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Psychodrama with the Institutionalized Elderly: A Method for Role Re-engagement

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Chronic institutionalization of elderly patients in hospitals, psychiatric centers and nursing care facilities is a major problem facing health service providers. The author presents a model for understanding this problem in terms of role reduction and role loss. A model based on psychodrama theory and practice is offered which provides a method for role re-engagement and reversal of institutionalized behavior patterns. A case study illustrating the application of this theory is presented.

The institutionalized elderly have traditionally been underserved by the health care delivery system (Hudson, 1978). In most settings such as nursing homes and psychiatric facilities, the elderly are seen as withdrawn, isolated and cut off from human and material resources. Theories such as disengagement theory have been offered as a model for understanding these behavior changes which occur in old age. The debate between disengagement and activity theory has been unflagging for several years. On one pole of this argument is the notion of withdrawal and disengagement as a natural part of the aging process. The opposite pole takes the position that involvement in life's activities as much as possible, and the maximum use of potential, is a model for healthy aging (Havighurst, 1971).

Psychodrama group psychotherapy provides a framework for exploring these models in terms of role reduction and potential role re-engagement. This paper will present a discussion of psychodrama and its use as a tool for enhancement of the experience of old age among institutionalized people.

Role Theory and Self-Concept

Before introducing the concepts of psychodrama theory and its specific applications to work with the elderly, a brief discussion of role theory is

necessary. J.L. Moreno, the founder of psychodrama, deviated from traditional self-concept theories when he proposed the idea that the concept of self emerges from the roles we play in life. To Moreno (1946), the infant is born initially with only psychosomatic roles (e.g., the breather, the crier, the eater, etc.). Eventually, through its interaction with its environment, the growing organism develops social roles in relationship to other members of its milieu. Psychodramatic or fantasy roles also emerge which help form the person's concepts of imagination, wishes and dreams. A normal, healthy person eventually develops a repertoire of roles with which to reciprocate other roles in the social environment. The concept of reciprocity is an important part of Moreno's role theory, for it states that roles exist only in relationship to other roles; no role exists without a reciprocal role. Roles, however, may be reciprocated through internal or fantasy processes, as in the case of schizophrenia or delusional ideation.

