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New Uses of Psychodrama

From antiquity, drama has provided mankind with cultural enrichment, emotional catharsis, growth promoting self-awareness, and healing for the human spirit. Psychotherapists have long recognized the importance of their patients' responses to drama shared at therapy sessions. Moreno has provided the unique founding concepts for psychodrama with its therapeutic uses (1). Byrd and Olsson, applying psychodrama techniques to the teaching of psychiatric interviewing skills, coined the term Pedagogic Drama (2).

This paper describes new applications of psychodrama to the teaching and supervision of psychotherapy. It also presents some new psychotherapeutic approaches to patients with narcissistic and borderline disorders, and to psychosomatic patients with alexithymia. Vignettes from teaching and therapy settings are used to illustrate the pertinent concepts and techniques.

Basic Concepts of Psychodrama and Pedagogic Drama Equivalents

Psychodrama is the use of drama in a large group therapy setting. Its cornerstone concepts, as described by Moreno, are creativity and spontaneity. Spontaneous enactment of mental phenomena and interpersonal situations are valued over "just talking about it." These qualities of spontaneity and creativity are combined both to see the "same old situation" in a new way as well as to see a new and perplexing situation as amenable to some old and familiar wisdom. Pedagogic drama has equivalent concepts, phases, components, and techniques to psychodrama.

Psychodrama in its classic Moreno form has 5 components:

1. *The stage* is the tangible, elevated center of activity where visual spatial perspectives allow patient and audience-group to concentrate. Neither psychodrama nor pedagogic drama require an elaborate stage but the action should take place in a clearly indicated area of the therapy room or classroom.

2. *The Director* is responsible for the flow of perspectives and techniques that helps the patient discover what he needs to see and experience about himself. The director-clinician is responsible for moving the process through the various phases: *warm-up*, getting the audience to associate, relax, trust, and begin the group development of a theme or topic; *setting the scene*, specifying the detail of the life situation; *rising-action*, developing intensity around the key themes and conflicts presented by the patient; *declining-action*, diminishing intensity toward resolution, if possible; *share-back*, discussion of the reactions of audience, patient, and director. In pedagogic drama the director is the instructor and is responsible for maximizing learning through efforts to ensure that as broad an array of symptoms, signs, and other psychopathological phenomena are portrayed. The warm-up and setting of the scene are achieved by assigned readings, lectures, or films. The rising action is a clinical interview, enacted family or group session, or other portrayal of clinical events. The share-back is the class discussion after the pedagogic drama or at stop-actions during the drama.

3. The *patient-protagonist* is the person who presents his life situation for exploration and therefore facilitates both his own treatment and that of every psychodrama participant-observer. In pedagogic drama the patient is a professional actor, selected student, or the instructor who portrays family, group, or individual psychopathological phenomena.

4. *Antagonists or Auxiliary Egos* are people from the treatment staff or audience who try to portray the patient and his significant others so that the patient can experience his life from new perspectives and attempt meaningful behavior changes. They must "put on another person's skin and walk around in it for awhile." In pedagogic drama these auxiliaries are professional actors, students, or teachers attempting their adventures in learning and clinical empathy.

5. *The Audience Group* cements psychodrama as a true large group therapy technique. Everyone attending is involved, whether active participant or observer. In pedagogic drama, the didactic preparation and attitude toward

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learning of the classroom group is analogous to the resistance or psychopathology of the patients in a clinical group therapy setting.

Of the many psychodrama *techniques*, we will discuss only the three basic ones:

1. *Role Reversal* — At the initiative of the director, the patient is asked to suddenly shift role with the person to whom he is talking. For example, a husband embroiled with his wife in heated conflict is suddenly forced to take her role. In pedagogic drama such a reversal can help an interviewer suddenly experience the impact of an unempathic question as he is forced to reverse roles with the patient. It is possible to substitute members of the student audience for the interviewer or patient at any time; this keeps the students alert and the presentation of information lively.

2. *Doubling* — Here a staff member or fellow patient is asked to stand close to or behind the patient to speak out the inner thoughts, feelings or perceptions of the patient. These are allegedly not heard unless the person doubled chooses to speak. Doubling is crucial at the time a role reversal is made. In pedagogic drama, this technique is effective in examining the counter-transference reactions of the therapist or interviewer at such interruptions of the simulated flow of a therapy interview.

