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AN EXAMINATION OF THE CRITERIA GOVERNING THE
SELECTION OF ROLE-PLAY TECHNIQUES EMPLOYED IN A
REHABILITATION PROGRAMME OF ADULT PSYCHIATRIC PATIENTS

A thesis submitted for the degree of

Master of Education

in the University of Durham

by

Barbara Howarth

October, 1982.

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"An examination of the criteria governing the selection
of role-play techniques employed in a rehabilitation
programme of adult psychiatric patients"

Barbara Howarth

Abstract

The purpose of this study is to examine the criteria which govern a role-play group leader's decisions in the selection of techniques and to define and categorise the possible techniques available. It is not intended to measure outcome, although as the leader's evaluation of 'effect' may influence the future selection of techniques, this feedback of response and consequent action is included in the analysis of factors determining decisions.

The particular role-play sessions studied were held weekly, under the leadership of the writer of this thesis. They took place in the rehabilitation unit of a large psychiatric hospital where the groups of patients involved were in a transitional phase between hospital ward and discharge to independent living. Role-play was intended to aid that transition.

This investigation into role-play direction takes account of factors arising from background sources, such as the theory and practice of role-play as therapy and psychiatric illness and treatment, and from more immediate influences such as the needs and wants of the group members. It is a consideration of the continual appraisal and re-appraisal of the face-to-face situations occurring in role-play sessions; of alternative strategies and leader's choices. The points raised in discussion are empirically supported by: (a) a case study, including the leader's written observations and comments made at the time of the patient's membership of the role-play group; and (b) tape recorded extracts of selected role-play sessions.

INTRODUCTION

INTRODUCTION

The thesis is an investigation into the influences on a role-play group leader which may determine what that leader does in role-play sessions that are designed to help patients prepare for discharge from a psychiatric hospital. It is based on the writer's experience of the use of role-play and a specific role-play project carried out in a hospital rehabilitation unit.

The intention is to trace the sources of influence which may underlie a leader's choice of action in the immediacy of directing a role-play session. It involves establishing and categorising both criteria which might prompt choice, and techniques which could be chosen.

Recognising that some factors affecting role-play may arise long before the leader comes face to face with the group of patients concerned, while others may only be presented 'on the spot' by circumstances in a session, the thesis has been developed almost as a journey. It begins by identifying criteria governing technique selection derived from principles of the leader's *raison d'être* which suggest that role-play may be an effective help to people recovering from mental illness and hospitalisation, and narrows to those which stem from patient problems and individual needs and wants of participants.

As the thesis is based on the writer's own use of role-play as part of a rehabilitation programme for adult psychiatric patients, it seems appropriate to begin by describing the writer's way in to this field of work and study.

It was from within the experience of drama in an educational context that I began to discover the usefulness of role-play as a potential learning aid which could be purposefully directed.

Educational role-play is described by Corsini as a method -

".... whereby people act out imaginary situations for purposes directed to self-understanding, improvement of skills, analysis of behaviour or to demonstrate to others how one operates or how one should operate". (1)

As a classroom teacher I aimed to use the enactment of 'imaginary situations' to reveal behaviour, to encourage participants to consider the implications of cause, effect and change of behaviour and also, where appropriate, to allow the experience of new behaviours, so that simulated experience could perhaps improve comprehension and effectiveness in related 'real' situations.

My first experience of transferring the use of role-play techniques from the sphere of child education to that of possible therapy for psychiatric patients, was made at the request of a Consultant Psychiatrist at Winterton Hospital, who could envisage benefits for certain selected chronic schizophrenics on a long-stay ward.

After observing weekly role-play meetings with such a group of patients, over a period of several months, she concluded that role-play seemed to be "a valuable approach to treatment of symptoms of residual schizophrenia and institutionalisation".(2)

During my direction of the above sessions my own observations of effect had also encouraged me in the view that role-play activities could be an aid to the more effective living of chronic long-stay patients.

Role-play was later included in the rehabilitation programme of psychiatric patients in a newly opened Rehabilitation Unit at Winterton Hospital because it was hoped that it could also help patients facing the prospect of leaving the restrictive hospital environment to meet a wider range of experiences and social contacts in the outside community. This then was the second venture in which I was invited to explore the use of role-play as a form of psychotherapy.

