ward door--something that was generally not done. Additionally, there was a significant increase in fighting among the patients.

A meeting was held. The staff psychiatrist, the Director and the psychodrama staff supervisor discussed the behavior by the patients on the ward. The conclusion was that the patients' difficulties were prompted by their feelings of still being "dead" from the psychodrama "burial" scene from which they had not been "deroled." A decision was made that in the next therapy session, the Director would "ressurect" the group. Both the staff psychiatrist and the psychodrama staff supervisor concurred with the Director's decision. The psychiatrist reported that the patients had been coming to him asking that he help them by allowing them to stop their attendance of the psychodrama group therapy sessions. He related at this meeting, that he told them that this therapy was a necessary part of their treatment plan and that they were required to attend. The following week the "resurrection" was to take place.

The second related session to be reported here is the "resurrection" scene. The group arrived on time and entered one by one into the room. The Director spoke with the group members, finding out how they were and what was going on in their lives that they wished to share with the group. He then told them that he had something that he wanted to do with them that he had not done, as yet; namely, bring them back from the dead by resurrecting them much the same way that he had, a few sessions before, buried them. The new patients, those who weren't present at the "burial" scene, became the angels' choir; the Auxiliary became the choir leader and led the singing. The choir sang "Amazing Grace" during the "resurection" scene. The Director and his patient auxiliary, Mr. Roade, went to each person in the group and spoke to each saying, "You are not dead. You are now, at this time, given new life. Arise and be alive again." Each patient was touched on the shoulders by the Director or Mr. Roade and helped to arise from his or her chair and stand. After all were standing, the Director thanked the choir for their help and directed them to leave the stage and become themselves again. The group was then told, by the Director, to be seated with the new life in them. After all were seated, the group was informed by the Director that the stage had now become a place where there was a lovely hillside. On this mountain hillside was an angel waiting for each of them, each person with a new life, to come and report what he or she intended to do or become with and in that new life. The angel wanted to learn at least one new thing that they were going to get for themselves in this new life. Patients came to the stage one at a time. Nineteen of the 25 patients present walked onto the stage to talk to the "angel." Nine patients who had not been present for the "burial" scene were among those who spoke to the "angel." The Director (the "angel"), went to each of those who had been present at the "burial"

scene and who hadn't gone to speak to the angel, and stood before each, saying that he had brought the mountain to them. Each responded. Some said that he/she was going to get a good job, get well and out of here, be brave; and another response was plans of being with family. Some patients smiled, (Ms. Mills, Ms. Gladstone, Ms. Barton, Mr. Roade, Ms. Bogart, and Ms. Grettel); one patient who hadn't lifted her eyes off the floor prior to this time, looked up as she smiled, (Ms. Bogart). The group left the psychodrama room after the brief closure discussion, quietly, some smiling, (Ms. Grettel, Ms. Day, Ms. Barton, Mr. Roade, Ms. Gladstone, and Mr. Schieb), and talking to one another, in an orderly fashion.

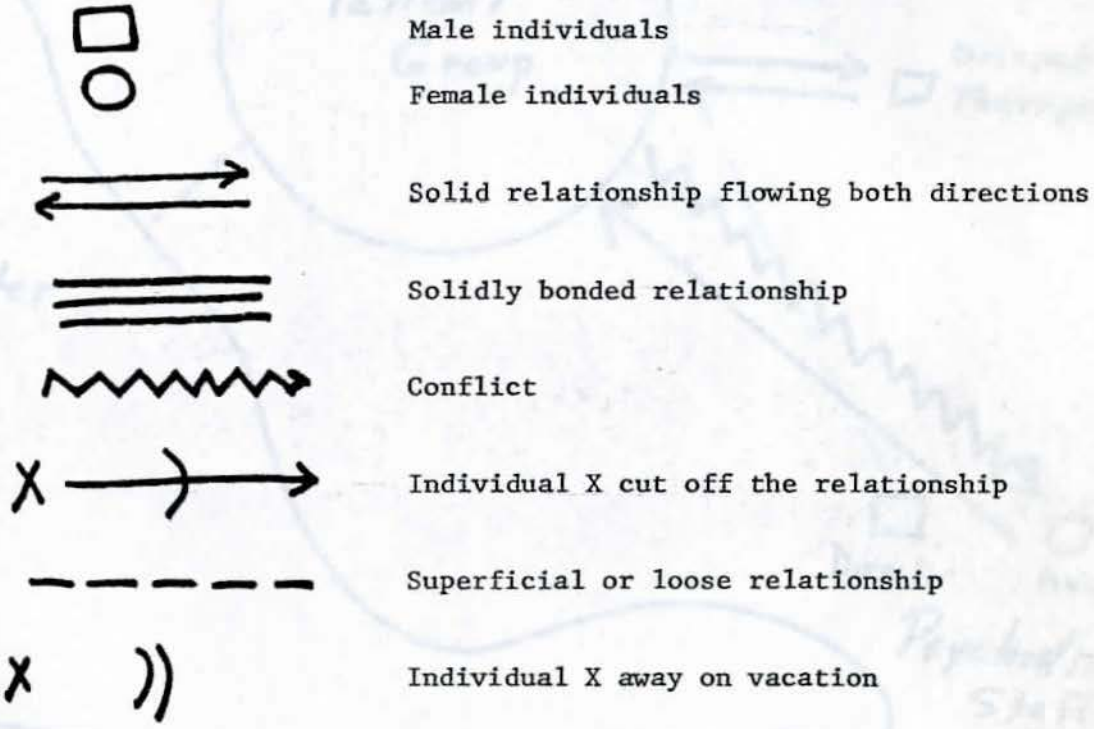
Dynamics Following the Two Specific Psychodrama Sessions