3. *Soliloquy* — The scene is stopped and a key person in the scene (usually the patient) delivers a lengthy monologue about his feelings, doubts, fears, or plans of action. A double can help the patient with comments from his unacknowledged thoughts and feelings. A soliloquy may also be used as a warm-up technique. The pedagogic uses are many, not the least of which is the depth exploration of issues about therapist burn-out, countertransference dilemmas, and co-therapist conflicts.

Specific Applications of Psychodrama to Supervision and Teaching

At individual psychotherapy supervision it is often helpful to enact the trainee's patient as accurately as one can with psychodrama. It usually requires many preliminary hours of listening and data gathering by the supervisor. The practice of direct exchange with the thusly dramatized patient can teach the therapist-in-training to deal with defenses and behaviors directly.

Similar pedagogic drama techniques are used to portray various psychopathologic entities to students. This requires careful preparation and mobilization of sublimated theatrical-exhibitionistic trends in the teacher, but can aid student learning of interview technique and basics of psychotherapy. Some centers have used professional actors or actresses for this purpose.

In the supervision of groups of co-threrapists, group therapists, or family therapists, role playing techniques can have similar pedagogic impact. Co-therapy problems, problem patients, and sub-grouping phenomena can come under helpful scrutiny as the therapist colleagues portray an individual, a group, or family with whom one of them is working. This supervision of group therapy via a pedagogically based group composed of group therapists or co-therapists often seems preferable to dyadic (individual) supervision with process notes or recordings. This allows for the following benefits: (1) *Recreation of impasses and severe resistances;* (2) *Countertransference phenomena* can be brought into focus by pedagogic drama via parallel family-of-origin scenes from the therapist's family and that of the patient who poses a countertransference dilemma in his group; (3) *Co-therapy communication problems, theoretical orientation divergences,* and *conflicts about interpretative approaches* can be delved into in a more relaxed atmosphere via pedagogic drama than by second hand process note reconstructions. Group supervision allows more pedagogic drama auxiliaries for such explorations, though the flexible supervisor can role play multiple group members if necessary with dyadic co-therapist supervisors; (4) Simulated groups can be used to illustrate *didactic presentations of the various group therapy approaches* (psychoanalytic, experiential, gestalt, T.A., etc.) (5) *Cathartic pedagogic drama approaches to group therapist fatigue, "burn-out"* and *interprofessional tensions* as they relate to learning group therapy, are often helpful *early* in the curriculum.

In the hospital setting, psychodrama can be used to focus on the resolution of staff-patient, staff-staff, staff-physician, or staff-family-of-patient problems. A weekly or monthly ward staff meeting can be enriched by such techniques and tensions eased for the patient's sake and staff learning.

Psychodrama can be used also as a part of agency consultation work. Psychodrama or pedagogic drama can be a palatable way of presenting perspectives on potential solutions or resolutions for staff or client dilemmas at inpatient units or outpatient settings.

Therapist Renewal for Practitioners of Psychotherapy

Some of the playful, active, sublimatory aspects of psychodrama have further application and implication for therapist renewal. Freud advised re-analysis of analysts every five years. Psychodrama groups offer one vehicle for therapists to share ideas, frustrations, discouragements, and joys of their personally demanding work. These therapist renewal psychodramas are helpful with "impaired" or just plain tired therapists at retreats with colleagues. They always promote renewed capacity for learning.

This is achieved through creative use of doubling, role-reversal and soliloquy. We will discuss detailed clinical examples of the use of these techniques, especially with less articulate, less introspective, and more concrete patients. We have found that borderline and narcissistic patients unamenable to psychoanalytic psychotherapy can be approached via some of these modern adaptations of psychodrama. This is particularly true in the so called alexithymic patient.

A final series of case vignettes will focus on patients with alexithymia and/or psychosomatic symptoms. This area is chosen because of its challenge to all forms of therapeutic approach and because it is felt by some observers to be refractory to any psychotherapy approach, particularly psychodynamic psychotherapy (11-13). It should be noted that we do not present these cases to suggest a "cure" achieved at such psychodrama sessions, but combined with milieu and small groups at inpatient or day hospital settings, these uses of psychodrama afford additional leverage for treatment.

