The psychodramatic space and its potential for alleviating acute distress: an action research study of an open-ended therapy group in a psychiatric in-patient ward

**Keywords**: psychiatric hospitalization, group therapy, mental illness, action research, psychodrama

The research presented in this paper is intended to serve as a framework for understanding the potential of psychodramatic group therapy to alleviate the experience of loneliness and distress in psychiatric in-patients. In contrast to many other studies dealing with treatment of mental illness, this paper does not deal with the phenomenological aspects of psychopathology or etiological explanations based on psychoanalytical theories; rather, it deals with participants coping with the experience of mental illness and psychiatric hospitalization within the space created within the psychodrama group. This approach follows a wider trend of psychodrama providers who prefer an alternative to the prevalent language of psychiatric diagnosis and labeling (Kellerman, 1998) and of specialists in the field of psychiatric rehabilitation who criticize the biological and phenomenological approach to classification and treatment of patients suffering from mental illness, arguing that these methods focus on symptoms and illness and ignore the healthy parts of the patients and their own subjective experience (Roe & Lachman, 2005).

## Coping with Mental Illness and Psychiatric Hospitalization

The experience of coping with mental illness has been described, among others, by Patricia Deegan, one of the forerunners of the *recovery movement*. Deegan describes how a diagnosis of mental illness paints a person’s entire perception and subjective experience. She describes the social isolation, the feeling of failure, the detachment and alienation, which takes over a patient following his diagnosis (Deegan, 2004). Other studies illustrate how awareness of the disease or medical diagnosis, in itself elicits symptoms of depression (Roe & Lachman, 2005) or even of post-traumatic stress in patients coping with severe mental illness (Frame & Morrison). All this is intensified by the effects of stigmatization and social rejection, and in particular by self-stigmatization, further exacerbating the difficulty of coping with mental illness (Corrigan & Rao, 2012). Self-stigma results in a loss of identity, \_\_\_\_\_\_, provokes a sense of hopelessness and low self-esteem, and leads to social withdrawal and depletion of social connections. (Orkibi, Bar, & Eliakim, 2014)

Moreover, the hospitalization and treatment experience is often in itself a traumatic experience. Recovering patients undergo difficult treatments, involuntary hospitalization, sometimes they must be physical restrained or placed in isolation. They are medicated, sometimes involuntarily, suffering adverse effects which can result in a feeling of alienation from one’s own recognizable self, and may be also subject to verbal threats as well as physical, sexual, or emotional abuse by other patients or staff members (Schur, 1971). It is in this challenging environment that various therapy groups are offered to psychiatric patients, including psychodramatic group therapy.

## Group Therapy in Psychiatric Departments

Many studies have revealed the immense benefit of group therapy in people coping with some shared distress, especially patients suffering from severe mental illness (Kanas, 1996; Fagin, 2010). Coping with mental illness is often accompanied by a loss of internal and interpersonal dialogue, and a personal experience of one-dimensionality and emptiness. The individual feels empty and hollow, sees himself as an outside observer of his own life. For these conditions, an effective therapeutic technique can conjure diverse situations and rich dialogue, offering partners to mirror one another, and providing visibility and a voice to convey the patient’s inner narrative (Lysaker & Lysaker, 2004).

There is research detailing the conditions and limitations which affect the nature of group therapy for psychiatric in-patients. These include the physical limitations of a psychiatric ward, the patients’ state of acute distress, incidence of violence and self-injury (Holloway, 2010), and a high turnover of patients. This constant turnover dictates the group’s open-ended nature, with patients joining and leaving frequently throughout the course of the group (Schopler & Galinski, 1984/2006), which Ebenstein and others categorize with “single-session groups” (Evenstein, 1998; Manor, 2010). Yalom, in his book, details the circumstances surrounding group therapy in psychiatric wards. He describes power-struggles that arise between the various members of medical and para-medical professions, the rapidly changing group membership due to increasingly shorter hospitalizations, and the psychopathological heterogeneity in the various departments. Other factors include the presence of multiple groups leads to blurring of membership among the different groups, the time spent together when outside the group, and the norms for sharing information among staff-members (Yalom, 1983, 1995).