1. There was a higher attendance, usually two or three more patients than before.
2. Patients arrived on time or early for therapy. Three patients, (Ms. Wicker, Mr. Roade, and Ms. Grettel), began to walk over from the ward instead of waiting for the bus. They were consistently early the next four sessions.
3. Patients arrived energetically and talking among themselves as they entered the psychodrama room. Often they came in talking about issues that were of concern to them. (Ms. Day, Ms. Byrd, Ms. Grettel, and a new patient, Ms. Heide.)
4. There was anger expressed on the part of some patients who had not shared their anger before. (Ms. Day, Ms. Grettel, Ms. Heide, Mr. Hart, Ms. Fay, and Ms. Brae.)
5. Relationships within the group changed, as well as relationships of individuals to the group as a whole. New friends were made, old dyads and triads ceased to exist, and some patients left the ward,

either permanently or for a short period of time. (Those will be noted in detail below.) Alliances were made, on the ward, by patients with patients, and by patients with some of the staff members. The patients tried to get themselves released from having to go to the psychodrama group therapy sessions, and enlisted the aid of a new staff member, the clinical psychologist, to intercede on their behalf with the staff psychiatrist.

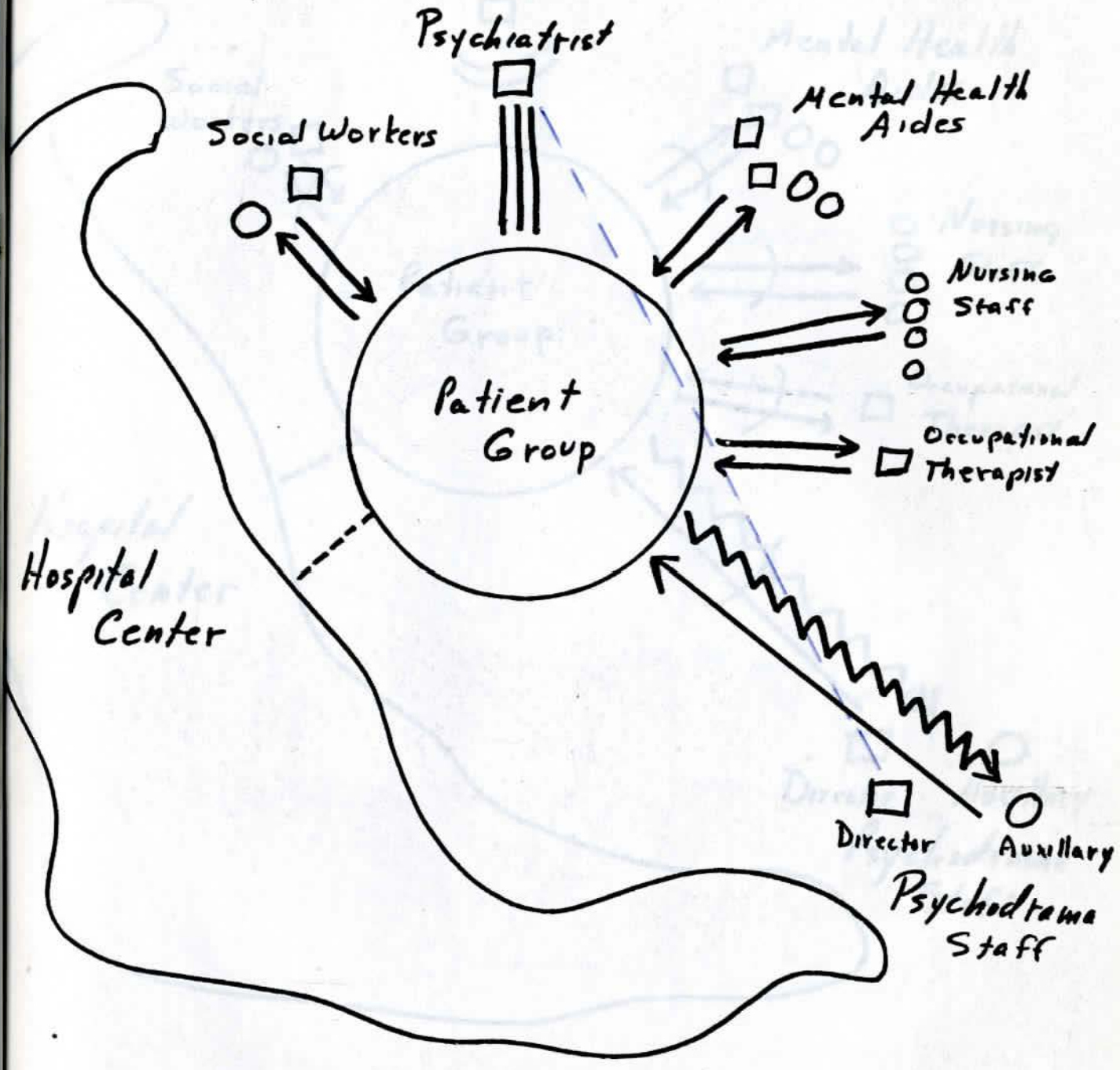
The following four pages of sociometric diagrams, and text, will show clearly the chages mentioned above.