Sifneos coined the term "alexithymia" or "the absence of words for feelings" (14). He described these people further as having an impoverishment of fantasy life, a constriction of emotional functioning, and a tendency to describe endless situational details or symptoms. He said they prefer to use action to avoid conflicting situations, and during an interview they give the impression of being defensive. They blush or cry copiously at times and assume rigid, dull postures as if frozen into one position (15). The recent literature indicates that alexithymia is not only found in classic psychosomatic patients but also in medical patients and "normals." It needs to be distinguished from post-traumatic states, socioculturally based operational thought, and other psychiatric disorders such as schizophrenia or borderline states (16).

Sperling wrote:

> The acting-out patient achieves immediate discharge of impulses by some actions with an external object in reality, while the psychosomatic patient tries to accomplish this by some actions with an internalized object inside his body. Unlike the (more) than imagined object relationships, scenic arrangements in which definite interactionary patterns are displayed. There is no conceivable fantasy that does not have this characteristic of staging (19).

Many patients who tend to "act out" rather than introspect or verbalize seem to be attentive and interested in psychodrama at a day hospital program. The action of psychodrama offers catharsis of hostility, anger, and frustrated dependency.

In psychodrama, the "stage" can literally be set and the "interactionary patterns" played out in a safe, supervised, and appropriate manner, thus helping the alexithymic patient to verbalize vague inner stresses and conflicts (20).

Hull found empirically that patients with higher verbal activity in therapy groups had fewer physical complaints (21). The following clinical vignettes speak for themselves.

1) "The War-Within": Psychodrama of a Headache

Mr. P. was a twenty-six-year old married, black, Vietnam war veteran who presented to a day hospital treatment setting with the primary complaint of severe headaches and difficulties in his family relationships. The conclusion by screening physicians and neurologists was that the patient's primary difficulties with headache were "functional" and not related to treatable organic causes.

The Psychodrama Session

As the usual warm-up phase was being conducted on the day of this patient's psychodrama, he was sitting quietly in the audience, appearing attentive but tense and with a furrowed brow. The director was proceeding with a loosely structured, bantering-with-audience type of warm-up approach, where gentle probings were being made as to which life problems had been discussed in any of the small group therapy settings at the day hospital recently. One of the patient's fellow group therapy members suggested that the problem with his headaches be approached on the psychodrama stage because the group's efforts had been ineffectual towards getting him to discuss his "problems." After very little persuasion, the patient proceeded to the psychodrama stage, where a brief soliloquy and empty chair techniques were used to set the stage for the symptoms of his headaches. They were described as quite intense, pounding, and occurring at least four times a day. The patient often awoke early in the morning with a complaint of headache and would be unable to get back to sleep. Occasionally, he would awake dreaming in the middle of the night with intense headache and be unable to get back to sleep because of haunting scenes of Vietnam. When asked about the most difficult situational dilemma involving his headache, the patient immediately said that arriving home at the end of the day with his family was the most difficult situation.

The psychodrama scene was set for the patient's coming home where his wife and three children were usually awaiting. His ten-year-old daughter was particularly demanding, clinging, and almost constantly asking him to do things with her and for her as soon as he arrived at the door. His five-year-old son was described as rather passive, serious, and always very supportive towards his father, asking the others not to bother their daddy when he had a headache. This little boy already complained of headaches himself, while the three year old daughter was incessant in her demands for daddy's attention. The first

Pedagogic Drama in a Group Psychotherapy Training Program

The faculty at most group therapy training programs feel that psychiatric diagnostic skills are of basic importance in screening potential group members, in assessment of progress of the individual patient in the group, and in the performance of the complex leadership responsibility of the mental health professional who leads a therapy group. An effective group therapist not only confirms diagnoses but continually seeks to aid and facilitate positive changes in the diagnoses of group members via the impact of therapeutically led group process. Lectures in the topic of psychopathology are dry, but the following procedure may enliven group therapy teaching.

Each of the twenty students in group therapy was asked to spend ample time studying, reviewing, and thinking about psychiatric descriptive and developmental diagnosis in standard textbooks and DSM-III (3). These study efforts were to provide raw material for each student's preparation for the portrayal of a patient or client being considered for group therapy. Each student was asked to present, via his role playing, as much clinical detail as he could produce effectively for a screening interview.

There were two consecutive two hour teaching sessions in "Basic Psychopathology." On the first Wednesday, two volunteers agreed to play the part of a male and female co-therapy team who was preparing to start a private practice, outpatient, 1½ hours per week, insight-experiential oriented, open-ended group with a diagnostically heterogeneous patient/client population of 6-8 members.