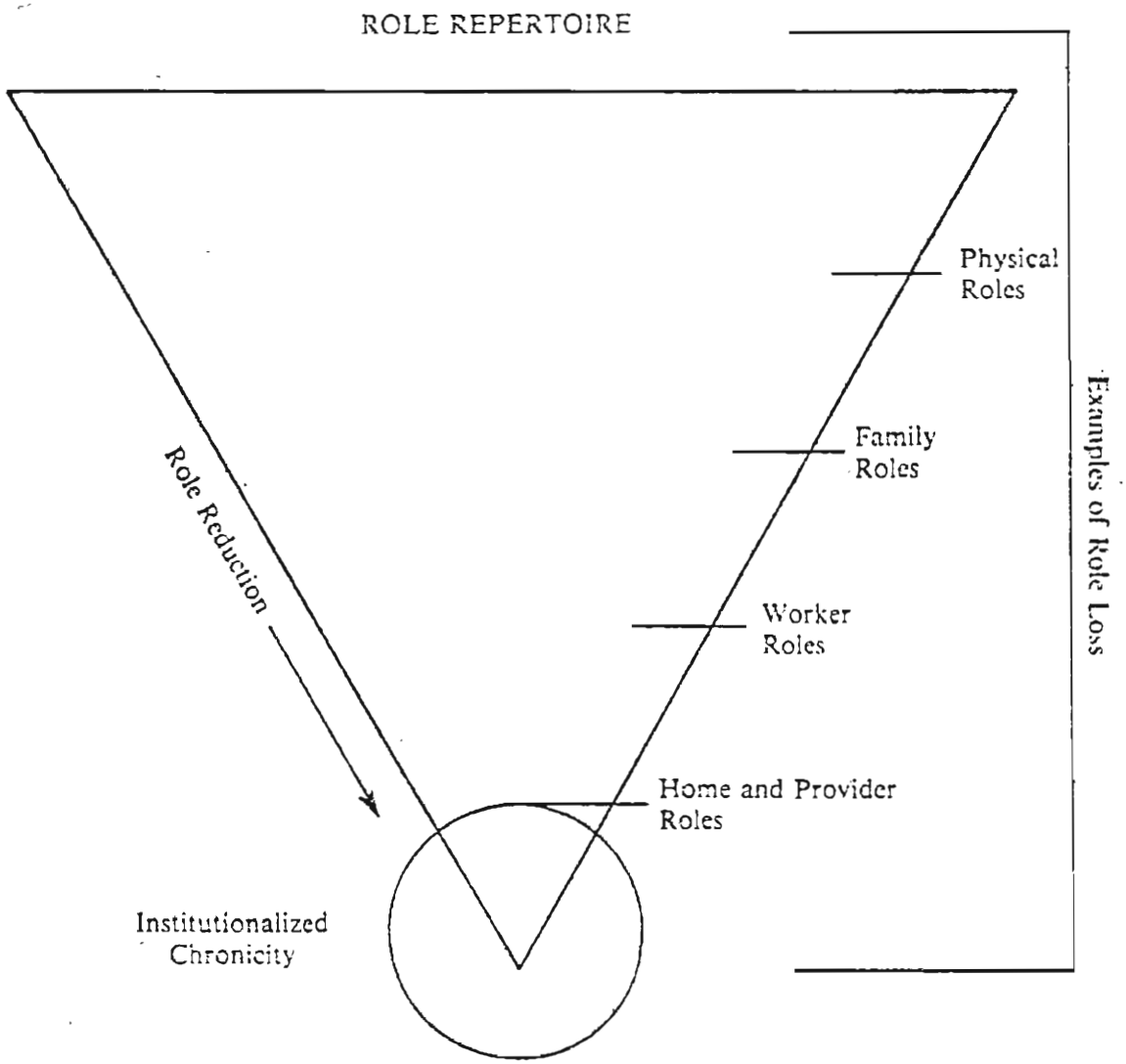
Old age can be conceptualized as a process of role reduction, or loss of roles. In developing from childhood through middle age, an average person has built a substantial role repertoire. At some point roles begin to diminish. This can be a result of the aging process, whereby certain physical functions (i.e., psychosomatic roles) begin to fade. It can be a function of time, as in the case of children leaving the home and taking with them the reciprocal correlate of the parental role. Or, the role reduction can be a function of society, as in the case of mandatory retirement, which rapidly removes a large number of self-validations related to the worker role.

The healthy older person makes adjustments to these role losses. While the volume of roles may be reduced, the elderly person living in society has a role repertoire large enough to maintain some social interaction (e.g., shopper, club member, volunteer, grandparent, etc.). The institutionalized elderly person, by contrast, may continue to experience more and more role reduction. When role loss becomes so advanced that the person is left with only a few role options, we have the condition referred to as chronic institutionalization. Chronicity, by this model, is not related to length of stay or length of incapacity. Rather, it implies an attitude and role set, which can be reversed. Figure 1 offers a picture of this concept.

The process of role education, therefore, can be seen as supporting disengagement theory. To the extent that society and the elderly person reciprocate roles leading to disengagement this may be true. However, we encounter in this a chicken-or-egg situation which questions whether it is society or the older person which starts the process of role reduction and disengagement.

A major element of psychodrama theory is the principle of spontaneity. Moreno (1953) defined spontaneity as "a new, effective and appropriate response" to life's issues, problems, and concerns. It is through spontaneity

Fig. 1: Role Reduction Leading to Institutionalized Chronicity



that humankind has evolved and adapted. It is likewise through spontaneity that individuals on a day to day basis find different approaches to life's obstacles.

Role reduction in the institutionalized elderly person may not be only the process of disengagement mentioned earlier. Rather, role loss may be seen as a reduction of spontaneity and creativity in the older person. Since increased spontaneity is a goal of all psychodrama interventions, the psychodramatic approach offers a method for reversing the process of role reduction and fostering re-engagement.

Psychodrama

The interactive quality of the group experience is one element which differentiates psychodrama from other forms of group psychotherapy. Group members are called upon to serve as therapeutic agents for one another, thereby contributing to a shared experience for the entire group (Moreno, 1946). Fundamentally, psychodrama is concerned with promoting growth and development rather than responding to pathology. This philosophical underpinning is related to the theory of spontaneity, which assumes that individuals have the capacity for finding novel, effective and appropriate patterns of behavior.

