

ADLERIAN PSYCHODRAMA WITH SCHIZOPHRENICS

WALTER E. O'CONNELL

Veterans Administration Hospital, Waco, Texas

We have come to the concept of Adlerian psychodrama from the observation that whenever a group of people congregate to take concerted rational action for the amelioration of schizophrenia rather than to play descriptive diagnostic games, they will, if successful, soon be following the trail of Adler, whether or not they are aware of their affiliation. This paper attempts to outline such an experience. While psychodrama in combination with Adlerian theory has previously been used in various situations (e.g., 4 & 15-20), this is to our knowledge the first such application with mental hospital patients.

When we started a psychodrama group seeking to adhere to the techniques and theory of J. L. Moreno (11), we soon found ourselves deviating from these. For one thing, both patient and non-patient participants felt an implacable urge to intervene with various degrees of interpretations and new experiences on the stage, rather than follow automatically the directives of the patient's delusional system until the latter somehow exhausted his repertoire of defensive responses. The directors found Moreno's theory too abstract and his stage accessories too expensive. They then settled for a home-made stage and the effort at "here-and-now" building of patients' self-esteem and social interest via that neglected resource, positive human reinforcement. Interaction with patients was thus predicated upon this solid Adlerian perception of the schizophrenogenic style of life: abysmally low self-esteem, self-defeating fantasy life, and lack of esteem-gaining social skills (1).

The latest ideas expounded by behavior scientists with Adlerian undertones have continually been incorporated into the group thought and action. Various kinds of double binds (3, 9, 10) have been used for demonstration and were the topic of short ad-lib lectures by the directors. Mowrer's dictum that it is easier to act one's way into thinking than vice versa (12) has been used as method to stop the escape into abstraction. The A-B-C theory and internalized sentences of Ellis (5), as well as Arieti's writings on the "referential attitude" (2) of the patient prior to becoming delusional, have been used to help the patient realize that he is not the helpless victim of an impersonal disease process. He is rather actively making decisions, even when he

conforms to the "do nothing, say nothing, be nothing" life styles of the chronic schizophrenic and the typical mental hospital. The average patient gradually learns that he reacts to fear with behaviors which, in the long run, only compound future anxiety and rejection.

ORGANIZATION AND APPROACH

The main psychodrama group was organized two and one-half years ago by a psychiatrist and two psychologists, including the author. Most of the patients are chronic schizophrenics, mainly from the building of the participating psychiatrist. The number of patients is usually between 15-20 males, with 1-17 years of hospitalization, as a rule, exceeding five years. Usually about three are in individual psychotherapy with the director, and most of the others in bi-weekly psychotherapy groups. Personnel from all levels of the hospital hierarchy have participated in the weekly sessions as auxiliary egos, i. e., people who play parts to encourage affective interactions and reinforce patients with approval for showing "guts" enough to tell others about their problems and be open to alternative approaches. The number of psychodrama groups has now expanded to three, with seven volunteers (five females and two males) from outside the hospital. The two male volunteers are former patients who were in psychodrama and individual psychotherapy and are now working in the community. They are priceless coaches and mentors for the group, living articulate models of what the problems in living are for the schizophrenic and how they can be faced with help.

Before the groups became a functioning reality, a number of personality quirks, more pronounced with non-patient members, had to be resolved. Initially there was strong reluctance to approach the stage, and the group formed around its old secure conference table. Action was expedited when tables were removed and all chairs placed facing the stage. Next, the protective staff armor was slowly removed and people emerged from behind test equipment and pill bottles to speak in the vernacular rather than in terms of psychiatric entities, fixations, and Freudian mechanisms. The latter two are never used without the director explaining that these are essentially expressions of incapacitating fears that have been learned. And he adds, "It was learned and so it can be unlearned." Such interpretations in terms of learned fears, e. g., fear of assertion, closeness, or even thinking, appear to make more sense to the schizophrenic patient and are more easily incorporated in his thought and action patterns.

The omnipresent fear of co-professionalism among staff members (8) was also tackled until the whole group could accustom itself to freedom-of-speech-and-interpretation for all. While our female volunteers have always been more immune to this reaction, it is a very rare professional in a mental hospital who is not somewhat jolted for a time by the prospect of literally rubbing elbows with and allowing equal interpretative time to his co-worker in psychodrama, the hospitalized chronic schizophrenic.

Of course this democratization of time and space does not mean that patients' interpretations are accepted. The professional therapist is usually the expert, but only because of his typically more plausible and hopeful explanations and not because of irrational prohibitive powers. Even before we were aware of the writings of Szasz (21) a new twist was put on the label of mental illness. As an explanatory concept it was not allowed. For example, one could not solve a problem by invoking the phrase "mental disease," e. g., "I hit her because of bad nerves," or "They say I have mental illness and I'm resting up to overcome it." Anxiety, fear, hatred, and other more colorful common, affective words carry more meaning.