(1) Raymond J. Corsini, Roleplaying in Psychotherapy, Aldine Pub. 1966, Forward XI.

(2) Merrica D. M. Goodall, Role-play with Chronic Schizophrenics, 1976.

The role-play group activities with the rehabilitation unit residents were intended to help in their treatment. There was no original thought of any type of research. Although notes on procedure, recordings of events, comments on effect, were made, they too were intended to assist with treatment or to facilitate retrospective consideration of role-play sessions, with a view to improving the continuity of content, or developing the use of techniques.

The role-play group was well established and sessions had been held for several months before the idea of investigating any aspect of role-play as psychotherapy, for research purposes, emerged.

In their study of psychotherapy systems, Ford and Urban express the view that:

"increased understanding and effectiveness of psychotherapy lies in systematic and rigorous application of scientific methods to its study". (1)

When it was suggested that in addition to holding role-play group meetings to help patients to overcome any residual effects of illness and prepare for living outside the hospital environment, I might also produce some written study of role-play used with psychotherapeutic aims, I was particularly anxious that in facilitating any kind of research I did not destroy the 'helping function',⁽²⁾ which was the primary aim in the group's activities.

Ford and Urban do also suggest the reservation which a therapist might have about the application of 'rigorous scientific methods' to evaluate therapy practices, saying:-

".... his commitment to his patient places severe restrictions on what he sets out to do His task of 'healing' patients restricts the observation he can make on their behaviours, limits the collection of data, and circumscribes the variety of treatment conditions he is permitted to employ". (3)

(1) Donald H. Ford and Hugh B. Urban. Systems of Psychotherapy, Wiley & Sons Inc., 1963, p.5.

(2) See Lawrence M. Brammer and Everett L. Shostrom. Therapeutic Psychology, Prentice Hall Inc. 1960, p.4.

(3) Ford and Urban, op.cit., p.7.

In my own role-play work in the rehabilitation unit I was apprehensive about the adverse, counter-therapeutic effect of too much interference with the sessions. Thinking that measuring the outcome of role-play practices may require such methods as the setting up of control groups, the completion by patients of questionnaires or the presence of additional people in sessions, who were there not to participate but merely to make objective observations, I was afraid that manipulation of patient experience to satisfy experimental conditions may damage any 'healing' process which the established and accepted meetings in the unit might achieve.

I therefore decided that any research into the particular role-play project in which I was currently involved should be enquiry into my own motivations and methods as a role-play group leader. I hoped that the observation and collection of data required would interfere little with the format or function of role-play meetings.

Observation of the behaviour of patients prior to, during and after the experience of activities in role-play sessions is likely to be an important part of developing the use of role-play as therapy. Observation by the leader, though subjective in that it is made from a position of involvement with the activities and their effect, is nonetheless valuable in the refining or extending of the practices and in evolving theories about their use. The leader may also rely on the observations in or out of therapy sessions, made by other people concerned with the welfare or treatment of patients.

This amassed information, though perhaps unacceptable as scientific evidence for a researcher, can be a rich and influential source of guidance for the leader in situations where interpretation of information is an intrinsic part of his continuing function as director of his particular form of therapy.

Establishing other factors which help determine a role-play leader's actions and choice of activities is the central aim in the thesis.

As described, in transferring my own role-play methods from school to hospital I had come from using role-play as a learning aid toward educational goals, to using role-play as a learning aid toward therapeutic goals. The objectives were often very similar and this way into psychotherapy, via experience in some associated field, does not seem uncommon.

"Psychotherapy is not a profession but a varied and sometimes ill-defined set of practices engaged in by members of a number of different professions. Each profession requires that its members be trained first and primarily to do something else; medicine; psychology; social work; nursing or religious ministering. In short psychotherapy represents ancillary activities engaged in by various professionals, whose preparation in the area of psychotherapy may be quite variable". (1)

The above quotation suggests that many of those involved in 'ancillary activities' designed to have a therapeutic effect on an individual or a group of people who have suffered some mental illness, have come to be involved, not because they are expert in psychotherapy or even in the problems and/or illnesses of their patients, but because their original training and professional experience had familiarised them with, and developed their use of, a 'set of practices' which was subsequently thought to have potential psychotherapeutic value.

