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# Psychodrama with Blind Psychiatric Patients

**KERRY P. ALTMAN, PH.D.**
*Dr. Altman is a Staff Psychodramatist, Psychodrama Section, Saint Elizabeths Hospital, Washington, D.C.*

**stract:** *After reviewing the general principles of psychomatic group psychotherapy, the author provides a descripanalysis of the first six sessions of a psychodrama group for l psychiatric patients that was initiated recently at Saint beths Hospital in Washington, D.C. He also offers sugns for using action methods with such patients.*

Therapeutic work with blind psychiatric patients encompasses many aspects of rehabilitation. Psychotherapy must be integrated with education and training to facilitate a patient's progress toward community placement or independent living. Although many skilled and talented therapists are working effectively with blind psychiatric patients on an individual basis, little has been written about the use of group psychotherapy with blind adults.

Keegan (1974), reporting on his successful short-term group approach with blind adults in a rehabilitation center, suggested that further work using this approach could have therapeutic value with a variety of rehabilitation clients. Earlier, Kubler-Ross and Anderson (1968) described a modifed group-therapy approach with blind clients at The Chicago Lighthouse for the Blind. According to these authors, the development of group cohesion and the creation of a "safe" environment in which to discuss personal concerns lent support to the use of a group method with these clients. In an article about successful group intervention with blind clients in a rehabilitation program, Wilson (1970) stated that group therapy

> is useful in helping clients to learn to cope with the following behavioral reactions which are associated with disability: feeling inadequate to the stress of undergoing rehabilitation; handling the meaning of the loss; learning to accept reality in a flexible manner; learning to cope with the frustration and conflict; coming to terms with guilt feelings; handling shock and the period of mourning; and learning to accept the altered body image (p.238).

Although all these authors discussed the therapeutic value of group work with blind clients, none of them addressed the use of action methods in the group approach. Goldman (1970), however, reported positive results from a short series of encounter microlabs conducted with visually impaired rehabilitation clients, but he specifically excluded clients who were psychotic or suffered from other severe mental illnesses from his encounter groups.

In 1961, J. L. Moreno, the founder of psychodrama, addressed the question of whether psychodrama, which relies heavily on the use of movement, was feasible with a blind population and stated that "due to the lack of physical mobility on the part of the blind. . . a technique has to be invented which gives the imagination of the blind, physically and mentally, full reign" (p. 54). Despite his encouragement, there is no evidence of attempts to employ psychodramatic group psychotherapy in the treatment of blind psychiatric patients.

The following brief description of basic psychodrama theory and technique will prepare the reader for the session-by-session discussion about the psychodrama group recently initiated with blind psychiatric patients at Saint Elizabeths Hospital.

## Psychodrama

Psychodrama was introduced to the psychiatric community at the turn of the century by J. L. Moreno, a Viennese psychiatrist. While still in Europe, Moreno pioneered several areas of mental health including sociometry, role theory, and the use of action methods in psychotherapy.

In the 1920s, he emigrated to the United States and established the first theater of psychodrama in Beacon, New York. His interest in group phenomena led to innovative work with psychiatric patients at his small mental hospital at Beacon.

Moreno continued to apply his theories about psychodrama and sociometry to his work and in 1931 coined the term

"group psychotherapy" (Moreno, 1953). In 1937, at the request of Dr. William A. White, Moreno agreed to oversee the building of a psychodrama theater at Saint Elizabeths Hospital in Washington, D.C. Since its introduction more than 40 years ago, psychodrama has evolved as a major form of therapy dealing with the full range of psychiatric disorders represented among patients at the hospital.

In addition to direct patient services, psychodrama has been used at St. Elizabeths as a training tool with a wide variety of hospital and community groups: for example, hospital staff, alcoholism and child abuse counselors, teachers, and police groups. The FBI currently uses the services of the hospital's Psychodrama Section to provide hostage negotiation training for its law-enforcement personnel.

Psychodrama differs from other forms of group therapy in several basic ways. The first major difference is its emphasis on action. Psychodrama theory views group members as creators of their world. Through the action therapy of a psychodrama session, a person experiencing difficulties has the opportunity to create new roles and behaviors that offer new approaches to old problems. Moreno called this creative element of psychodrama "spontaneity" and defined it as a novel, effective, and appropriate response to a new or old situation.