There was a brief role-played planning session with the male and female co-therapists about their group. This extemporaneous session proved very valuable in highlighting co-therapy dilemmas even before a group was assembled. Whose office would be used? Would they interview prospective clients or patients together? Separately? Both? How would they arrive at agreement about acceptance, fees, a time to meet, group rules, diagnoses to be excluded, etc.

They interviewed 8-10 patients as portrayed by classmates and chose six for their group. As the series of interviews proceeded, the drama was interrupted for class-audience discussion, questions, and diagnostic concept discussions. Assessments and informed guesses were made as to how each patient's own natural life history in groups (family, school, scouts, adolescent peer groups, etc.) could be used and explored as a means to assess both diagnosis and prognosis for potential effective membership in the group. Specific DSM-III criteria were stressed as these diagnostic sessions were enacted and discussed during "freezes" or "stop-actions." Some students portrayed patients they were working with at their agencies for presentation at the pedagogic drama.

For class number two, the next week, they were instructed to study what dilemmas their chosen diagnostic entity of pedagogic presentation would pose in a therapy group. They were told to come prepared both to role-play these dilemmas and to be familiar with what techniques a group leader might use to deal with these clinical problems.

At the third class session, a simulated first group meeting and another of six months into the treatment process were enacted. The group was quite innovative and accurate in dramatizing typical dilemmas presented by patients with anxiety disorders, character disorders, and substance abuse, in a group. Stop-action allowed for in-depth discussion of interpretations or interventions focusing on individual intrapsychic levels and on the "group as a whole" or group process level. Pedagogic role-substitution with other members of the class allowed for lively participation and innovation by all of the class. No students dozed during the sessions as they had in previous years' basic lectures.

The application of pedagogic drama in the teaching of the subtle clinical psychopathologic phenomena of "borderline" and narcissistic patients in groups is intriguing. The use of multiple doubles and rapid role-reversals to represent pathological splitting, idealization, grandiosity, devaluation, twinship, merger, alter-ego, and mirroring transferential phenomena is fruitful in portraying what goes on with these patients as they often confound the group and the leader (4). The volumes of work by Kernberg, Kohut and others about these patients come to life via pedagogic approaches (5-9). Our teaching in this area, by means of pedagogic drama, is only limited by our own imaginations as teachers of psychotherapy.

New Uses of Psychodrama in Treatment

In the use of psychodrama in the treatment of borderline and narcissistic disorders we have barely scratched the surface. Kernberg states:

> In broadest terms, psychoanalytic object-relations theory represents the psychoanalytic study of the nature and origin or interpersonal relations, and of the nature and origin of intrapsychic structures deriving from, fixating, modifying, and reactivating past internalized relations with others in the context of present interpersonal relations (10).

The psychoanalytic literature stresses the use of the dyadic psychoanalytic treatment setting, but at psychodrama groups we can present the patient with powerful evidence of his use of splitting, denial, projective identification, twinship, merger, idealization and devaluation.

scene of the psychodrama proceeded into the patient's arrival home and a double was assigned to represent the patient's headache itself. The double pounded a chair in a loud, thumping, pulsating sound to accompany his rather harsh comments of torment towards the patient as "his headache." Finally, after confronting his family with anger, the patient received superficial support for his retiring to the bedroom to try to ease the headache. After he had left for the bedroom, the family discussed their feelings of being abandoned, not wanted, and pushed aside by daddy. The wife, in a soliloquy, delineated her ambivalent feelings about being supportive towards her husband and her resentment and anger for always having to deal both with the children and with him and his irritability during the headache episodes. These episodes had become an almost daily occurrence.