In the midst of these limitations, Yalom describes the benefits that group therapy offers to these psychiatric in-patients. In addition to Yalom’s definition of 11 “therapeutic factors” of group therapy in general (such as instilling hope, universality, altruism, etc.), he highlights a few goals for group therapy specifically within an in-patient ward. These include encouraging a patient to be involved in his treatment and recovery process, encouraging a desire to maintain and continue with treatment even after discharge; demonstrating to the patient that talking about one’s problems and sharing can help; identifying problems with the help of the group, in order to work on them later in one-on-one therapy; alleviating loneliness and bridging barriers between fellow in-patients; providing a tool for patients to help and support one other, which empowers patients, giving them a sense of capability and self-value; and lastly, easing the anxiety that is experienced in psychiatric hospitals by offering a safe and protected space within it (Yalom 1983, 1995).

## Psychodrama Therapy for Patients with Mental Illness

The unique nature of psychodramatic group therapy is beneficial in ways that traditional psychotherapy is often inadequate. Roine and others describe the ability of psychodrama to evoke spontaneity and uncover creativity in difficult patients (Roine 1997, Schacht, 2007). Farmer (1995) highlights the way in which the psychodramatic stage allows patients to approach their feelings and thoughts in situations where the verbal dialogue of analytic psychotherapy is limited. These techniques are especially beneficial for difficult populations, such as at-risk adolescents, alcoholics, and those coping with anorexia (Karatas, 1994; Karp, 1994). Another advantage of psychodrama is its effectiveness in a wide range of psychopathologies, including depression, anxiety disorders, obsessive compulsive disorder, post-traumatic stress disorder, and other related phenomena such as self-stigma of mental illness (Orkibi et al., 2014; Vieira & Risques, 2007).

Moreno, the founder of psychodrama, was the first to highlight the potential of psychodrama as a tool even for people coping with severe mental illnesses. Contrasting his approach to Freud’s, he mentions that Freud has consistently stated that psychoanalytic therapy is applicable only to patients capable of evoking transference towards the analyst, and thus precludes the possibility of psychoanalytic treatment for psychotic patients and those with severe narcissistic disorders.  Moreno, however, argues that such disorders do not preclude the possibility of treatment by using psychodramatic therapy (Fox, 2008).

Moreno's conception of working with patients suffering from severe mental illness is detailed in an article dealing with the treatment of psychoses through psychodrama (Fox, 2008, Moreno, 1939). The focus of the psychodramatic therapeutic process is not, according to Moreno, a transference of the patient to the therapist, but rather the encounter between people and the psychodramatic roles, which underlies the value of this method for patients with severe mental illness and psychotic states. Psychodrama integrates the emotions that arise in interpersonal encounters and the interactions of different roles with techniques such as projection in order to induce the recovery process even in patients with severe illness.

Through the reality on the stage, techniques of psychodrama therapy allow the psychotic patient to express even his delusions and hallucinations in an accepting way that legitimizes his experience. These techniques do not reinforce patients’ delusions or undermine reality, but rather allow psychotic patients to restrain the psychosis using their own powers. This is achieved through the ability of psychodrama therapy to adapt itself to each patient, allowing for expression of the world as they experience it.

Moreno describes techniques for psychodrama specifically designed to be accessible even for patients with the most severe mental illness that may not be capable of participate in the regular psychodrama process. For example, the *substituting role technique* provides a patient to take on a symbolic role very distant from his own self if he is unable to play the role of himself or those close to him; thus the mirror technique enables even those patients who has trouble acting out an role on the psychodrama stage, to “see themselves” on stage using a friend who plays his part in their place. For those patients that cannot participate whatsoever in the therapeutic psychodrama theater, Moreno suggests another technique: the *auxiliary world* technique, wherein a patient’s entire daily environment becomes his psychodrama stage, and all the people in it participate, becoming “auxiliary egos”.

This auxiliary world technique is intended primarily for psychiatric in=patients in extreme and uncommon conditions. In practice, psychodrama therapy is utilized routinely in many psychiatric wards. This study presents findings from psychodrama group therapy in an acute ward of a psychiatric hospital in Israel and examines how the psychodramatic stage can provide some solution, albeit partial, to the distress and loneliness experienced by psychiatric inpatients in acute states.