Psychodrama originally evolved as a method of promoting growth and development rather than as a response to pathology. Therefore, its fundamental concern is the development of human potential. Swink (1979) defines psychodrama as "an action group psychotherapy in which group members, through an interactive process, act out conflicts, problems, aspirations and dreams" (p. 2). This interactional aspect of the group is fundamental to the theory and practice of psychodrama. All group members are viewed as therapeutic agents for one another. By assuming auxiliary roles and by helping one another create and encounter scenes from their lives, all members play an essential role as an integral part of the total group experience.

Moreno (1964) describes the basic elements of psychodrama as follows:

> The chief participants in a therapeutic psychodrama are the protagonist, or subject; the director, or chief therapist; the auxiliary egos; and the group. The protagonist presents either a private or group problem; the auxiliary egos help him to bring his personal and collective drama to life and correct it. Meaningful psychological experiences of the protagonist are given shape more thoroughly and more completely than life would permit under normal circumstances (p. vii-viii).

As Del Nuovo (1971) pointed out, a typical psychodrama session consists of three stages: (1) the *warm-up* phase, during which group members discuss their problems and choose a protagonist, (2) the *action* phase, during which they deal with a problem or concern on the "stage," and (3) the *sharing* phase, during which group members have the opportunity to express the personal feelings concerning the session or similar experiences they have encountered in their lives. Del Nuovo described some of the basic psychodrama techniques used to enhance action explorations of group issues:

> The *Soliloquy* is a monologue in which the protagonist speaks out loud feelings and beliefs he experiences within himself. This is done as if he is talking to himself. It helps him warm up to the conflict or situation he is about to encounter. The *Double* technique is one in which a fellow member of the group joins the protagonist on stage and tries to feel one with him. The task of the double is to express the feelings he is picking up from the protagonist as he goes through the scene with him. These are feelings or thoughts which the protagonist is not expressing. The *Role Reversal* is a technique wherein the protagonist exchanges roles with some other significant person in the psychodrama so as to perceive himself or a situation from another point of view or position. The *Mirror* technique is a feedback exercise wherein the protagonist is asked to observe the scene, giving the protagonist an opportunity to see what his behavior is like and how it is affecting others around him. Lastly there is the *Aside*. Here the action of the psychodrama is stopped or frozen and the protagonist is asked to express the feeling or thoughts going on inside himself. This helps the director to perceive more completely how the drama is affecting the protagonist. (p. 2).

## Group for Blind Psychiatric Patients

Setting up a psychodrama group for blind patients at Saint Elizabeths Hospital was essentially the idea of the Psychodrama director. Since psychodrama services were provided to virtually all other patients, including those who were deaf, the director wondered whether a psychodrama group would be useful for blind patients. In consultation with the rehabilitation staff who worked with these patients, the director learned that blind patients had participated sporadically for several years in traditional talk therapy groups. Although special considerations were certain to arise, the staff of the Blind Rehabilitation program supported the idea of trying psychodrama with their patients in the hope that it would help the patients improve their socialization skills and offer them a new way of exploring personal issues.

The use of action methods with blind individuals is not actually a new approach. When learning a new skill, blind rehabilitation candidates are often exposed to real-life situations (e.g., a new building or restaurant) in which to practice new skills. Psychodrama merely extends this "in-vivo" learning to the field of mental health by allowing patients to explore emotional issues in an active way.

The group discussed here consists of six patients (four men and two women), three staff members, and the psychodrama director. All patients are members of the Blind Rehabilitation program and have been hospitalized at Saint Elizabeths for at least two years. The patients range in age from 48 to 75 (mean age, 58); five are totally blind.

All six patients have long histories of psychiatric disorders. Two were diagnosed as suffering from schizophrenia, paranoid type, before the onset of blindness. Two have histories of alcohol abuse predating their blindness; one of them also has episodes of unpredictable assaultive behavior. The fifth patient has a history of schizophrenia and behavior problems that appear to be unrelated to his blindness. The sixth was blind at birth and has lived in institutions for more than 50 years. Although he has been diagnosed as psychotic and somewhat mentally retarded, the effects of institutionalization cannot be discounted as a significant part of his problem.

