

CHAPTER 8

The Role of Dramatherapy
in an Extremely Short-term
In-patient Psychiatric Unit

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The Challenge

In the times when psychiatric hospitals were influenced by psychoanalysis (that is, before 1960), a patient's treatment not uncommonly might last three or four years (Rubenstein and Lasswell 1963). Short-term usually meant less than one year. When general hospitals opened psychiatric units in the 1960s, short term meant six months or even 90 days. In the 1980s during times of cost-containment and diagnostic related groups, short-term meant one month. Now, due to managed care systems and tighter federal regulations, short-term means one week. We call this extremely short-term.

What kind of treatment, other than medication, behavior control, and discharge planning, can occur in seven days for people with serious psychiatric conditions? Specifically, what type of *psychological* work can occur? In fact, psychotherapy in any recognizable form is usually not offered. Psychological treatment has shifted to psycho-education and cognitive-behavioral interventions that are discrete, available in writing, and narrowly focused on symptoms (Leibenluft and Goldberg 1987).

This chapter will discuss the fundamental challenges of providing dramatherapy within a short-term in-patient psychiatric unit, and attempt to articulate how dramatherapy can be a useful treatment modality in such a setting. The essential point will be made that dramatherapy can serve the specific, limited goals of the modern psychiatric unit, without giving up its values of creativity, expression and relationships.

In one short-term unit where we have worked, there is an active milieu program run by a multi-disciplinary team of doctors, nurses, occupational

therapists, social workers and creative arts therapists. The master treatment plan is developed based on the assessments of each discipline. There are at least 36 hours of group activities available each week for the patients, including verbal group therapy, art, drama, music, video, assertiveness training, family education, and a relaxation group. Each patient attends approximately five hours of group work per day, in addition to meetings with his/her individual doctor and other medical treatments.

Since patients are continuously entering the unit, every day there is a new set of members in the groups. There can be little development of themes from one group to the next. Safety and trust, the foundations of group therapy, are constantly disrupted and therefore rarely achieved. Patients are often taken out of groups to see consultants and to receive various procedures. Therefore, communication among the staff must be excellent and timely for the transfer of information during the day to be helpful. Therapists must be active and structure their groups quite firmly.

Although a case could be made for not having groups at all, several studies have shown that units that *have* a group program are more stable and effective than those that do not, although the individual modalities have little effect on the outcome (Yalom 1983).

In this hurried, 'get down to business' atmosphere, how can the creative arts therapies fit in? Drawing pictures, writing poems, and making sounds and acting in dramatherapy seem at best reminders of the leisurely psychoanalytic tradition of self-exploration and insight. At worst, they can be characterized as regressive, distracting, over-stimulating activities that may undermine the in-patient team's fragile attempt to get the patients organized, calm, and functional enough to be able to leave. Even Yalom (1983) in his book on in-patient group therapy, notes that the arts groups offer 'a more sporadic and counter therapeutic experience' (p.13). After two decades of bringing creative arts therapists into these units to replace occupational therapists, now occupational therapists are being returned to focus on rehabilitation and activities of daily living.

The Contribution of Dramatherapy

In order for dramatherapy to contribute to the treatment efforts of an extremely short-term in-patient unit, it must satisfy the following conditions: the entire therapeutic effect should be accomplishable in one session; it must be an obvious contribution; and it cannot be expected to impact directly on an illness itself, such as schizophrenia.

The reason we do not despair, and the reason that the creative arts therapies are supported and felt to be effective in our hospital, is that treatment need not be focused only on the diminishing of the illness process itself. Treatment can also support or strengthen the host and his or her resistance against the illness. This, we believe, is what creative arts therapies can do on an extremely short-term in-patient psychiatric unit.

Dramatherapy can strengthen both the individual patient as the host of the illness and the in-patient unit as the host of the patient. Let us describe their burdens: the individual patient being hospitalized for a psychiatric condition in almost every case is crushed — regardless of diagnosis — with shame, fear, hopelessness, and a sense of isolation. These feelings, especially if hospitalizations have been multiple, lead to a general demoralization and resistance to treatment, which express themselves after discharge in noncompliance with treatment recommendations and rapid relapse. Good advice from staff therapists, excellent psycho-educational materials, and practice building skills of daily living go down the drain under the press of demoralization and shame. The psychiatric patient, managed and unheard, is left with the feeling, 'I am and always will be a worthless human being'.