Professor Parloff describes psychotherapy as a 'varied and sometimes ill-defined set of practices'. In investigating my own use of role-play in a rehabilitation programme for adult psychiatric patients I considered it important not only to analyse my own motivations by examining the criteria governing the selection of role-play techniques employed, but also, in order to illustrate connections between criteria and techniques, to define and categorise the 'set of practices' themselves. Establishing the practices used in this particular role-play project is therefore an associated aim in the thesis.

(1) Professor M.B. Parloff, American Psychologist. Vol.34. No.4, April '79, p.299.

CHAPTER I

THE ROLE-PLAY LEADER'S FRAME OF REFERENCE,

A. The leader's expectation of the practices

CHAPTER I

The role-play leader's frame of reference,

A - criteria governing the selection of role-play techniques employed in a rehabilitation programme of adult psychiatric patients arising from the leader's expectation of the practices.

Although a role-play leader's regard for patient welfare and therapeutic aims may induce his resistance to the impositions or restrictions of certain experimental conditions, in a way, he, and perhaps every psychotherapist, is in an experimental situation all the time. He tries out various hypotheses, observes results, adjusts if necessary, before repeating or proceeding to his next set of conditions. Observation of effect thus becomes one possible determinant of subsequent application of psychotherapy techniques.

During role-play sessions continual feedback of response, though important, is an element which only exerts an influence once sessions are under way. Certain other criteria likely to govern role-play decisions may be established even before leader and group members come together.

"As soon as a therapist begins to act, he does so on the grounds of some expectation, in terms of some frame of reference". (1)

If, as suggested in the introduction, the 'set of practices' that is used as a psychotherapeutic aid has been developed in some other professional context, a frame of reference to guide the planning and early decisions of the group leader who directs its use is likely to be constructed from such theories and ideas explored in the leader's previous experience as remain relevant to the new situation, plus additional information sought to meet the demands of that new situation.

In the more specific transference of role-play techniques from educational drama to therapy for patients in a psychiatric rehabilitation unit, the initial frame of reference from which criteria for technique selection can be established is likely, as in this project, to arise from:-

(1) Ford and Urban, op.cit., p.13.

- A. The leader's expectation of the practices, related to
- (1) The different philosophical/theoretical positions of professionals examining human behaviour and learning, and associated approaches to psychotherapy.
 - (2) The incorporation of various approaches to psychotherapy into the the use of role-play to promote sound mental health and adequate social functioning.
- B. The leader's expectation of the participants, according to the kinds of help other than medical, economic, educational and spiritual that adult psychiatric patients seem to need. These are likely to be based on:-
- (1) The advice of the patients' doctors.
 - (2) The leader's understanding of:-
 - (a) The causes and effects of original mental illness.
 - (b) The causes and effects of institutionalisation.

In this chapter it is intended to discuss influences in the 'frame of reference' arising from:-

A. The leader's expectation of the practices

- (1) The different philosophical/theoretical positions of professionals examining human behaviour and learning and associated approaches to psychotherapy

The study is not designed to cover all the various theories on normal and/or abnormal human behaviour. The aim is to outline selected concepts and hypotheses which had a bearing on one particular role-play project but which may be equally relevant to other role-play schemes.

When building on personal experience to extend therapeutic practices into a new context the opinions and ideas of forerunners in similar fields may be assimilated into a personal philosophy in either an innovative or a supportive capacity. Contrary views of theory or practice will need to be reviewed in the light of a therapist's own past experience or he may decide to explore them in the course of his own therapy. Not all ideas need to

have had scientific verification for a psychotherapist to set up conditions to accommodate or test them within his own system. Assumptions or even queries arising from related literature, once they effect his actions become criteria for the selection of techniques.

There may be great variation in the amount and type of influence from literature which has effect on the formative ideas of the therapist. From one source he may accept and adopt very general principles, while from another it can be the merest detail of opinion or technique which he extracts.