# Methods:

## Action Research

Action research (AR) is a research approach that combines methodical investigation with practical action in the societal or communal setting. The concept of AR originates with the work of Kurt Lewin (1946) and John Collier (See Deshler & Ewart, 1995) on the subject of group dynamics, and is associated with activities designed to produce social change, liberate oppressed groups, and create an egalitarian society. Today, the term AR is use in a broader sense, to describe various kinds of research carried out by practitioners. This investigational approach, which in the past was commonly found only in education and teaching, is now an accepted method in various fields such as social work, organizational behavior, healthcare, public health, mental health, and others (Koshy, Koshy & Waterman, 2011; Meyer, 2000; Hutchinson & Novell, 2013).

AR is an approach that that sees the researcher as the primary research tool. The research is characteristically descriptive, drawing its data from the natural framework of the field work, emphasizing the process itself and attaching importance to the researcher’s interpretation of the observations (Greenwood & Levin, 2007; Stringer, 1999).

This study was conducted using an action research approach, following a psychodrama therapy group led by the author over a period of a year in the acute ward of a psychiatric hospital in Israel.

## The Study Setting and Participants

The research took place in an acute ward in a psychiatric hospital in Israel. Patients admitted to this ward are adults over age 20 suffering from some acute crisis leading them to be hospitalized voluntarily for a period lasting usually from one to three months. The circumstances leading to their hospitalization was varied, including, among others, depression, disorders such as schizophrenia and manic-depressive disorder, anxiety and other stress disorders, as well as various psychotic states. The psychodrama group was an open-ended group, allowing for high turnover and variability of the group’s participants (Miller & Mason, 2012; Schopler & Galinski, 1984/2006). The study followed this group for nearly a year, during which the group met 40 times, with 85 different participants overall. The author led the therapy sessions.

## Materials

The study utilized participant observation. Materials include detailed verbatim transcripts of all the therapy sessions during the course of the study (the transcripts were written by the group facilitator immediately following each session), as well as other documents including drawings, songs and letters written by the participants during the group meetings. All materials were used with the express consent of the participants and with the institutions approval, and materials were edited with pseudonyms and any identifying information were removed.

# Findings

The results of the study is presented in three main thematic categories: a) manifestations of distress in group participants, b) the doubling technique in the therapeutic process, and c) the use of psychodramatic group sharing. The first section is an illustration of psychiatric patients’ acute distress and the manner in which they expressed this distress, while the latter two sections focus on the role of psychodrama therapy in coping with this distress.

## Manifestations of Distress in Group Participants

Alongside the turnover of group participants throughout the year, the consistent element was the manifestation of distress of patients - the depression, despair and fatigue, helplessness, guilt, fear, and isolation.

Almost every week, especially during the “group pulse-check” segment at the beginning of every session, patients recounted and described a sense of depression: descriptions of sinking into despair, the apathy and dysfunction that led to their hospitalization, fears and anxiety that accompany the depression at night, sleep that is completely dependent on sleeping pills, and mornings where the depression dominates their body and mind. Mornings are a struggle to get up from bed, move the legs and begin the day. Young mothers relate being unable to care for the children or even feel any joy from them, because of the enveloping depression. Those who were beginning to recover, feared sinking once again into that depression.

It was apparent that the group activity had profound significance for the patients. This at times entailed discussion and sharing, and at times was accompanied by psychodramatic techniques such as vignette, role-reversal, or *doubling*:

Daniel[[1]](#footnote-1) was hospitalized two days ago because of his depression. He is divorced, lives alone, and is distraught about the future. He sank into his depression and stopped working a few weeks ago. This has already happened to him multiple times before. Last night he didn’t sleep at all, despite his sleeping pill.

Elena also tells about her depression. She was discharged from the ward about a month ago, but then relapsed into depression and was hospitalized again. She tells that mornings are the hardest for her. She cries all morning, and improves throughout the day.

We discuss depression a little. About how Daniel and others have been in this situation before, and recovered from it. Daniel says, “This doesn’t mean anything about the future.”

I “double” for Daniel: “When I am depressed, I cannot see how things will get better. I can’t see the light at the end of the tunnel. In my mind I know that [in the past] it has always been temporary and I [always} got better, but when I am inside the depression, it’s hard to feel that things could be good again.”

Here, Daniel shares his story of coping with depression. This was followed by a similar story by Elena. A dimension of universality was established within the group (Yalom, 1995), or a *mirror response* (Folkes in Fehr, 2003) where an individual can see himself in one of the group members. The brief group discussion and the doubling technique were used with Daniel in an attempt to expand his mental field and broaden his narrow perspective of helplessness, the sort of “tunnel vision” that characterizes patients experiencing depression. The double was utilized to find a balance between identification and confrontation: allowing Daniel to sense that his emotions and helplessness are perceived and understood, while at the same time offering an alternative point of view, by echoing memories of better times he had in the past when he was able to escape his crisis.