Two staff members (one of whom is blind) are therapists in the Blind Rehabilitation program; the third is the head nurse on the ward where five of the six patient members live.

The contract established with all group members called for a trial period of six sessions. Each member agreed to evaluate the psychodrama group after the sixth session to determine whether it was of value to the patients and whether it was worth continuing.

## Initial Sessions

*Session 1.* The primary focus of the initial session was to introduce the group members and the director to one another.

ter this warm-up period, the director initiated an exercise which each member assumed the role of a significant member of his or her social network or "social atom." While playing this role, each member introduced him- or herself and told us something we needed to know about the group member. All members perceived this exercise as relatively nonthreatening and regarded it as an entertaining way of revealing information about themselves. The exercise not only helped introduce group members to some basic concepts of psychodrama but established a feeling of group cohesiveness. In addition, staff and patients were able to see how members believed they were perceived by significant people in their social network.

*Session 2.* During the second session, the members talked about their problems in dealing with sighted patients and staff in the Rehabilitation Medicine Building and expressed their feelings of fear and lack of trust when confronting people in the hall. This warm-up led to a psychodramatic exploration in which staff members assumed the role of an unknown person whom patients bumped into on their way to a familiar destination in the building. Several patients took turns enacting the scene and dealing with the person they encountered.

The psychodramatic exploration of this common occurrence served several purposes. First, it gave group members the opportunity to demonstrate to staff a frequent occurrence that provoked anxiety. Second, because the action was stopped periodically, the patients were able to give asides about the fear and anger the situation evoked in them. Some patients were assigned auxiliary egos that served as doubles. These doubles not only helped the patients express feelings that they resisted expressing but provided support and thus helped them experience their feelings as normal responses to a frightening situation. Third, when a patient was angry or abusive to the person he or she bumped into, role reversal was employed: i.e., the patient assumed the role of the "bumped-into" party and the auxiliary assumed the patient's role. This reversal of roles enabled patients to understand how their abusive reactions affected bystanders. Finally, and perhaps most important, patients had the opportunity to experiment with new approaches to old problems. Group support began to emerge during this session as members expressed their agreement or disagreement with different behaviors displayed by their peers.

*Session 3.* The central question that emerged during the warm-up at the beginning of the third session was, "How can my life have the meaning it had when I had my sight?" This session became the group's first protagonist-centered psychodrama session. Ms. A was chosen as the protagonist or central figure because her concerns seemed to represent those of the other members. She began by explaining that when she was sighted, she had worked as a waitress, which made her feel important and gave her a much higher sense of self-esteem than she currently had. Subsequently, we set up a restaurant scene so that Ms. A could play her old role; the intent was not to give her unrealistic hopes of resuming her career but to help her identify what the job provided that she no longer experienced. During the scene, Ms. A recalled feeling useful and helpful, taking pride in doing a good job, and receiving compliments on her work. When asked later to identify and demonstrate areas of her daily routine in which she could try to recapture these lost feelings, Ms. A mentioned helping other patients, working in the Blind Rehabilitation Section, and being open to compliments from other patients and staff as possibilities.

During the sharing phase, the other group members had an opportunity to describe their feelings of role loss and think about alternative ways of replacing lost roles. One member, a former prize fighter, began to reveal denial of his blindness by rejecting alternatives to a complete return of sight.

*Session 4.* Once again, the patients expressed concerns about personal safety in the building. They felt that their blindness made them particularly vulnerable to crime and abuse. Further exploration demonstrated that they felt they were picked on and ridiculed by sighted patients and staff, had lost their identity, and were seen as "the blind one."

Ms. B was selected as protagonist for this session, again because her concerns were representative of the group's. She described two situations that frightened and angered her. In one, a patient confined to a wheelchair repeatedly stopped in front of her door, causing her to walk into the chair on her way to the dining hall. The second involved a staff member who referred to Ms. B as "the blind one" and often waved her hand in front of Ms. B's face as a test of her blindness. To help Ms. B express the feelings evoked in each situation, we set up both scenes as psychodramatic vignettes using a double. Role reversals were then employed to help Ms. B see how her aggressive responses in these situations might affect the patient and the staff member. Ms. B had difficulty finding an assertive behavioral style that would be effective but not cause the offending parties to react with defensive stubborness. To help her, various group members assumed her role and demonstrated possible ways of dealing with the problem. This supportive "mirror" technique also gave group members an opportunity to display some ego strength and to express themselves as individuals rather than as "the blind one."