An examination of various theories of behavioural development and psychotherapy systems will present anyone seeking to use the relevant experience of others as a guide to his own psychotherapy practice, with many choices. Contrasting views need not all arise from different systems. Because philosophers and psychotherapists at times modify their own ideas and beliefs, what may be gleaned from their writing may depend to some extent on which period of their work is discovered - even on which book is read and when. Differences of opinion may emerge from within a theory or therapy system, or from a comparison of systems. A therapist does not need to accept all of any one philosophy or relevant therapy to select hypotheses, concepts or techniques which suggest basic assumptions about the prerequisites or functions of his own particular therapy.

The work of Sigmund Freud presents learning principles which seem fundamental to many subsequent systems of psychotherapy even though his largely deterministic view of personality development and the clash between man's basic instincts and his social upbringing may not be accepted in its entirety.

Freudian theory appears to underlie many psychotherapeutic aims and his suggested techniques, though specific to his psychoanalysis method, may imply desirable elements in the techniques of other forms of therapy.

"As a science psychoanalysis is characterized by the methods by which it works, not by the subject-matter with which it deals". (1)

Although, as suggested by Freud, it is the 'set of practices' which sets one form of psychotherapy apart from another, in an assessment concerned with the effective use of such practices, it is difficult to divorce the methods from the theory which determines their goals. The influence of one therapy system on another may well stem from the pursuit of common objectives rather than the use of like techniques.

When role-play experience is being used as a learning aid, as in the rehabilitation programme of psychiatric patients, criteria to guide a leader may arise from the relevance of some of the principles of Freudian theories of the learning process and the development of human behaviour and from the relatedness of role-play techniques to certain psychoanalysis techniques with shared objectives.

Freud maintained that the simplest behavioural occurrence was dependent on a set of antecedents and that an individual's response to a stimulus would depend to a great extent on his conscious or unconscious memories of previous experience of that stimulus.

The use of role-play, as a learning aid, is reliant on this basic supposition, that reaction to a stimulus will not be isolated, but will be related to previous experience of that stimulus. Its effectiveness, firstly, to reveal behavioural response, and secondly, if desirable, to attempt to modify that response, either in subsequent role-play experience or in real experience, will depend on the participants' conscious or unconscious memories of previous exposure to the stimulus. The possibility of influencing a response in real experience, by establishing or extending antecedent responses in role-play experience is basic to the purposeful direction of role-play to adapt behaviour.

(1) Sigmund Freud, Introductory Lectures in Psychoanalysis, Allen & Unwin Ltd., 1922, p.325.

Freud inferred that a person was frequently unaware of the 'set of antecedents' preceding a response and that bringing to awareness was an important part of therapy.

The use of role-play and the imaginary situations which add contextual detail, have potential not only for bringing the patient's responses to his own attention but also for bringing them to the awareness of those present who are responsible for his treatment. A latent response may be actually evident in a patient's spontaneous reaction to the simulated stimuli of the role-play encounter. Alternatively, a past response to what were at the time, real stimuli may be revealed in a re-enactment of a recalled experience.

Not only may the responses be evident in role-play, the stimuli which elicit those responses may be indicated, if not proven. Both cause and effect may be further explored if suitable role-play situations can be developed to qualify or verify either element of the reaction.

The aim of Freud's psychoanalytic therapy would seem to revolve around making the unconscious conscious.

"By extending the unconscious into consciousness the repressions are raised, the conditions of symptom-formation are abolished, and the pathogenic conflict exchanged for a normal one which must be decided one way or another". (1)

Freud differentiated between those responses readily brought to awareness, which he called 'preconscious' and those that require a great struggle to bring to awareness, which he called 'unconscious'. He suggested that disturbing thoughts or alien subjective responses may be kept from awareness - 'repressed'. Because they are totally opposed to what one believes one's responses and thoughts to be, once brought to awareness they are promptly repudiated or they incur a 'negative affect' - particularly anxiety.

Freud suggested that anxiety was the source of all manner of neurotic

(1) Freud, op.cit., p.363.

symptoms and illnesses. He viewed it as a fundamental response which occurred under certain antecedent conditions. The antecedents may be situational events, innate responses or thoughts. He refers to 'situations of danger' - any circumstances in which the individual is helpless to terminate the growing tension. In extreme instances, where tension is excessive, the situation becomes 'traumatic'.