The form or structure of a psychodrama can be described in three phases: 1) The *warm up*, in which current group concerns are discussed and an issue for exploration is chosen. Frequently a protagonist for the session is also chosen during this stage. 2) The *action*, in which the issue or concern is brought to life in concrete, dramatic form; and 3) The *sharing*, in which group members are given the opportunity to express their personal connections and reactions to the session.

In many therapeutic psychodrama groups, the protagonist may experience catharsis through release of feelings for which he or she has had no previous outlet. The concept of catharsis in psychodrama involves not only a release of emotion, but an incorporation of new perceptions and cognitions. Following catharsis, the protagonist may be encouraged to find new spontaneous approaches to the problems presented in the session. With institutionalized elderly patients, sessions which focus on psychodynamic restructuring may be inappropriate or at least difficult without some basic exploration of the dynamics of the group itself. Drawing on his work with elderly patients, Buchanan (1981) stated that "while catharsis is an important goal in intensive psychodrama, the major goal is always to increase the spontaneity and creativity of group members as exemplified by the birth of new affective and behavioral roles."

Initial phases of a psychodrama group with institutionalized elderly will focus on issues of socialization, reduction of isolation and withdrawal. Before any personal therapeutic interventions can be attempted, a climate-supporting therapy must be established. Therefore, sessions directed in the early part of a group's history should focus on developing group cohesion and a sense of membership and group identity. One way to foster this atmosphere is to focus on experiences which are common to group members. Birthdays, cultural origins, previous jobs, and holidays represent issues which all group members can relate to, and which offer an opportunity for individuals to share a part of themselves as well as to learn a little about other group members. In institutionalized settings it is not uncommon for

people who have been living on the same ward or section for many years to be unfamiliar with the names of their peers. This lack of knowledge is often not due entirely to mental deficiencies or other organic problems. Often, patients have merely accepted the chronic institutionalized role which they have come to interpret as "a good patient is a quiet patient."

Role Re-engagement

A typical early session might focus, for example, on one patient telling a story about his name: whom he was named after, how his parents chose the name, or any other aspects which seem interesting. Other group members may be chosen to enact the scene, taking roles of parents and grandparents, going through the process of naming their child. It is possible that such a session could involve several short scenes or vignettes, providing an opportunity for several group members to express a personal aspect of their lives in action. The choice of relatively nonthreatening topics for these early action explorations can help group members develop a sense of ease with this approach.

In addition, these early sessions represent the beginning of role re-engagement. Group members begin to display in group interaction social roles which may have been dormant because they have not been reciprocated for some time. Initially, the psychodrama director may have to assume a more active role, directing questions and eliciting responses from group members. The director and therapeutic auxiliaries can place demands on group members by assigning roles which require assumption of a reciprocal role, thus fostering role re-engagement. For example, an auxiliary might assume an inquisitive role toward a quiet group member, asking a question which the member can answer. Or the leader might pose a general question to the group such as, "Where did you last live before coming here?" The leader can ask each group member in turn to respond to the question. Each response offers potential for forming connections within the group. For example, member A is from New York. The leader can ask "Who has ever visited New York?" From this line of questioning, a session can evolve, exploring, for instance, an imaginary tour of New York City with group members taking the roles of tourists, guides, etc. The idea is to foster communication, interaction and socialization. Through this interchange, members are encouraged to re-develop social roles to meet the role demands created within the session. The essential goal of this approach is to help group members activate roles which have been unused for some time.

Where the re-development of a specific role is impossible because of physical or mental impairment, finding appropriate role substitutes becomes the goal. For example, one patient in an on-going group was

hospitalized after the death of her husband. For more than 35 years her sense of self-worth had been tied to her role as homemaker, and the social shock of rapid role loss upon her spouse's death was a major factor in her hospitalization. She is presently suffering from a variety of physical disabilities and is wheelchair bound. While no amount of social or psychological intervention can restore her health, bring back her husband, or give her the homemaker role of former years, a strategy for intervention is possible. For this woman, a sense of responsibility, caring, and purpose were all an integral part of the larger homemaker role. First in psychodrama, and later in the ward community, this woman explored options which would give her the sense of meaning that she had experienced previously. With encouragement and support she began to take part in watering plants and letting other ward members know when mealtime arrived. While these may seem like minor accomplishments, they represent an important step in role re-engagement.