Treatment can focus on this demoralization and shame, on the sense of being alone and hopeless, encouraging the development of pro-treatment attitudes and an optimistic view towards the future. These effects can have a profound and immediate impact on the course of treatment of the psychiatric patient (Zimpher 1987).

Likewise the in-patient psychiatric unit is beset with unbelievable challenges and stresses that usually make it boil with dysfunctional staff dynamics and burnout. The constant arrival of seriously ill patients who are suicidal, psychotic, demented, or mute creates a sense of danger and fear. The intense time pressure to treat these patients and the understanding that the treatment is inadequate, that the out-patient resources are insufficient, and that the patients will relapse, also places significant stress on the staff. Hierarchical boundaries among the disciplines are required to maintain a sense of order, but do not usually match the functional needs of the organization, so an absent MD attending may have less importance than a bachelor's degree occupational therapist who is central to the planning of the weekly program. The resistance and demoralization of the patients infects the staff, who become angry at the relapsing patients, undermining their own sense of efficacy and enthusiasm. Typical staff attitudes are, 'Something terrible is going to happen', 'We just keep getting dumped on with these sick patients', or 'This place is crazy'.

Treating these staff dynamics can have an immediate effect on staff functioning and the overall ward atmosphere, which then can increase the effectiveness of each individual treatment component offered the patient.

Strengthening the Individual Patient

Dramatherapy groups at our hospital aim to help the patients move from being victims of the illness to survivors, by encouraging them to take a more active role in their treatment, helping them to understand that they are not alone, and relieving them of feelings of isolation and despair by uncovering their creative potential. Dramatherapy, by utilizing the method of play as a distancing device, allows for self-revelation under the guise of imagery and metaphor. The evocation of positive, humorous, creative, and spontaneous contents within each patient reassures them that they are not completely worthless or dead. They become empowered by the realization that their attitude toward their illness is largely within their control.

The form of dramatherapy used is the Developmental Method (Johnson 1982, 1986) which involves spontaneous play beginning with simple, repetitive movements and sounds, and then develops into images and more structured role-plays and improvisations. By maintaining a free-flowing 'playspace', more superficial images are let go and more personal images arise, usually about their identities as psychiatric patients facing serious illness. The method allows the patients to play with rather than define their problems. Laughter, relief, equanimity, and connection are often the by-products of this type of dramatherapy group. The developmental method is particularly effective in improving relationships and creating a sense of unity, cooperation, and support within the group. 'The result is a greater tolerance of one's self and relief from anxieties generated by rigid interpersonal stances' (Johnson 1986, p.18).

Case Example of a Dramatherapy Session

The dramatherapy group meets once a week. This is the first time this particular group of patients have been together for dramatherapy. Some patients were in the group last week, but many will be discharged before the next session. Patients attend five hours of groups daily, so in this session they are not meeting for the first time.

The following is a brief description of the group members including their admitting complaints. Jay is 15 years old, with a diagnosis of attention deficit disorder. He has been on unit for four days for getting into fights and

uncontrollable behaviors at home and school. As he is an orphan, he will be placed in another foster home upon discharge. Kevin, 32, has a history of alcohol and substance abuse. Admitted for suicidal thoughts and diagnosed with severe depression, he has been on the unit for six days. Judy, 55, has a long history of depression and this is her fourth psychiatric admission in two years. She has been on the unit for eight days. Lou, 42, has a long history of anti-social behaviors, including theft. He was admitted for suicidal ideation, and has been on the unit for two days. Allan, 52, has had difficulty remaining sober and has reported an increase of suicidal thoughts before admission. In two days, he will be transferred to a 28-day Detox program. This is his second admission in six months. He has been on the unit for four days. Greg, 40, has a history of untreated depression. He has lost his job recently due to his depression, and has just arrived on the unit. Meredith, 29, has a history of alcohol and substance abuse, but has never before been treated. She has been on the unit for four days.