The expressions of depression were often accompanied by those of despair, weariness, and hopelessness. These may arise as a result of the illness, and in trying to cope with the outside world, or secondary to the hospitalization itself. A concrete example is found in one meeting in which participants were asked to write a letter to someone who was significant to them. One of the group members, Adam, chose to write a letter to himself:

“Letter to Adam: Adam has no more strength, I’ve lost all hope, these horrible feelings won’t let me be, and every day in this ward is hell for me. I feel I might go insane, I want to go home. Every day my mother fights with me, that I’ll agree to stay here longer. In the ward, everything feels sad and gloomy, and I just cross my fingers and hope that I’ll have the patience to last until I can be discharged”

This expression of distress, the ability to share it with the group while they do the same, is in itself beneficial. Adam’s letter prompted an opportunity to let him experience a new perspective using role-playing, and then to simply echo Adam’s words and feelings using a double:

I place a chair across from Adam, and ask him to sit in it. I ask him how he would respond to himself. He says, “You need to be patient.” As he returns to his own seat I ask him if he was persuaded – he says he was not. I create a double for him – “It’s difficult, I don’t have the patience.”

There were cases in which, alongside the depression, despair, and constant fatigue, the group presented with suicidal thoughts or the wish to die. Usually these were not immediate and concrete feelings, and were almost always accompanied by the wish also to live, but they were perceptible in the group space:

Anna: “I’ve been here for two months already, and it’s not getting better. Every day I just want to die. But I promised myself that as long as I’m here I won’t do anything [reckless].”

Later, Anna chooses a hoop from the center of the circle, and tosses it outside the circle, “banishing” it.

Anna: “Those are thoughts of suicide. I want to be rid of them. I don’t want **to want** to die.”

I, as a double to Anna: “I want to live?”

Anna hesitates.

I try an alternative double: “I want **to want** to live?”

Anna: “Yes — I want to want to live.”

Other emotions that commonly arose in the group included guilt, loneliness, and a feeling of defectiveness surrounding the “illness.” The “illness” is in quotes – not because it is not real, but rather because often the world of the patient is completely colored by shades of the illness, and is accompanied by self-labeling, loneliness, and strong feelings of guilt. When asked to address a significant character from their lives through a letter, speak to an empty chair, or use role-playing, patients often expressed feelings of guilt. They feel consumed by feelings of guilt towards close friends, partners, and especially to parents, or parents towards their children.

At times, psychodramatic role-playing enabled participants to forgive themselves, at least temporarily:

Raphael began reading a letter addressed to his son, in which he asked for forgiveness for his illness, and everything his son had to go through as a result over all those years. He says that he hurt his son, that he misses him. As he read, Raphael burst into tears.

I ask Raphael to reverse roles, and he responds to himself in the place of his son: “I understand your situation, I miss and love you too, Dad.”

## The *Double* In Psychodrama Therapy

Alongside the many manifestations of patients' distress, one could also see the power of the psychodramatic stage to make a patient to feel visible, to inspire hope and serve as a chamber for self-expression, cultivate a human encounter, and facilitate sharing. One of the most powerful therapeutic tools in this context was the *double*. The double in psychodrama is meant to act as an additional “I”, which allows a protagonist to express those things that are most difficult, to share thoughts and feelings that may be difficult to articulate into words, and pose repressed conflicts while providing a sense of safety and support. The double echoes the thoughts and feelings of the protagonist, while ensuring a sense of being seen and heard, expressing empathy, closeness, and understanding of the feelings and perspective of the protagonist.

In this group of in-patients, it was almost always the group director who acted as the double, group members did not commonly double for one another. This may be a reflection of the open-ended nature of the group; the constantly changing group membership did not allow for long-term experience with the double technique and the confidence to undertake the role of a double for other group members. At times, however, the patients did ask that others would double for them:

David explained to the others what a double is, and I suggested that he demonstrate to the others. He preferred not to, and asked me to double for him.