*Session 5.* With the Christmas season approaching, group members began discussing their feelings about Christmases, past and present. Although one member was excited about Christmas, most were saddened by the prospect of not spending the holidays with their families. The session evolved to a group-centered psychodrama in which patients and staff members exchanged Christmas gifts around the Christmas tree. The fantasy gifts were not only material things but wishes and hopes for one another's future. This session fostered the development of group cohesion and support during the Christmas season, and the metaphor of gift-giving enabled members to express feelings of closeness and to become aware of the therapeutic support they received from one another.

*Session 6.* During the warm-up to the sixth session, the group talked about family members and friends they had not seen for a long time. This discussion stimulated feelings about personal achievements and shortcomings during their hospitalization. One at a time, the patients called on staff members to assume the roles of absent family and friends and discussed their progress and shortcomings while in the program. Each group member then reversed roles with the staff member, identified the steps necessary for future progress, and further clarified his or her personal objectives and goals. The mirror technique was employed to help one patient examine how he avoided responding to a family member's questions. From this objective position, he became aware of his nonfacilitative interactive style and later experimented with a more effective and appropriate one.

To honor the initial contract, we devoted the remainder of the session to evaluating the first six sessions. Without exception, the patients said that the group had been a valuable therapeutic experience; several identified it as the highlight of

their weekly program. The group unanimously decided to continue the weekly sessions and agreed to use part of the next session to discuss areas for future work. The group will continue to meet once a week for an indefinite period.

## Discussion

Although no objective testing instrument was used to evaluate the patients' progress at the end of the six weeks, a discussion with the three staff members who participated in the group revealed several interesting findings. One patient, who had a history of leaving group meetings after 15 or 20 minutes, was able to remain in each psychodrama group session for the entire hour and fifteen minutes. Two patients, whose treatment goals included improvement of socialization skills, had become less withdrawn and were beginning to initiate appropriate social interaction with other members. Another patient seemed to be making progress in controlling her explosive behavior. Another began to use her rehabilitation skills more often and later left the hospital to live in a community-based foster home.

It is important to note that these informal findings are based on observation, not on empirical data. Evaluative research on the use of psychodrama with blind people will be necessary to enhance our understanding of how effective action methods are with this blind population.

## Special Considerations

Although all types of group work with blind psychiatric patients involve similar concerns, additional considerations must be addressed when using action group psychotherapy with this population:

1. Because psychodrama is a powerful psychotherapeutic tool, it should be used only by a qualified therapist. In addition, the psychodrama therapist should be thoroughly trained in the use of psychodrama and action methods by a recognized training body.

2. Because a basic understanding of the blind person's experience is essential for positive therapeutic intervention, the therapist should be trained to work with this specialized population.

3. Because psychodrama requires some staging of scenes and the use of available props such as chairs and tables to create settings for the action, safety is an issue. Sighted group members can deal with it by allowing the blind members to participate actively in setting up the scenes. This active participation also serves to enhance the group members' warm-up to an issue to be explored.

4. Because blind group members are perfectly capable of using their remaining senses to follow the action during explorations of individual or group issues, the group leader should guard against a natural tendency to "inform" them about what is happening in the group.

5. Because the psychodrama therapist is usually only one of several members of the therapeutic team, he or she must insure therapeutic effectiveness by working closely with the other professionals involved in the patient's treatment.

6. Because ongoing supervision is desirable in all therapeutic work to provide the therapist with an objective look at the issues and concerns that arise during the therapy sessions, it should be available to the psychodrama therapist.

This description of initial psychodrama sessions with blind patients in a psychiatric hospital is not meant to be a definitive statement about action methods with a blind population. Rather, I hope that it will encourage future endeavors and that other individuals who work in creative arts therapies will explore the possibility of adapting their disciplines to therapeutic work with blind psychiatric patients. ■

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