Symbols Used for Sociometric and Family Systems Diagrams



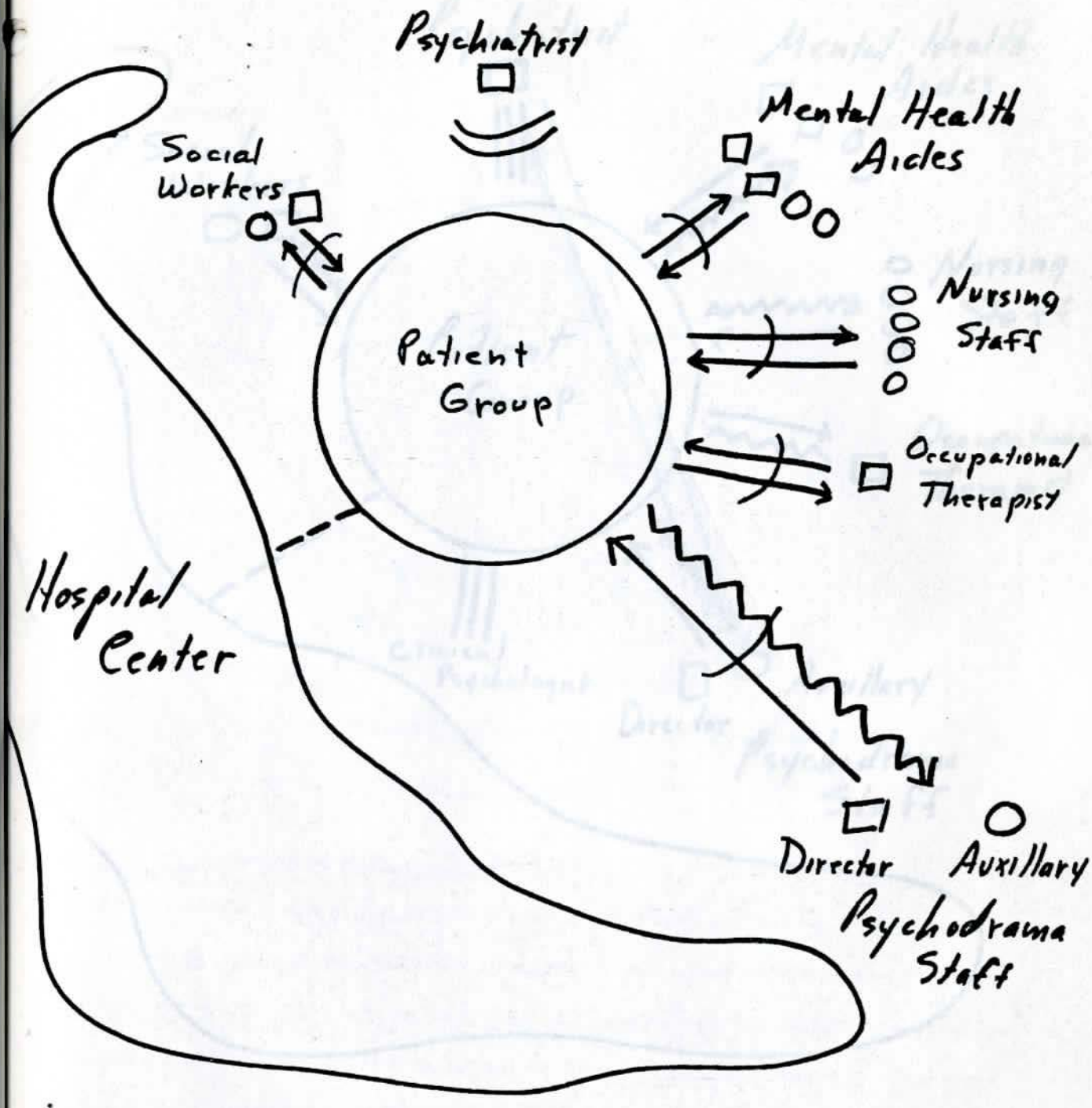
Sociometric Diagrams

Before the "death and burial" scene:



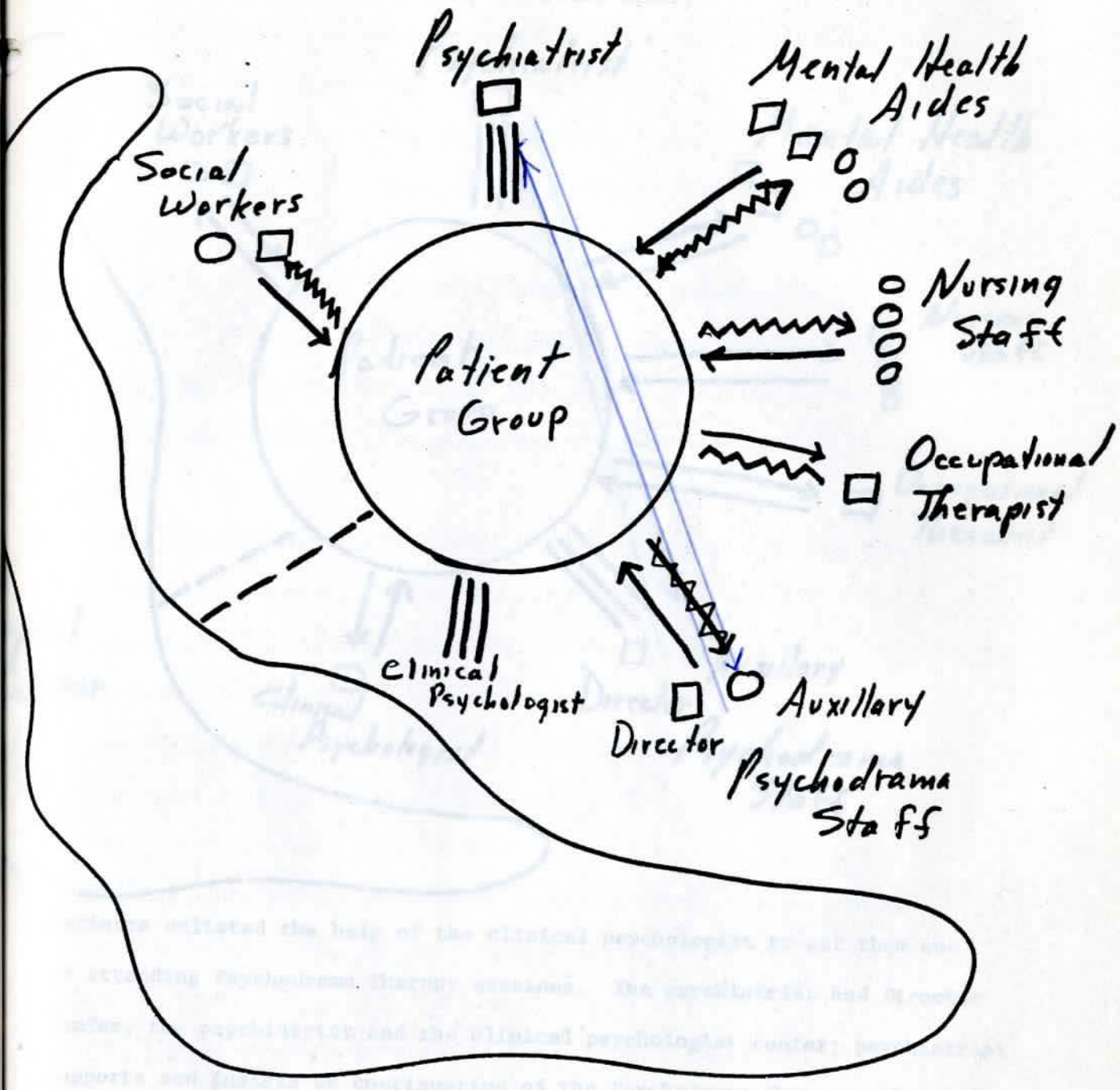
The group's behavior was passive during the Psychodrama Therapy sessions. The Staff on the ward "mothered" the group, allowing them not to work on themselves.

After the "death and burial" scene:



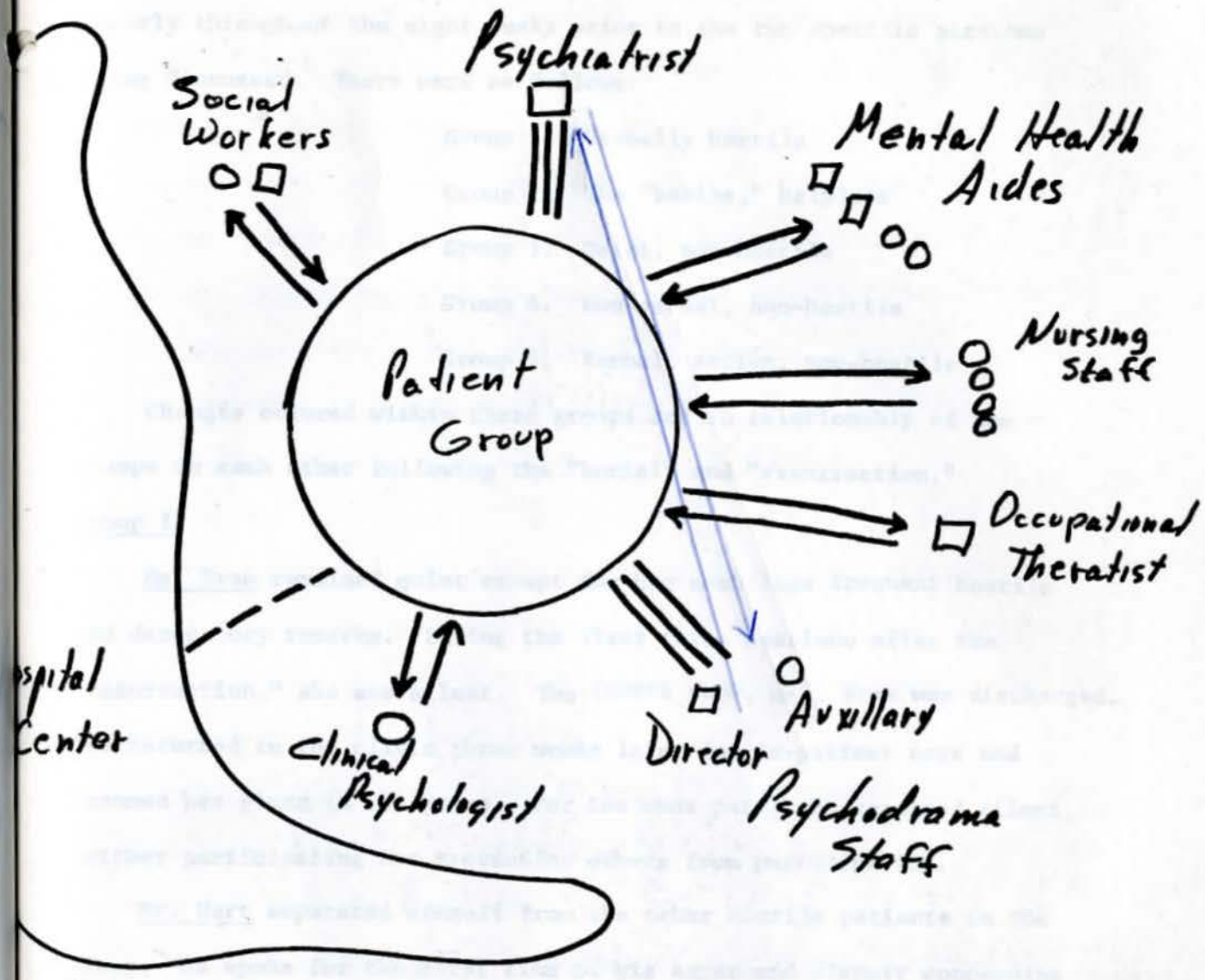
There was considerable tension in the group upon coming to the Psychodrama sessions at this time. Also there was refusal to cooperate on the ward.