Beginning of the session

The group members arrive without saying much to each other. They sit quietly in the chairs arranged in a circle. The therapist says to Judith, who has not attended any groups since admission, 'I am glad you made it to the group'. Judith says, 'I'm not!' and sits down angrily. Jay says, 'James is not here; if he gets to stay out of the meeting how come I have to stay?' Meredith arrives late and sits with her arms crossed and head thrown back, staring at the ceiling.

The therapist instructs everyone to stand, stimulating much groaning and complaining. 'Why can't we sit down and do this?' Meredith asks. 'My legs are sore!', Judith says, 'I am tired and I don't want to be here.' Lou speaks with sarcasm: 'Here we are, all at the crazy ward'. Greg is quiet. No one is talking to anyone else, just throwing complaints to the therapist. There is a feeling of unease and discomfort in the room.

The group is instructed on how to mime bringing down the dramatherapy curtain, which they do with little enthusiasm. The therapist begins an imaginary ball throw exercise. They toss the ball and say the name of the person who is catching it. They begin to make eye contact and connect with each other. Individual personalities begin to emerge. Alan throws the ball to Judith as if he is pitching in the world series. Judith volleys the ball to

Meredith, who in turn 'dumps' the ball to Lou as if she is passing a heavy load. Lou mimes dropping it. Jay turns the ball into a basketball and makes a fancy pass to Greg. There is some nervous laughter in the room.

The therapist shifts into the sound and movement phase (Johnson 1986). Alan begins a movement of rocking back and forth on his heels, his arms swinging. The group copies him. When he senses the group has the movement he passes to Kevin, who changes the movement to a slashing with his arms. The group quiets down and the flow strengthens. The therapist asks the group to add sounds to the movement, many of which are soft and guttural: groans, 'ha', 'ho', 'wow', 'psst', 'hush', 'shhh...' Judith turns and says to the very quiet Greg, 'shhh'. He makes a surprised face. The group laughs genuinely.

Middle of session

Images of danger and sadness are building in the group through the sound and movement phase. The flow of movement and sound is now strong, the patients are engaged and interested. There are many gestures of pushing down. The therapist encourages everyone to hold their hands toward the center, pushing into the center. Out of this movement an image emerges. Alan says, 'We gotta keep it down'. They are standing in a tight circle, bent at the waist, holding 'it' down. Lou throws a cover over 'it'. Therapist asks the group 'what is it?' 'What is it?' is asked again as they are all staring at the center. 'I don't know', Meredith answers, 'but it's there!'

Jay pulls the cover off of 'it' and shouts: 'Ah ha!' Judith reaches down and pulls a small imaginary object off the floor. 'What is it?' the therapist asks. 'A caterpillar,' she responds. They are instructed to pass it around the circle. As they hand this 'it' around the circle, 'it' becomes more and more scary; first 'it' transforms into a spider, then into a dead mouse, or a rat, and someone throws it onto Lou's back. He responds as if there is something deadly crawling up his back. The therapist asks 'Should we pull it off?' The group agrees to this action. Alan pulls 'it' off and he whispers as he shows it to the group, 'This bug can tell you why!'

He places his hand with the 'bug' into the center of the circle. The group all put their hands into the center and slowly move in a circle, building and playing off the sound of the word, 'why'. Whispering 'why', Alan says, 'This is the Why Master'. The therapist says to the group, 'When you hold this bug you can ask it *why*'. Meredith takes the bug from Alan and asks it reverently, 'Why are we here?' Kevin answers spontaneously 'Because we didn't take care of ourselves!' The group nods and begins to whisper 'why'

again. Kevin holds the 'bug' and turns to Alan, and asks him, 'Why are you leaving Monday?' and Alan responds, 'To take care of myself, to go where I can learn to stay sober'. Alan then turns to Greg and asks 'Why are you so unhappy?' Greg responds, 'because I am so alone' and he takes the bug from Alan. The group gathers around Greg. Greg looks at people in the eye, and there is a feeling of connection and understanding within the group. The therapist says this is not only the 'why master', it has other properties too. Jay shouts 'It's the friend master!'