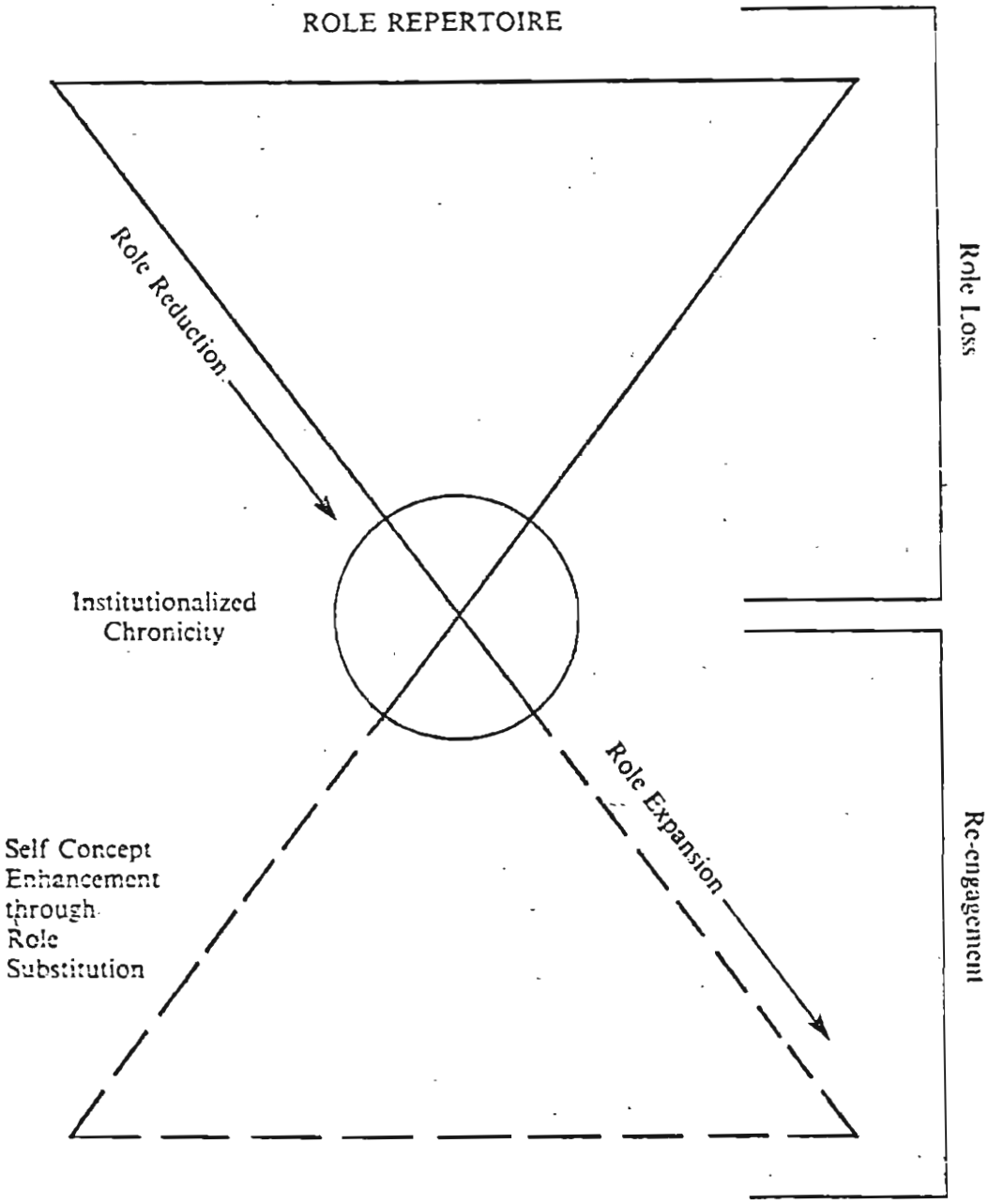
Role re-engagement has a synergistic quality to it. Just as original social roles are built upon the roles which precede them, so are the re-developed and substituted roles. Even the seemingly small amount of role re-engagement seen in early parts of a group's development can provide a springboard for re-development and re-engagement of additional roles. Therapists working with chronic, institutionalized elderly patients must carry with them an adjustable yardstick with which to measure change, and must recognize the value of small increments of progress. Figure 2 illustrates the hourglass model of role re-engagement.

Case Illustration

Psychodrama methods have been applied in therapy groups serving a wide variety of patients since psychodrama was first introduced at Saint Elizabeths in 1939 (Altman, 1981). The following example is based on an experience in a group there for elderly women. It illustrates how psychodrama is used to identify role deficits and how it can begin to address these losses.