ONGOING PROCESSES

With these premises in mind the group started with everyday superficial transactions to illustrate individual differences, and to encourage assertiveness which was positively reinforced when it appeared problem solving rather than avoiding.

Over the years the staged interactions have always revolved around the patient and the significant problems in his life: family, work, and hospital problems. Many times the esteem-deflating double bind is staged to help the patient recognize it and attempt to break out of it by being less immaturely dependent and defeated. He learns that there are no standard answers for everyone, least of all the implicit psychoanalytic ploy, decried by Mowrer (13), that there is automatic hostility which must automatically be dumped on someone else for one's mental health. Here Ellis' (5, pp. 215 ff.) fruitful view (the B of the A-B-C), that what the person tells himself about the situation is instrumental in bringing about an emotional response, is of supreme importance. Moreno's "role reversal" technique likewise counteracts the patient's narcissistic static view of others as inveterate rejectors: Through taking the role of the significant other, the patient frequently learns how unreasonable it is to demand

changes from another. He is then thrown back upon Ellis' B, with the experience that the greatest potential for change resides within, if he thinks it is possible, and will pay off for him in increased happiness. Another useful technique is the "mirror," employed when the patient is reluctant to approach the stage: If someone else takes his role, it usually is not long before the patient rises and enters into the process, as himself. Moreno's "double" technique (someone behind, speaking the patient's thoughts) was a definite failure. It was not realistic enough, and the patient frequently left the enacted scene to argue with his double.

A glimpse at the start of a typical session from the eyes of a director might provide a clue as to the interactions involved.

The patients and volunteers are seated in a circle facing the stage. A number of spirited conversations are taking place as the director approaches. In contrast, some of the new or more withdrawn patients sit in isolated silence staring intently at nothing. As the director enters there is a flurry of wit tossed at him. The patients are encouraged to enjoy their moments of indirect hostility, because such actions are only noted when the patients feel strong enough to weather possible retaliation.

PATIENTS. Hey, doctor, where you going all dressed up? Preaching, or dancing?
He's going to ask Dr. Leskin for a pass, if he can get to see him. Bet he can't get one . . .

DIRECTOR. Looks like we've got a lively bunch of lads today. Ready to tackle the puzzle of daddies and bosses . . . Let's see how we can do it without stumbling into more trouble. It's not hard to win respect when you don't run away from anxiety . . . Who's going to be the first to take advantage of this rare opportunity to change and to improve on their courage?

Three patients raise their hands and start to talk.

ED. It's not really a problem . . . But the evening aides push us around . . . like jail . . .

BILL. I'm going home for three days, and in group Dr. Bell asked me why I never asked to stay home. I'd like to try to convince my mother and step-father . . .

FRANK. Damn! I never should have been born . . .

DIRECTOR. Good! We've got three guys ready to deal with their problems before us all and see what they can do to solve them, rather than make them worse. Ed and Bill—we've heard from you recently, so we'll take Frank's problem first, OK? Then, we'll get to yours soon. Frank hasn't been up here for a couple of months, but most of us know he's been trying out some approaches to people. That takes real courage. And it seems like he's been getting some bumps, but isn't going to crawl into a hole and hide. Now we're getting some place. Tell us more, Frank.

FRANK (*getting up on the stage*). I never had a girl, and I don't know how to act . . . They'll laugh at me . . . or yell "rape." I used to stand off . . . and they say I'm a screw-ball.

DIRECTOR. Makes you feel lousy. But you never had a friend, never trusted anyone. No friends, no one to let off steam to—and we'd all be nuts.

SAM. Yea, that's sure our problem . . .

HARRY. Frank's been driving the secretary and OTs [occupational therapists] crazy trying to be nice to them. *Laughter, even from Frank.*

FRANK. They won't marry me . . . They listened to me talk and no one else ever did . . . so I kinda feel . . . (*voice trails off*).

DIRECTOR. If we're anxious, and someone helps, they become important to us. So let's get into it, Frank.

FRANK. When I was home I sneaked out to see if I could find a girl . . . Mother and father wouldn't like it . . . They'd think I was getting sicker . . . Went to bowling alley. Mrs. Bruck could be a girl . . . and Dr. Leskin and Mike be a couple of these wise guys at home wanting to fight me . . . (*to director*) My mouth's getting dry, maybe I shouldn't . . .

DIRECTOR. Frank, you're going to be nervous. We expect it, but you're going to have to face these situations.

RAY. That's right Frank, go to it.

And so the session starts. Before Frank leaves the stage certain points will be discussed, again and again. Focus will be upon his feelings that people will always do something bad to him, and that he will be overpowered. Eventually his actions which bring negative action from others will be examined and alternative behaviors attempted. When possible, the director will bring in opinions and praises from others, "between the acts."