I spoke as his double: “I know exactly what a double is, but I prefer that others double for me. I am little too embarrassed to double for someone else, and I’m afraid of taking that responsibility. What if he won’t agree or won’t like the double I’ve made for him? What if I embarrass him? I don’t want to embarrass anyone or stand out too much.” David smiles and thanks me.

Here the double acts not only to demonstrate the technique of doubling to the group, but also to offer David commentary on his own behavior, to clarify and illuminate his thoughts and worries, and help David be better understood by his friends and himself. Even in this demonstration of the double, David was offered a message of empathy, an assurance that the group director hears and understands him.

The doubles were used for many purposes throughout the year. At times, the goal was to increase a sense of visibility in patients who felt transparent, invisible:

We returned to Clara who unexpectedly began to describe to the group how sometimes she follows people around the ward, and is often told to stop following them. I doubled for her: “I feel lost here and no one sees me.”

There were times when the double acted to clarify chaotic situations in the group, relieve stressful or threatening situations, or reduce anxiety for some of the participants. In one meeting, one of the participants, Eddie, was apparently in a psychotic state when he began to express his feelings towards a woman in the group, in a bizarre, inappropriate, uncontrollable and even threatening manner:

Eddie sits in the empty chair and begins to talk about Naomi (a new participant in the group). He is incoherent, tries to describe how much he loves her, and how he is happy about their connection. “I have patience,” he adds. There is a sense of awkwardness and discomfort in the group; Igor suggests moving on to someone else.

I double for Eddie - “Naomi, I am very glad I’ve met you, it makes me happy that we’ve gotten to know each other, and I may also have some feelings for you.” I ask Naomi if she would like to respond or to say something; she declines, so I move on to other participants.

Eddie’s remarks were seen as bizarre, uncontrollable, and threatening. The double was used to humanize him; express his feelings in a more coherent and relatable way. This restored a sense of control and order in the group, alleviate pressure from Naomi who was the object of Eddie’s address, while at the same time allowing Eddie to cool down, and moving on without ignoring or offending him.

Other times, the double was a means for bringing group members together and allowing them to express closeness, offering means of expression of empathy between the participants whenever it seemed they were trying to express empathy. Such an opportunity arose in one meeting right after one participant, Laura, told of her experience being raped:

Michael says he is usually against the death penalty, but he thinks it is an appropriate punishment for anyone who stabs or rapes someone.

I double for Michael, speaking for him: “I’m telling you this because that’s what I think, but also because I’m trying to tell you, Laura, how much your story touched me. I feel your pain, and I’m here with you.”

Michael responds, “Exactly!”

Michael’s response to Laura’s story took the form of an opinion about the punishment fitting for rapists. Michael’s double enabled him to express himself in a different way – more personal and emotional, and express empathy towards Laura. His response, “Exactly!”, demonstrates that he indeed felt empathy and compassion towards Laura that he was trying to express.

## The Role of Group Sharing

In addition to the use of “doubling” and other psychodrama techniques, the group "sharing" method created a space for sharing, an experience of universality and mutual support. This sharing phase in psychodrama is the phase in which group members share their personal life experiences as they relate to the work of the protagonist. In practice, the psychodrama activity in the patient group did not always focus on one protagonist, and there was not always a clear separation between the “group pulse-check” at the beginning of the session or the main activity, and the sharing phase. Within the patient group, “sharing” was a space where participants could share their feelings, their troubles, and whatever else they were undergoing. This space often evoked an experience of universality; a discovery that the individual is not alone in his experience and in his distress:

The group members share how they are doing this morning. Judah shares that he is confused about his place in the world. When he doesn’t observe the commandments of Judaism he feels emptiness, yet when he tries to observe the rituals he becomes unbalanced and triggers manic episodes. Another participant, Abraham tells him that when a person brings oneself closer to religion, at first God gives a push forward, but afterwards one is left [to struggle] with it alone. I ask Abraham if this is something he has personally experienced; he says yes, and adds: “We are souls attached together, souls that speak.”

When a particularly painful sentiment was offered during the group sharing, it was frequently possible to see how the participants tried to offer support, empower, and encourage one another, say a good word, and to offer solutions, perspectives, or suggest an alternative approach:

Anna tells the group about her suicidal thoughts: “I’ve been here for two months already and nothing is better, I want to die every day, but I promised that as long as I’m here I will not do anything…People always tell me I look better, but I don’t feel better.”