After the "resurrection" scene:



Patients were active, angry, verbal, and worked in the Psychodrama Therapy sessions. No longer were there complaints about coming to therapy.

After the "resurrection" scene, six weeks later.



Patients enlisted the help of the clinical psychologist to get them out of attending Psychodrama Therapy sessions. The psychiatrist and Director confer; the psychiatrist and the clinical psychologist confer; psychiatrist supports and insists on continuation of the Psychodrama Therapy. One session of the Psychodrama took place on the ward instead of in the usual room. The triangle of the patients' playing the Psychodrama staff against the ward staff is broken. Work in the Psychodrama room improved at a greater rate than before.

Within the whole patient group, sub-groups had been functioning clearly throughout the eight weeks prior to the two specific sessions being discussed. There were as follows:

Group 1. Verbally hostile

Group 2. The "babies," helpless

Group 3. Quiet, non-hostile

Group 4. Non-verbal, non-hostile

Group 5. Verbal, active, non-hostile

Changes occured within these groups and in relationship of the groups to each other following the "burial" and "resurrection."

Group 1.

Ms. Brae remained quiet except for her much less frequent hostile and derogatory remarks. During the first three sessions after the "resurrection," she was silent. The fourth week, Ms. Brae was discharged. She returned to the clinic three weeks later for in-patient care and resumed her place in the group. For the most part, she reamined silent, neither participating nor preventing others from participating.

Mr. Hart separated himself from the other hostile patients in the group. He spoke for the first time of his anger and dispair concerning his wife's leaving him. He gave support to the others in the group for the first time.

Mr. Shibe began to interact with the younger women in the group. He shared some of his concerns during the group time. He was released four weeks after the "resurrection."

Group 2.

Ms. Day became very verbal with her expression of her anger. She was making adult statements and exhibited self-assertive behavior. She

was discharged two weeks after the "resurrection." She returned two weeks later, appearing weak, whining, depressed and somewhat hostile.

Ms. Wicker became rebellious and hostile at times. Three weeks after the "resurrection" she refused to return to the clinic, following a weekend visit at home. Four weeks following her refusal to return, she was returned by her mother in a very depressed state.

Ms. Grettel began to function on a much more adult level. Her clothing and hair, as well as her verbal behavior, improved. She was less demanding of the group and of the Director and Auxiliary to do things for her. Six weeks later, she was discharged.

Group 3.

Ms. Barton had memory recall, became more verbal, and participated on the psychodrama stage and from her chair in the audience. Her contributions were warmly given and received. She was discharged five weeks following the "resurrection."

Ms. Gladstone shared more of herself in the group, coming on the stage to participate and express her feelings. She was discharged five weeks following the "resurrection."

Ms. Fay improved her personal grooming by coming to the group therapy sessions with her hair neatly combed. Previously, she had always arrived with her hair in tight pin-curls. She volunteered to participate in the group warm-up.

Ms. Byrd had been greatly disturbed during the "resurrection" scene. She had been assisted from the room and back to the ward during the scene because of her shaking all over and incoherent speech. The session following the "resurrection," she became verbal, understandably so; although the conversion symptom of shaking continued--though at a

diminishing rate. Three weeks following the "resurrection" she was coherent, able to write her name, and had begun to work on her own issues. Additionally, she became able to aid others in their work.

Group 4.

Ms. Bogart raised her eyes from the floor to watch the "action." She increased her motor activity during each session following the "resurrection," moving about the room and at times, unable to sit at all. Six weeks later, she began to talk in the sessions.

Group 5.

Mr. Roade withdrew from his usual role of being the helper and father figure to the group. He remained, for the most part, quiet and attentive. He did not do any of his own work after being told that he could best help himself and others if he allowed himself to allow others to do their own talking and work.

Ms. Heide joined the group after the "resurrection" scene and dominated the group often, with her continuous talking and volunteering to be on stage. The first four weeks following the "resurrection," the group allowed her to take much of the time. The last four weeks she was told, and agreed, to be much more quiet and give others time to work.

Two other patients, both of whom arrived after the "resurrection" scene, dealt with issues of separation.

The inner dynamics of the group after the "death and burial" scene was that it solidified itself in its anger toward the Director and the Auxiliary. The anger was expressed verbally and repeatedly in terms of statements such as the following: "Why don't you do something to help us? That's what you get paid for and you aren't doing anything worth-

while for us at all. Being in psychodrama is just a boring waste of time." The group's anger had to do with not liking their position of having to face, psychodramatically, the reality of their behavior. Nor did they like the realization that no one was going to make them well again other than themselves. They did not like the idea of having to do their own work, and facing that truth about themselves.