While the patient was alone in the bedroom, a fascinating dialogue took place. He was asked to reverse roles with the double who had been assigned to represent his headache. When the patient arrived in the role of his headache, he began to be sneering and tormenting in the tone of his voice. He said, "I got you under my control, baby." The headache spoke of his sadistic joy at restricting the patient's fun, marital, sexual, and family relationships. The headache reminisced about the days in Vietnam when the headaches had first begun, about the long boredom of patrols, constant anxiety about death, and the responsibility for buddies lest slip-ups in responsibility led to immediate death. As his own headache, the patient proceeded to describe what he felt were his numerous past sins of getting numerous women pregnant and not caring for the children that ensued. It became very clear as the "headache" proceeded in his vehement discourse, that in the current situation, the headache acted as conscience for the patient and did not allow him to "hit the street." Thus, the headache seemed to curtail any possibility for the patient to go out and dance, drink, or at anytime enjoy the companionship of his wife or other social relations. As an aside he remarked, "How could I chase other women anyway, I always have the headache!" The entire super-ego function seemed to be relegated to the headache. This seemed to come out of an apparent fear of loss of control and resulting total irresponsibility. When role reversal was done and the patient became himself again, he was asked to express his feelings to this headache that "had a spell on him." He proceeded angrily to accuse the headache and curse out the headache for its tyranny of restrictions and guilt provocations. The director shifted attention to a dialogue between the wife and the "headache" which revealed her great frustrations at her husband's inability to have sex often enough with her because of the domination of the headache. She said, "You are like some strange and enticing mistress, you take him away to the bedroom at the very moment that I want him so much." As the "headache" (via a double) was in similar dialogue with his children, the patient learned indirectly about their anger with the headache because of the way it took their daddy away from them and particularly his son's fear that he "may get headaches like daddy when I get older some day." At the feedback ("loveback") phase of the psychodrama, the patient was struck with the controlling, accusing, and unmercifully conscience-ridden meanings that this headache seemed to have for him. He related his intense depression at the early morning awakenings with the headache and noted that they reminded him of the early morning hours of his agonies in Vietnam. He was urged by his fellow group member and by the therapists to take control of more of his "conscience" and personal responsibilities, thus having less need for "the headache" to take over these functions for him. The patient admitted that in most group therapy sessions he would have a constant pounding headache, therefore accounting for his silence in group therapy. When asked by the director on the stage whether he had a headache during the psychodrama, he said, "No, at no moment did I have a headache." At the share-back, other patients in the audience spoke about similar substitute consciences they had in the forms of other somatic symptoms or overly dependent relationships with family members, "to do for me." Very supportively, the audience urged him to speak up more in group sessions as he had in the dialogue with his headache.

Comment

This case serves to illustrate how elaborate detail of a patient's experiential, somatic, symptom situation can lead to helpful psychodramatic techniques directed towards elucidating the multilayered symbolism, meaning, or defensive functions that a headache or other somatic symptoms can have. The use of a double to represent a symptom or body organ itself, with the patient in subsequent dialogues with the symptom or organ, can be very helpful. Dialogue with a symptom seems helpful without insight as an obligatory companion. The dynamics that the somatic symptom has in the family constellation, social relationships, and vocational situations can be elucidated through similar techniques on the psychodrama stage.

2) Large Group Relaxation Techniques at the Psychodrama of a Headache; Peer Group as Bio-Feedback Agents

Harold, age 55, retired, mildly depressed and in the midst of one of his daily headaches sat looking discouraged and tense during the warm-up at our weekly psychodrama. During the unstructured warm-up he finally erupted: "I never have participated at psychodrama

here because it seems so silly! But today I just can't stand my headache! I fear I will become violent and tear up this room; I feel like this most of the time."

Harold told of his "workaholism" of many years. Now, despite comfortable retirement pay, a "beautiful, sweet wife," and all the time he could want to engage in his favorite projects, he was incapacitated by daily headaches. He felt that no one at the day hospital or anywhere really cared. He went on and on with his lonely, furrowed-brow discourse about his crippling companion of headache. He seemed impervious to the group members' expression of empathy, gratitude for his help at small group, and some interpretations about his reluctance to accept help or comfort from anyone. He said that these efforts were just as futile as his wife's similar efforts at the breakfast table that very morning.

The director commenced to set the scene in the kitchen of the patient's home that morning. A fellow patient played his excessively benevolent wife. A parallel scene was set up to one side and behind the present day breakfast situation. This ghost scene from breakfasts past contained the patient's now deceased, ultrareligious, benevolently controlling and demanding mother and father. These split off introjects were played by two staff members who would comment abruptly, periodically, and with harsh superego attitudes that the patient had discussed at prior small group therapy sessions at the day hospital.

As the action rose in this scene the patient grabbed his head, began to tremble and cry, saying, "I can't stand the pain." The director froze the action and quickly chose two patients from the small group whom the patient trusted the most. They were placed behind and at either side of the patient. The peer patient at the right rear was instructed to place his right hand over the right forehead of the patient and his left hand at the right shoulder and neck area. The peer at the left rear was told to place his left hand at the left forehead and his right hand at the patient's left neck and shoulder muscle areas.