Sharon says that she sees that Anna is suffering and is depressed, and she wishes for her to feel better, that it is hard for her to see her like this. She says Anna is lovely and deserves to feel well.

Isaac also speaks of depression, of despair over destroying himself and losing everything, of great fatigue; That he just wants to hide from reality and sleep. David talks about faith and tries to encourage Isaac.

Here we can see how the group sharing has become a space of mutual support: Sharon tries supporting Anna and David encourages Isaac. Later Anna and Isaac receive additional gestures of encouragement and support from the group. It is not always clear whether the distress heard is the personal distress of Anna or Yitzhak, and to what extent these empowering words belong to Tammy or Sharon. Sometimes it seems that all of these voices are the voice of the group itself. That each participant exhibits distress and need, at times despair, alongside great strength, optimism and the desire to help. Sharing within the group served as an important space for expression of these voices and for dialogue between them.

Sometimes, when the group space was overcome with distress and painful feelings, the sharing phase acquired a certain ceremonial status that enabled this shared experience of dealing with the distress. This allowed for the space, where Anna and Isaac were able to share their suffering. The following shared segment took on a different character than usual:

We place a circle of hoops in the room, and each hoop represents a feeling that arose during the encounter: sadness, confusion, optimism, depression, camaraderie, joy, shame, fatigue ... Each participant chooses a hoop (not necessarily the hoop he placed in the center of the circle) and tells the group what he would like to do with it.

Boris chooses the hoop labeled “despair,” to tell Anna not to lose hope. Isaac chooses (David’s) optimism. Yehuda chooses faith and optimism. He addresses his words to Anna and Isaac, and talks about God, who, even if it is difficult to understand, always has our interests in mind. Finally, I take the partnership hoop, and say that I’ve felt a lot of that partnership within the last hour.

Here, the hoops allowed the participants to give away or take from each other some of their strengths as well as their distress. This was a powerful manifestation of the concept of sharing – dividing the stresses and emotions among the group. The concept was best expressed by Laura at the end of a difficult encounter during which she shared the story of her rape with the group:

Schering: “I would like the participants to mention one thing they will take with them when they leave the room.” Most of the participants wish for Laura to feel better, healthy and strong.

Laura herself says: "I take some of the pain of each person in the group.”

I ask, as Laura’s double, “Do I also take with me some love from the group?”

Laura: "I'll try.”

I, as Laura’s double: "Do I see the group’s love?”

Laura: “Yes”

Laura's statement that she takes "a little bit of the pain of everyone in the group," together with the double that invites Laura to take " from the love of the group too," concisely expresses the concept of division that underlies the concept of sharing. Distribution of the heavy burden, as well as the resources and strengths of the participants in the group. This distribution is the essence of the receptacle created by the psychodrama group. A chamber of cooperation, reciprocity and human interaction, which serves as a response, if only partially, to the distress of psychiatric patients.

# Discussion

The findings of this study illustrate a picture of acute-care departments of psychiatric hospitals in Israel, in which patients express distress but also participate in sharing, support of one another, and a personal encounter within the framework of psychodrama, that enables them to cope with this distress.

Such manifestations of distress described in the essay include expressions of depression, despair, helplessness and weariness, loss of will to live, and self-labeling of the patients. These descriptions are similar to the findings from research of symptoms that arise in patients following a medical diagnosis and awareness of depression (Moore et al., 1999; Roe & Lachman, 2005), descriptions by Schur (1971) of patients coping with severe mental illness being “engulfed by their patient-role,” as well as the findings of self-stigma and acquired helplessness, loss of self-belief, despair, and loss of will which characterize the experience of coping with mental illness (Deegan, 2004).

Furthermore, the patients must also cope with feelings of guilt and loneliness; they find themselves consumed by feelings of guilt towards close friends, partners, and especially towards parents or children of the patients, while also experiencing the loneliness and distress associated with hospitalization. Hospitalized patients suffer the separation from friends and family, loss of independence, and the difficult circumstances associated with psychiatric hospitalization (Morisson et al., 2003; Holloway, 2010) in addition to the experience of coping with mental illnesses themselves, as described in the research literature (Roe & Lachman, 2005).