The group's relationship to the Director and the Auxiliary, as mentioned above, became verbally hostile following the "burial." Following the "resurrection" the members of the group, after a few sessions, became cooperative, friendly and willing to work. The members of the group took the initiative to begin work on their issues, no longer demanding that the psychodrama staff do it for them, and make them better. They came to the therapy room each week angry, actively working and with fewer and fewer complaints about having to do psychodramas. The last four weeks there were no complaints at all.

The group's relationship to the unit's staff, after the "burial" was beligerent and argumentative. Following the "resurrection" less tension was evident on the ward with the nursing staff and the other staff members. An open channel of communication with the psychiatrist continued. About one month after the "resurrection," the patients enlisted the aid of a new staff person, the clinical psychologist, "to help them get out of going to psychodrama." She spoke to the psychiatrist about canceling psychodrama. The psychiatrist supported the need for continued psychodrama therapy. The psychodrama staff held one session on the ward, instead of the usual location, as requested by the patients. This was done in order to yield some of the staff's power and, simultaneously, maintain its authority. It was a powerful session. Following that session, one month after the "resurrection," the patients never again protested coming to the psychodrama therapy session in the assigned location. They continued to work in the sessions very well. The triangle

that the patients had set up of playing one parent surrogate against the other, was broken. It had become clear to them that their unit staff surrogate parent and their psychodrama staff surrogate parent were both in authority and unified in their efforts toward insisting that the patients do their own work.

Summary

There was a marked change in the verbal productivity of the patients who participated in both the "burial" and "resurrection" scenes. The timing of the "burial" scene and the scene itself was a catalyst for the changed behavior by the patients in that it focused their attention on how boring and passive and unproductive they really were. Psychodramatically, what occurred was that the patients experienced their own deadness, or "death"; something which was their biggest fear. Although there is no concrete evidence that the "burial" and "resurrection" scenes were direct causes of the changed and subsequent improved behavior, the only significant variables which preclude such evidence are having the addition of the clinical psychologist to the unit staff, and the departure of several of the patients and the return of three of them.

There was an observable meshing of groups, i.e., the passives became more active and assertive; and the active, hostile patients became less hostile. Members of the group began to deal with their own issues in a more adult manner. Confronted with the reality that they would no longer be "taken care of" as children by either the unit staff or the psychodrama staff and still be "alive" they chose to begin to be productive. Patients participated creatively and spontaneously following the scenes until the end of the therapy sessions, two-and-a-half months later.

Conclusion

I have presented reasonable evidence that the patients' behavior improved in connection with the two specific and related psychodrama sessions presented.

The question now remains, was the changed behavior a result of the lack of "deroling", with reference to the 'death' scene; or would the responses have occurred in any event, since the Director's action of pronouncement of the death and the burial provided the patients with a God like figure, thus meeting their possible fantasies of being one who can determine their very existence?

Since there was assertive action on the part of the patients, (they stood up for themselves against the ward staff,) between the 'death' and the 'burial' scenes before the Director may have encouraged their 'saviour' fantasies; therefore it cannot be concluded that the Director-God like role was the total or main cause of the changed behavior. My conclusion is that the lack of "deroling" had a significant effect on the patients, causing improved behavior.

I further conclude that in a setting in which patients are scene only once weekly there are appropriate times to refrain from "deroling" psychodrama participants, thus gaining a theraputic effect. There is no set rule to follow concerning when and what type of patients would benefit form such prodedure. Leaving a participant or participants in a role would seem to be indicated if the role now assumed would be one more productive, satisfying and fulfilling; and if it would be one which was substantial enough to avoid the setting up a a situation that would be viewed by the participant as failure.

Additionally, the new role needs to be one in which the participant would be safe from being a danger to self or others.

In my opinion the new role, if carefully selected, might well provide one or all of the following: safety, new found self-worth and pride, and a focus on areas to be looked at and worked on at a later time.

SECTION TWO

Intake Case Study Report

Intake Case Study

Sandi Janson

Lindenwood 4, Spring 1976

Supervisor: Jack Cogley

Patient Information — Jane Allen
Garrison Blvd., East Baltimore, Md.
5' 3", 155 lbs., Negro, Baptist
Birthdate: December 22, 1949

Education: She is in her final year of a four year college program in Special Education. She withdrew from school last April. Her mother has been paying her way through school in conjunction with Federal Grants.

Appearance: Her clothing is usually neat and clean, and of modest cost. She is usually neatly groomed while being overweight.

Medication: Occasionally used Valium. Now uses only a non-prescription drug as a sleeping medication.

Occupation: Domestic, or companion work. She had been a full-time student.

Intelligence level: Normal to above normal.

Marital Status: Married in 1966, separated in 1971.

Dates and Place of Consultations:

May 25, June 6, 10, 16, 24, 1976.