End of session

The group is instructed to pull down the magic dramatherapy box, and the therapist says that they can put in any questions that they might have and in addition they can take out whatever they need. Jay is the first to reach in. He says he has taken out a family that he can live with. The group applauds for him. Kevin reaches in and says he has Alan's phone number so he can call when he needs a buddy. Judith leans over the imaginary box and puts in the question, 'Why am I so messed up?' The group makes comforting sounds. She then reaches in and takes out a 'friend' to talk to. Lou puts the original bug into the box, and does not want to take anything else out. Greg reaches in and begins to fill his pockets. The therapist asks him what he is putting in the pockets. He responds, 'The group, my new friends'. Alan whispers a question into the box, 'Will I make it?' and the group whispers back 'Yes'. Meredith shakes down her whole body, saying, 'I am just a load of questions, get them off me'. She gets the assistance of the group and they throw these undefined questions into the box. Lou quickly reaches for the lid, they put it on and send the box up into the ceiling. After the group lifts the box they applaud, spontaneously. The group is over, and as they leave, they are chatting and laughing. Before Greg leaves he says to the therapist, 'At first I thought this group was stupid, but I feel better now!'

This group is a good example of how a dramatherapy session can contribute to the morale, confidence, and social support of extremely ill psychiatric patients. The therapeutic effects are increased pro-therapy attitudes, and decreased feelings of shame and humiliation.

Strengthening the In-patient Unit

In-patient psychiatric units are not fun or safe places. The tensions and hierarchical dynamics among the staff and patients are very intense, and often go unexamined. In our hospital we utilize a dramatherapy format called the Video Group to address these systems issues and to strengthen the unit psychologically (Johnson 1984).

The video group meets once a week. Within the hour and fifteen minute session the patients will make a short news broadcast for the unit. It is hosted by two patient anchorpersons who read the news of the week, and the Lost and Found column about patients who were admitted and discharged. Then a short skit that highlights one of the news stories is presented by a group of patients.

The patients are instructed that the purpose of this group is for them to portray how the community is doing, particularly any problems they may be having living together in such a small place. The patients are allowed to make fun of the staff role as part of unit-wide issues, rather than as individuals. They are not allowed to tease or make fun of specific patients who are not participating in the group. The video is then viewed in the community meeting the next day by both the staff and patients, and the issues raised by the video are then discussed among the entire community.

The video group has been in existence on the unit for many years, and it serves several purposes for patients and staff. First, the video serves as a barometer of the internal world of the unit, a literal 'milieu biopsy' (Levine 1980). Since most of the patients participate and are encouraged to express whatever is on their minds, the video often becomes a powerful expression of what their needs, feelings, and impressions of the unit are. The fact that it is presented before the entire community in a legitimized format helps everyone focus on the issues. The staff wrap-up after the meeting often involves a further elaboration of the issues raised in the video group. The weekly video becomes the metaphor-for-the-week of the unit, and the themes emerging from it often shape the discussions in other groups held afterwards. For example, after a video that humorously portrayed the patients' inordinate dependency needs on the staff, and in a community meeting in which patients demanded more attention, the writing group explored the theme, 'How do you take care of yourself?' and the assertiveness training group focused on, 'Why be assertive if I can depend on someone else?'

Second, the video group evokes very humorous portrayals of staff members' difficulties, poking fun at the obvious system problems that beset every in-patient unit. The hierarchical tensions and fears that are common in such settings lead to a suppression of normal criticisms of the staff, which

then stimulates acting out behaviors. These authority dynamics are relieved as the entire community sees with the distance provided by the video screen the truth of the patients' perceptions about their environment. The humor, however, serves to communicate the healing message that the staff are human too, and the debilitating projections of staff = healthy, and patient = incompetent, are disrupted and corrected by such portrayals. The patients also see the staff react non-defensively to the criticisms on the video, modeling an appropriate way for patients to express needs, thoughts and criticisms without defending against the shame. The result is that the video serves as an ice-breaker and structuring device in the community meeting, easing the group's anxieties about large group meetings and providing tangible items for the agenda.