OUTCOMES

What has been the value of all this? In spite of the lack of statistics and graphs, all personnel and most patients mention some benefits, with the personnel claiming more. Since we have been trained to question verbal behavior, what about more direct forms of change? First, the patients are much more motivated to attend psychodrama, even though they may be "captives" and enter reluctantly at first, than ordinary group psychotherapy where they sometimes grumble because they are "wasting time" by attending group sessions (when they could be indulging their "avoidance needs" elsewhere). Also, very little wandering off the topic is noted in psychodrama, for attention is focussed upon the real life "play" on the stage.

The psychodrama groups have had a number of successful graduates over the years. They share a characteristic also noted in the majority of individual psychotherapy cases: There is much less of the interminable coming-and-going, of discharge and re-entry, among

these patients. It seems that ego autonomy (or "free will") can be a learned ability even in facilities whose motivation for existence is not primarily therapeutic (6).

Contrary to popular psychiatric opinion, the exhibitionistic patient does not benefit from psychodramatic experience as much as the fearful withdrawn individual. The rigidly outgoing person was mainly showing stabilized defenses used to deny problems, but the fearful person generally was not in possession of such hardened methods of avoidance. Too, those with assertive psychopathic traits very often tried to test the strength of staff relationships by attempting to analyze the personalities of the psychiatrist and psychologists. Only when this type of patient could be made to realize his defensiveness, its lack of constructive gains, and the fact that the participants readily admitted to anxiety and refused to "play God" were the slightest improvements forthcoming. The latter ploy was always used to deal with the unrealistic schizophrenic view of himself as monopolizing all the anxiety in the world. (" . . . you'll always have problems and some anxiety. The important thing is what you do about it.")

Volunteers and many hospital workers report that patients become more meaningful to them as people struggling blindly with anxiety. Generally these participants have been exposed to Kraepelinian lectures with a touch of Freudian pessimism. It is oftentimes a long road before these people reach a point where they believe they can add something very positive to the determiners of another person's behavior, e. g., aid in the development of a humanistic identification.

DISCUSSION

The greatest potential for future exploration is naturally that of psychotherapy. Of all the methods extant the approach here presented appears to offer the best setting for increasing self-esteem, teaching of a hopeful theory or philosophy of emotional disturbance, and ensuring that the resulting insights will be practiced.

Psychodrama could be used for both theoretical research and diagnosis, although the former has not yet been attempted here and the latter has been generally frowned upon. It is fairly difficult to make a determined subject-object stance and put the patient under the descriptive diagnostic microscope when one sees the slow improvement in symptoms and is part of this growth process oneself. If we

had a standard Adlerian diagnosis combining self-esteem, compensatory fantasy, and social skills, psychodrama would be the ideal setting for this measurement. For which is the better technique for understanding: asking a patient about his adjustment in a structured interview, or combining this with actual experience with a surrogate?

Yet, we do not want to overvalue the influence of this kind of psychodrama. It is merely an hour or two a week in the patient's existence. Unlearning and relearning cannot take place quickly, if at all, in a setting where the influence of learning is hardly mentioned. The patient's internal negative reinforcements, the family's un verbalized neurotic needs (7), the Babel of theories (mostly accentuating hopelessness), the lack of material and interpersonal rewards and even punishments, neglect of a program for teaching social skills, the dearth of release alternatives when relatives will not cooperate, and even the national policy to reward materially the continued avoidance of interpersonal relationships (i. e., monetary compensation), all combine to tempt the therapist with the belief that he is Sisyphus reincarnated.

Still, if patients are hospitalized because their behavior bothers others (6) and are usually motivated by their denial-of-relationships with people (10), what treatment is more appropriate than that which aims to desensitize fears and develop social interest? Mowrer (14) has a point which bears thinking about when he writes that schizophrenics have low self-esteem because their actions merit this. It is true that much of their future feelings of worth will follow from the insight developed in human interactions, some of which will have been afforded by psychodrama. If our mental hospitals were to subscribe to a non-"rejection mechanism" (6) approach without providing personnel trained in an Adlerian orientation, the result would be catastrophic. Merely accepting psychological treatment as the *modus operandi* is no answer. One still must decipher the abstractions (e. g. "get patient to identify with you," "do supportive psychotherapy and strengthen defenses") to realize one's part in developing I-thou encounters.

SUMMARY

Psychodrama groups for hospitalized mental patients are described. Founded on the ideas of Moreno, the original group soon switched to an Adlerian emphasis. The change was motivated by the relative ease in communicating Adlerian premises and the fact that they make sense in treating schizophrenia. Some of Moreno's tech-

niques are still used but the core of the rationale is based upon the Adlerian triad of low self-esteem, avoidance of reality, and poor social skills.

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