Garwyn Diagnostic and Treatment Center,

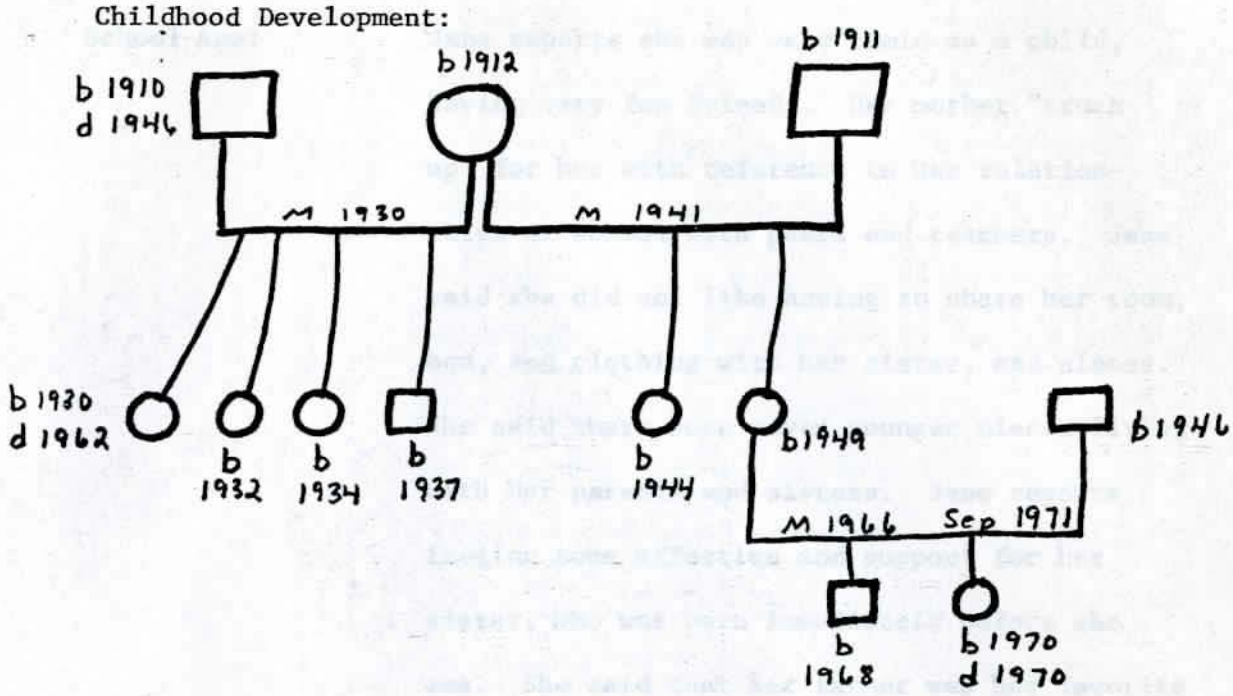
Baltimore, Md.

Medical History: Jane reports an inability to sleep well at night. She said this started about two years ago and has been continuing off and on since then. The difficulty began about the time she began living with the man she is presently living with, Ben. She said she had a paralysis of her right hand last November, while taking exams at school. She reports that the paralysis continued for 48-hours. This was the motivation for her coming to the Center. She told me that when she was fourteen-years of age, she was given an abortion by her mother and another woman who was identified as a nurse. She said she had been unaware that she had been pregnant and aborted until she later was in great pain and very weak and asking to see a doctor. At this time, she said she overheard her sister talking about the abortion. Other than the above, her health is generally good.

Hospitalization: Caesarian section childbirth of a son, at age 16, and a daughter at 19. Both births were while married. Both procedures were normal.

There have been no other hospitalizations, either for physical or mental illness.

Childhood Development:



She said her mother told her that her health at birth was good; and that her weight at birth was over five pounds. All the children were told that they were "nervous" babies. Jane is unsure if she were breast fed; however, is inclined to believe so. She was told she walked at the age of one. She does not know when she began to talk, when or how her toilet training took place. She does recall receiving enemas from infancy on through her childhood; and tensing in reaction to the discomfort. She mentioned that she was not touched much as a child and that she cried a lot. Her father seemed to her to be an emotionally absent

figure in the family. She recalls fighting a lot with her sisters and nieces.

School Age: Jane reports she was very timid as a child, having very few friends. Her mother "stuck up" for her with reference to her relationships at school with peers and teachers. Jane said she did not like having to share her room, bed, and clothing with her sister, and nieces. She said there were seven younger nieces living with her parents and sisters. Jane reports feeling some affection and support for her sister, who was born immediately before she was. She said that her father was her favorite parent because he understood her. The message from him was, "You'll always be my baby." She does not recall what he communicated concerning life, love, or posessions. Her mother was a powerful figure to her, seeming to be in charge of everything; her mother was willing to fight Jane's battles for her, as well as being in complete control of the father. Jane has a very unclear memory concerning her first attendance at school. She is not sure if her mother or an older sister took her and she doesn't know if she wanted to go or not.

Adolescent dating experiences began at the age of thirteen, as she reports, with groups of young teens gathering at friends homes, (never hers), for parties. She said her mother did not tell her about caring for her body, and allowed her to run without supervision. Jane says she did not learn to keep her body or her clothing clean, nor did she receive any guidance concerning dating or sex from her mother. Jane reports that she did not know that sexual intercourse could lead to pregnancy. She said her first sexual intercourse took place at the age of thirteen at a party. She did not realize that she was pregnant, at fourteen, until after the abortion. She said that no one told her anything other than that she "had a cold in her stomach."

She relates that she met her husband when she was fifteen-years-old and married him when she was sixteen. She was attracted to him, she recalls, because he was three-years older than she and would be able to take her out of her mother's house and away from having to share everything with all those other girls. She said that she was happy to be in a place of her own. Her parents' marriage seems to be one in

which the man is very passive and gives control to a domineering woman. Jane reports little respect for her father and dislike for her mother.

Marital History/Family Relationships:

Jane married Keven in 1966, their first child, Keven Jr., was born in 1968. In 1970 their second child, a girl, was born. Jane told me that her daughter died of "sudden crib death" at the age of eleven weeks. She reports that marital conflicts became more frequent following the child's death. The separation from her husband took place a year later. Jane said that just previous to the separation, her husband joined a rigorous religious sect. Since that time, Jane has attended revival Baptist churches, Holy Pentacostal churches and is presently seeing a female religious healer.