Third, the video group is an arena for demonstrating patient competencies. The news broadcast format is a familiar and well-respected symbol of competence in our culture, and most patients are able to demonstrate mastery of the anchoring, reporting, and role-playing required, despite their illnesses. The videotape becomes another reminder that as bad as psychiatric illness is, it does not remove everything from the person. This can be a profoundly reassuring experience for both patients and staff when they see it in the community meeting each week.

Thus, the video group can effectively stabilize and strengthen the unit atmosphere by giving staff and patients a sense of the issues confronting them as a group; by softening the rigid distinctions between healthy and sick; and by reminding everyone of the human and competent element in the patients that remains unharmed by the disease.

Case Examples of the Video Group

Case 1

This video group has mostly new patients who had been admitted within the previous twenty-four hours. There is a lot of grumbling at the beginning of the group about wanting to go home, and not needing to be on the unit. There is little sense of a community as there had been at least four discharges within 72 hours. In addition to the eight patients, three staff members were present, as well as a psychiatric technician, a registered nurse and the dramatherapist.

THE MISERABLE THERAPY CURE

(Close up on the Host (Dramatherapist).)

CONNIE: Hi! Welcome to 36 Minutes. I am Connie Chunkie and I am here to investigate a rumor of a magic cure to improve mental health. Yes, ladies and gentlemen, they have developed a new cure for mental health here on 6 west. It is called Miserable Therapy, and we are going in with a hidden camera to see how it works.

(A close-up of three patients sitting in a waiting room.)

CONNIE: (to the patients) So, how are you feeling? This is your first day here on the psychiatric unit?

PATIENT 1: Yes it is. I feel a little down, but glad that I am here.

PATIENT 2: Me too, looking forward to the treatment. *(Patient 3 nods)*

CONNIE: Here comes the staff...

(‘Staff’ is played by one real staff member, the RN, and two patients. They descend upon the waiting ‘patients.’ They are loud and demanding.)

STAFF 1: Have you taken your meds, you need to take your meds...

STAFF 2: You need to go to all your groups, get going now...

STAFF 3: Tell me how you are feeling, tell me all the details...

(They are shouting and overwhelming the patients with their orders. They leave and Connie sneaks in. They look like they are in shock.)

CONNIE: So how are you feeling now?

PATIENT 1: Angry, miserable, horrible.

PATIENT 2: Terrible.

PATIENT 3: Let me out of here!

CONNIE: Well, it looks like a pretty radical treatment, I wonder what stage two of the treatment is like. Here comes more staff.

(Staff member 1 enters.)

STAFF 1: Patient 1, how are you feeling?

PATIENT 1: Awful.

STAFF 1: Well, here is something to make you feel great! I just got word, you are to be discharged. I also have orders for 2 and 3 to go today too! The cure worked!

(Patients jump up and down obviously excited, happy and better!)

CONNIE: So there you go, audience. A Miracle Misery cure here on 6 west. They admit the patient, make their life miserable and then the cure of discharge makes them feel all better! Tune in next week for another 36 minutes.

When the patients worked on the skit they were laughing, both at themselves and at the staff making fun of themselves. The next day, after watching the video in the community meeting, both staff and patients discussed their experience of being new on the unit, and how it feels overwhelming at times to have to learn to fit in. The patients were able to talk about their personal experiences with each other and the staff, and reflect also on how the admission process might be made easier.

Case 2

This skit took place after a period of many changes in the program. Staff had been somewhat disorganized that week and many confusions about unit policies had been discovered. For example, one patient told a story in the beginning of the video group about the big run-around she got when asking about visitors. There were six patients and only one staff member, the dramatherapist, in this session. Usually more staff come to video group, but the lack of staff was an indication of the chaotic nature of the unit that week.

CAN I HAVE VISITORS, PLEASE?

VOICE OVER: Now for an inside view of the smooth operations of a local psychiatric unit.

(Close-up on a staff member (played by the dramatherapist) rifling through a pile of papers.)