> Ms. K is a 73-year old woman who has been hospitalized for 15 years. She carried an initial diagnosis of schizophrenia, paranoia type, but records indicate that the condition has been in remission for at least three years. Her lack of funds and family resources as well as her physical problems have made placement in a community residence facility difficult at the present time. While generally pleasant, Ms. K would never initiate conversation with other group members. Any question directed to Ms. K regarding her feelings about herself or

Fig. 2: Restoration of Role Repertoire



other group members would be met with the standard reply, "I don't know," or, "Leave me alone." The general feeling of the ward staff was that Ms. K was a nice [illegible] but everyone felt that she could be a more active group member, perhaps taking advantage of adjunctive groups offered to patients (for example, bibliotherapy, cultural enhancement group).

In one session Ms. K mentioned that she had had a sister whom she used to take care of when she was a teenager. The sister was sickly and eventually died, but Ms. K remembered her fondly. On further questioning, Ms. K described a scene at home where she would bring her sister food or other things she needed. With the goal of finding possible ways to engage Ms. K in the activities of the ward, we set up the scene in her family living room. Ms. K's sister D was in a recliner asking Ms. K to bring her things like a hair brush, some water or a newspaper. When asked how she felt about doing these chores, Ms. K responded, "I don't know." A trained auxiliary was chosen as a double and asked to hypothesize aloud how Ms. K was feeling. Ms. K was told that she could agree or disagree with the doubling statements. A patient playing the role of D continued to make demands on Ms. K. The double stated, "I hate doing this stuff," with which Ms. K strongly disagreed. Even in disagreement Ms. K gave us useful information about her feelings. Continuing to respond to her sister's demands, Ms. K looked displeased, yet she disagreed with the doubling statements; "I dislike doing this. I don't want to wait on her." At this point the action was extended with D making rapid, repeated demands. This surplus reality technique is used to elevate the dynamics of a situation. Finally Ms. K said, "You never say thank you." The auxiliary double, picking up on this, stated, "I wouldn't mind doing this if she would just thank me," to which Ms. K agreed. Ms. K was given an opportunity to say this sentiment directly to D, but it was still too threatening for her to do.

An issue for possible role re-engagement in the "here and now" ward environment was identified. The working hypothesis was that Ms. K might be encouraged to participate more actively in the ward programs, if she had a sense that her contributions were valued. Perhaps Ms. K could benefit from a more in-depth exploration of her issues with her sister, but such an exploration was beyond the scope of the therapeutic goals for this particular session. A deeper look at the psychodynamics of her family relationships would be more beneficial after Ms. K developed a sense of group membership and peer support.

The session was then directed back to the present group in which members were asked what small things Ms. K could do for them. One patient suggested that Ms. K could help her with making the bed in the morning. Another patient said that some assistance with her wheelchair at lunchtime would be helpful. At this point the director moved another patient's wheelchair to the opposite side of the group circle

and asked Ms. K to help push it back. The other patient, Ms. P, agreed to thank Ms. K if she would help her, and indeed Ms. K received Ms. P's thanks for returning her chair to its usual place. The sharing focused on times when other group members felt taken advantage of by family, friends or others. Ms. K accepted the job of helping Ms. P to the dining room, and staff members are more conscientious in their use of praise and compliments as an effective reinforcer for Ms. K. Several months later Ms. K began attending some of the supportive groups offered to patients on the ward.

Summary

The concept of role re-engagement explored in this paper offers a model for therapeutic approaches with institutionalized elderly people. The use of action group methods can provide an approach which fosters group cohesion, spontaneity, role re-engagement and role substitution. The group members can become therapeutic agents for one another, making reliance on chronic institutionalized behaviors less habitual, as these roles are reciprocated less frequently. Certainly this approach, as all approaches to chronicity, requires a great degree of stamina, but more importantly, it requires a willingness on the part of the therapist to seek a varied role repertoire to invoke the appropriate reciprocal role. What has traditionally been called "resistance" in these patients may well be our inability as therapists to find the effective role correlate.

It is important to acknowledge that all members of the institutional environment, including patients, staff and auxiliary personnel, represent potential resources for role engagement and continued role development. These resources can be mobilized to provide an on-going system which provides support and encouragement for each patient moving toward therapeutic goals.

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