Following her separation, Jane reports giving her son to her mother for most of his caring needs. She lived with her parents for four months, at that time. When she left that household, she left her son there and moved into an apartment, alone, for about a year. She says she had a lover who stayed with her often, but had a place of his own. He contributed little

or nothing toward the maintainance of the apartment or food bills. She said he was religious and kept telling her she "shouldn't get angry," and that she "had the devil when angry." Jane ended the relationship with him, stating that "all he wanted was my body and my money." Presently, she is living with a man, Ben, whom she met at a party about two years ago. She was attracted to him, she said, because he took care of her, (buying food, coming over and cooking and taking her out) without demanding money or asking to move in. Within a month, he has moved into her apartment. Several months ago they moved into an apartment in which he is paying most of the rent. She describes Ben as dumber than she, which she does not like, kind to her son, religious, unambitious, tied to his mother, and someone she can control. Two weeks after moving into "his" apartment, she said she brought her son to live with them, against her mother's wishes. Ben has a daughter who is living with her mother. Jane said that she is glad the girl isn't with her man because she doesn't "want to take care of anyone elses kid" like her mother does. She said her mother predicted that Jane would have a houseful of

kids and that Jane's niece would be a college graduate. She said that with the measure of financial independance granted by being with her present lover, and receiving Grant money for education; her relationship with her mother is more strained than ever.

Observable Behavior: In a group intake setting with other black women, Jane talks rapidly, laughs as others talk about men leaving or beating them, sits upright with feet forward from the chair and knees together and arms crossed with hands holding the opposite upper arm.

In individual intake sessions, she talks rapidly, asks for confirmation of her normalacy, slouches in her chair, crosses legs at knees, arms are uncrossed, laughs when she doesn't know the answer to a question.

Analysis: Orientation: Oriented in all three spheres: time, place, and person.

Insight: Poor

Judgment: Self-care skills fair to good.
Nutritional understanding poor.
Financial skills poor.
Interpersonal relationship skills poor.

Cognative Ability: Memory--far is fair to poor, near is good.

Abstract Ability: Untested.

Deduction Process: Poor.

Induction Process: Fair.

Dynamics: With her mother she is very angry. This anger is because of the following: Mother pushed Jane out of the favored position being the youngest, by bringing in the seven other girls; forced Jane to share everything and everyone she had with all the other girls; made predictions that Jane didn't like concerning Jane's ending up as Mother did, with a houseful of kids and no education; lied to Jane concerning Jane's pregnancy and aborted her without Jane's knowledge, understanding, or consent; failed to teach Jane what it means and how to be an adult woman; failed to teach Jane about dating, sex, and cleanliness.

The relationship with her father is one of ambivolent feelings. Jane feels appreciative for her father's attention and care of her as his "baby," and, at the same time, resents his not helping her to grow up. She further has conflicting feelings surrounding his easy going attitude which sometimes seems weak. She wants him to stand up to her mother and gain some control in the family and his life. This would relieve her of the burdensome

message that to be a woman means to be in charge of everything.

Jane's interactions with her son indicate that she is angry with him for being a burden and responsibility to her and forcing her to give up her "baby" status again in order to care for him. She is feeling guilty for not doing the "mothering" she was taught was right. She sees her son as behaving toward her, and her mother, and her father, in much the same way as she did toward her parents. She resents the reflection of herself which she sees as inadequate.

The dynamics with her lover, Ben, appear as follows: She sets the situation up so he looks dumb so she is in "control," as she is modeling after her mother's role. And at the same time, she was told she'd always be daddy's baby and conflict is set up within herself. She wants to be in charge and she wants still to be a baby and cared for.

The dynamics with me, as her intake therapist, is one mainly of avoidance. She does this by switching topics quickly, talking often about the unimportant present or the irrelevant

past, saying she wants to do something and is concerned about her situation and then does nothing about it. She continues to "run" when angry.

Finally, I see her remaining legally married to Keven for all these years as an indication that she still is emotionally dependent upon him and wants to keep that contact available; even though he has not supported her in any way for several years.

Freedom and adulthood are frightening prospects to her. She remains afraid because she has not learned how to deal with it.

Diagnosis: Personality type, 301.5, active dependent (hysterical). She is dramatic in her dependance on her mother and lover, giving way to expressing her anger via tantrums and withdrawal. Neurotic, depressive neurosis 300.4, as her major symptom as evidenced by her internal conflict with regards to what it is to be a woman, her feeling about her parents, the loss of her female child, and the loss of her husband.

Hysterical neurosis 300.1, as her minor symptom as evidenced by her conversion symptoms

experienced in the paralysis of her hand.

Treatment Plan: Physical care:

1. General physical examination because of lack of sleep and overweight, and to preclude any physical causes of her emotional difficulties.
2. Monthly client consultations with the resident psychiatrist for medication needs, if any.

Psychiatric care:

1. Individual therapy.

   Immediate goals: Establishing rapport and body awareness using a bioenergetic approach, in addition to the traditional approach.

   Enable her to slow down enough to be able to notice herself in her own process.

   Long-Term Goals: Focus on identifying her financial needs and means of meeting them appropriately.

   Focusing on her sexuality issues, ambivolence surrounding her motherhood, loss of her female infant, loss of her husband, relationship with her parents, son, lover, and husband.

Estimation of Time: Short term goals, one year.

Long term goals, one to two additional years.

Recommendation of Therapist:

Jane is in need of a therapist who will confront her, be loud at times, and not allow her to be comfortable being dependent, and often being told what to do. Either male or female would be effective if approached in the above manner. I will not be working with her because my practicum is about to be completed here, and I am seeking paid employment.

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