STAFF: *(with much hysteria)* There have been so many changes recently, I don't know what is up, what is down. I don't know any of the rules, which paper are they written on?

Dr Medicine enters. He is the medical director (played by a patient).

DR. MEDICINE: *(to the staff member)* Do you know what schedule we are running on today? Is it blue, red or purple?

STAFF: I don't know, yesterday was yellow, but today... I'll go and check.

(Staff member leaves Dr. Medicine. A patient comes to the Doctor to ask if she can have visitors.)

DR. MEDICINE: You say you want visitors!?! Oh dear, well, I don't know, let's see what the heck... OK, sure, bring in all the visitors you want!

Patient leaves. Staff members enter.

STAFF: We are running on the magenta schedule, Dr. Medicine!

PATIENT: Dr. Medicine said I can have my visitors tonight!

STAFF: Oh no, you can't have any visitors. That's against unit policy. The only way you can have a visitor is if the moon is full and you spin around on ruby slippers five times, patting your head. And that's only on every fourth Wednesday!

Patient leaves, crying.

PATIENT: I'm going to complain to someone about this!

Enter Dr. Mucky Muck. He is the CHIEF (he is played by a patient).

DR. MUCK: *(He is obviously angry.)* Hey you. I hear you are so confused down here. I have had so many complaints directed to my office I have had to hire an extra secretary. Now I have to come down here and fix it. From now on no more rules. The only rule here is no rules at all... and by the way, you are running on the white schedule from now on! And this person can have as many visitors as she wants. As a matter of fact, I will be her first visitor!

He leaves with the now happy patient.

Dr. Medicine and staff member start to blame each other for the reprimand.

VOICE OVER: So, ladies and gentleman, the moral of the story is think before you quote that rule!

The community watched the video the next day, and there was a discussion about the chaotic nature of the unit, and staff discussed how hard it was to communicate with each other and with the patients when policies are

changed. There appeared to be an easing of patient criticism of staff's mistakes in the following week, and the staff often referred to the video as demonstrating what their miscommunication can feel like to a patient.

Case 3

John had been on the unit for about five days. He had little interaction with other patients and remained isolated in groups. He was admitted for psychosis and obsessive thinking. He had spent many months previously on a longer term in-patient unit, and had not been out long before he needed hospitalization again.

When the dramatherapist asked for volunteers to be the anchor of the video John said no way would he appear on the video because he was too shy. He appeared to be listening though, and as we put the news together, he suggested we do a Late Night with David Letterman bit, the 'Top Ten List.' He was given index cards and wrote the top ten reasons to stay at this hospital, and proceeded to make fun of the worst aspects of the unit: the delicious and gourmet food, the comfortable linens and pillows; the pool in the top floor and well equipped gym (none of which we have), and so forth. He then was filmed reading off the list and throwing the cards, imitating the talk show host.

When the community watched the video the next day, John received a lot of praise for his participation. On the video we saw someone who was funny, competent and focused. He was able to put aside his preoccupations for the time and engage with the group in making their video a success. Both patients and staff remarked at that it was nice to see John in a different role. John was not cured of his psychosis, but was able to be successful and funny within the community. He was more than a young man who did not relate. He made people laugh.

Conclusion

Dramatherapy as a form of psychological therapy exploring the inner lives of patients is being driven out of inpatient psychiatric units in the USA, and moving over to partial hospital and day programs, nursing homes, and outpatient settings. Nevertheless, dramatherapy can be designed to help the short-term in-patient psychiatric unit to function more effectively by strengthening the host of the illness (the patient) and the host of the patient (the unit). Developmental dramatherapy can help patients accept and overcome the limitation of psychiatric treatment, instilling hope, and shifting the patient from the role of hopeless dependent to that of responsible community

member. The Video Group as a milieu intervention can free-up burnt out staff members, relieve pressure created by the rigid hierarchial boundaries in the system, and bond the patients and staff together in this important effort to defeat the illness. Whilst medication and case management may provide the engine and the gasoline to power the treatment vehicle, dramatherapy serves both as the battery to ignite the patient's wish to improve, and the oil to keep the engine running smoothly.

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