Besides the description of the patients’ acute distress manifested in the therapeutic stage, this study examines how the psychodrama group acts as an accommodating space for coping with the experience of distress of the participants by creating a space for self-expression and a human encounter, mutual support, and sharing. This study illustrates two therapeutic steps taken to create this supportive, accommodating, and encouraging space. The role of the psychodramatic “double” was demonstrated: its capacity to echo thoughts and emotions of participants, offer commentary and interpretation, and help patients feel they are better understood. The double was employed as a way to give a voice, through the double, to patients who struggled to express themselves, and to increase clarity in chaotic situations, reduce anxiety, and enable expressions of identification, empathy, and closeness among group members. This reflects the concepts of Moreno and his successors of the double as an “additional I,” which allows the protagonist to better sense that he is visible and facilitate expression of thoughts and feelings that may be difficult to formulate into words; the doubling technique allows the patient to confront repressed conflicts and provides a supportive environment and sense of safety in the psychodramatic space. This method relies on the empathy and sense of closeness and understanding between participants (Blatner, 2000; Fox, 2008; Holmes & Karp, 1991).

Next, the significant role of sharing in psychodrama was examined in this study; this refers not only to the sharing that takes place at the end of a psychodramatic vignette, but also to the additional spaces set for sharing within these group meetings. The study illustrates the role of sharing as a receptacle for visibility, mutual support, and a personal human encounter among the group members. In this space, participants could share themselves with the group, their feelings and thoughts, and sense the attentiveness of the other participants, who occasionally offered their responses as well. Patients could return to this space for the universality (Yalom, 1983), or the “mirror reaction” as termed by Foulkes (Fehr, 2003), in which participant discover that they are not alone in their distress, that their fellow group members cope with similar distress they can share these experiences with the group. The sharing space was a setting for dialogue between group members, about their experiences, values, thoughts, or emotions. For patients this may be one of the few places where they can encourage, compliment, or support one another, express their identification, offer alternative perspectives, or just listen empathetically. Here in this space, many of Yalom’s therapeutic factors manifested themselves – such as inspiring hope, universality, altruism, and solidarity (Yalom, 1983, 1995).

Moreno described the sharing phase as a phase where “strangers” in the group can reveal their emotions and cease to be strangers, can express their love for the protagonist, and allow for their own self-expression (Moreno, 1946, in Fox, 2008). This study demonstrates how sharing was utilized by psychiatric patients as a way to share the burden and divide it among the group members along with the resources to cope with it. This division is what Moreno described the fabric of life and human encounter which comprises the psychodrama group (Blatner, 2000), allowing its members to create an accommodating space of sympathy, cooperation, support, and sharing, which offers at least partial relief of the distress and loneliness of psychiatric in-patients.

# Methodological Issues and Limitations of the Study

Despite the profound significance of the findings of this study in understanding the potential of psychodrama in treating psychiatric in-patients, this study also has its limitations.

First, this is a descriptive qualitative study. It is not reproducible, and is not intended to precisely quantify the effects of the psychodramatic method or the level of distress in its participants, nor does it purport to definitively demonstrate a direct causal relationship between these two factors.

An additional methodological issue concerns the action research method, which in its nature blurs the boundaries between the researcher and the practitioner, or the research and the practice (as well as research and treatment).

Nevertheless, AR offers significant advantages – the relevance of this applied research, and the deep familiarity of the researcher with his subject; in this case this familiarity enables an intimate and unique encounter with a patient’s acute distress and with the therapeutic processes that arise in the psychodramatic space.

# Conclusion

The current study contributes to our understanding of group therapy by highlighting its unique features and potential in dealing with the distress and isolation of patients hospitalized in psychiatric hospitals. More specifically, the study adds to the current literature describing how the unique features psychodramatic therapy are useful in fostering spontaneity and creativity (Blatner, 2000; Farmer, 1995; Roine, 1997; Schacht, 2007), and its benefits in treating particularly difficult populations where traditional psychotherapy is most lacking (Karatas, 2011; Karp, 1994; Orkibi et al., 2017), especially in managing the wide spectrum of mental disorders and accompanying symptoms in patients with severe mental illness (Gatta et al., 2014; Veira & Riskques, 2007).

This study is unique in its approach which utilizes a direct and personal encounter of researchers and practitioners with the distress of psychiatric in-patients, within the setting of the therapy group, and using therapeutic techniques such as psychodramatic sharing that are not commonly found in the existing literature.

1. The quoted passages are excerpts from the transcripts written down immediately following group meetings. Fictional names are used. [↑](#footnote-ref-1)