The whole audience group was then instructed in progressive muscle tension-relaxation starting from the feet and moving upwards to calves, thighs, abdomen, chest, shoulders, neck, and forehead. The whole group and the patient did these progressively, first on the left, then the right, and then both sides together. Deep breath-in and slow breath-out was done with each relaxation step. The only two people not participating were the two human biofeedback peer group members. They were instructed to give out a high pitched sound if they felt tightness or tension and lower softer vocalization if they felt relaxation.

At first, the patient fought the efforts with verbal protests and muscle tensions reflected in piercing peer-produced sounds. As the exercise progressed and the parental presences were moved off stage into the audience group, lower pitched sounds began to predominate. The patient chuckled some and at the "share back" phase of the pschodrama looked and felt more relaxed. Peers from his small group pointed out how subtly controlling and benevolently intrusive he was in much the same fashion as his parents appeared during the psychodrama. Other audience members shared similar experiences "being just like their parents" but not realizing it until group confrontations. Although Harold was skeptical about some of these ideas, he had to admit he felt closer to the group and felt grateful for their help in helping him to relax. In subsequent weeks he seemed to be more open and expressive in his small group therapy. In fact, this type of combined psychodrama, relaxation and "peer contributed biofeedback" technique seems to enhance group cohesiveness in a striking way.

3) "Split-Brain Psychodrama" for the Alexithymic Patient

Bill was a 25-year old Vietnam veteran who recently entered the day hospital program complaining of stomachaches and immobilizing depression. In the hour prior to psychodrama, other hospital staff members were conducting an art therapy and educational program. Concepts of right brain versus left brain functions were presented didactically and were related to some of the patients' art work.

As the psychodrama began, Bill expressed how dificult it was even to draw pictures, much less talk about his feelings in group therapy. In fact, he and his wife had had a confrontation the previous weekend when he couldn't even get out to mow the lawn. He wondered why he provoked his wife in such a manner because once he got out and "sweated, pushed and struggled," he felt better; "Even my bellyache gets better."

In the psychodrama, the director staged the scene of conflict with his wife. As the scene was being set, the patient remarked in passing, "You know, she sounds like my sergeant in Nam sometimes." The patient struggled greatly to express himself, so a right brain double and a left brain double were assigned. As Bill sat in the kitchen with his wife at first pouting and silent, then angry and confrontive, his right brain double of feelings, intuitions, and motivation beleaguered his depressed, immobilized left brain of gloomied cognition and present inaction. Finally, at prompting by the director, the left brain physically pushed Bill up out of his chair and out to the lawn. As this was occurring Bill paused and associated to his sergeant and lieutenant in Vietnam. His sergeant, like the left brain, was "all business, by the numbers, and by the book." The lieutenant was "sensitive," "caring" and "intuitive, like my mother."

A parallel scene of earlier years with his right brain mother and left brain father allowed some focus on his

feelings of being caught between his parents and unsure of himself. Action pleased his father (sergeant) and reflection — feeling pleased his mother (lieutenant). Both his sergeant and lieutenant died in Vietnam as had both parents even prior to his duty in Vietnam. At subsequent small group therapy sessions, the emotional connections between the traumatic grief-loss-depression in Vietnam was explored in terms of his efforts to turn his wife into the lost objects of his military superiors and the earlier loss of his parents. So much emotional charge led her to feel tremendous frustration and him to feel immobile. His small group therapy became like his Vietnam combat unit over the next several weeks. As the group confronted, encouraged, and pushed, his situatiion at home improved and assertiveness toward job hunting became possible. Prior to admission he had sat around the house bemoaning and grieving about his medical-psychiatric discharge from the Army.

The concrete metaphor of right brain-left brain at psychodrama became both a cognitive and emotional means by which the patient could begin to experience his inner immobility and conflict in a tangible way. Although his insight into his intrapsychic dynamics was only modest, he and his small group used the concretized metaphors of the "split brain psychodrama" session as a means to frame their efforts at mutual confrontation, support, and rehabilitation. His somatic symptoms subsided and he became more verbal.

Comment

We frequently see psychodrama sessions interacting with and extending ongoing small group process at the day hospital milieu, culminating in an apex at psychodrama sessions.

The "Split-Brain" psychodrama has potential to teach the patient directly about walled off or split off emotional states via concrete yet creative imagery. The experiential processes of dramatization, creative confrontation, and action-experience via direct assertiveness training can theoretically approach the alexithymic problem from a broader spectrum of therapeutic activity than just verbal channels. This particular patient showed modest gains in this regard.

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