Some situations would be the original antecedents of anxiety but subsequently, other responses, such as thoughts and memories may restimulate the anxiety. Later, similar situations may be reacted to as 'dangerous' but the response would be a milder 'signal anxiety'.⁽¹⁾ This would be a much less intense experience which would not become traumatic if the individual could relieve the tension with appropriate action.

Role-play could offer a rehearsal ground for the handling of anxiety. It may be possible to allay intense anxiety in a future real situation by developing appropriate behaviours to relieve the lesser tensions created in a prior role-play situation.

There may be value to the patient not only in coping with the situational events associated with anxiety but also in the experience of coming safely through the emotion in a controlled situation. Control may be dependent on the leader's awareness and sensitivity to any signs of patient stress. The leader may need to make some judgement on the origin of the responses. Is the anxiety due to some element in the topic or content of a role-play incident, or is it provoked by the circumstances of the session or group itself?

Freud considers at great length theories about the many complex effects of anxiety. Ford and Urban simplify to the fundamental principle that:

"Anxiety leads to avoidance. In the case of situational events, the person may avoid attending to or thinking about them. Or better yet, he may physically remove himself from their presence". (2)

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- (1) Freud. The Complete Psychological Works of Sigmund Freud, Strachey. J. (Ed.), Std. Edition, Vol.20, pp.81, 166.
 (2) Ford and Urban, op.cit., p.128.

If the tension is such that a patient blanks off mentally from role-play session events or physically absents himself from them altogether i.e. walks out, he is not available to the therapy. The leader may need to act to prevent such avoidance. He may also become aware of other signs of stress (again as observed by Freud)⁽¹⁾ such as irritability, breathlessness or sweating. Such evidence of anxiety may prompt action by a group leader.

Display of more extreme neurotic behaviours though undesirable, may have diagnostic significance (as may an avoidance response) if they indicate to a trained observer, a source of antecedent tension. Freud's theories dealt extensively with symptom formation and characteristics. He related their origins to his views on the influence of childhood learnings on adult behaviour, and to antecedent conflicts and compromises which might precipitate pathological behaviours. He distinguished between neurotic symptoms which he suggested arose out of conflicts between instinctual drives (id) and the conscious, thinking, discriminating element of personality (ego), and psychotic symptoms which resulted from clashes between ego and situational events.

When using role-play in a rehabilitation unit where many patients may be approaching readiness to leave the hospital, extremes of pathological behaviour would not be expected very frequently. However, should they occur, a role-play leader who accepted the Freudian hypothesis that pathological behaviours may be eliminated if antecedent, repressed conflicts can be revealed, may gear his methods toward the 'discovery of the unconscious in mental life'.⁽²⁾

Freud's psychoanalysis methods laid emphasis on this principle of relieving symptoms by revealing root causes. His work was concerned primarily with neurotic patients. He suggested that neurotics still make active attempts

(1) Freud. Complete Works, Strachey, J. Ed., Vol.3, pp.92, 95.

(2) Freud. Introductory Lectures in Psychoanalysis, 1922, p.325.

to deal with situational events and to control their behaviour to accord with the requirements of society. For ideas on the use of role-play techniques to modify psychotic behaviours, where patients may have lost touch with external reality, a role-play leader may need to look to other theories of the learning process.

Although much of Freud's therapy was concerned with the discovery of causal factors in symptom formation, it did also extend to techniques which focussed patient attention on the effectiveness of alternative behaviours. When using role-play to help psychiatric patients to cope successfully with a variety of social situations which may be new or have lapsed from his experience, there would seem to be considerable value in using techniques which may bring even 'preconscious' thoughts to patient awareness. The externalising of inner responses in the speech or action of role-play interaction makes those responses available for consideration. This seems a useful aim in rehabilitation where to focus attention on expressed past or present attitudes or actions can be precursory to the consideration of reaction or adjustment to new circumstances.

Freud maintained that it was by logical thought that an individual achieved control over his behaviour. He distinguished between thought as memory images, and thought as the verbal symbols which could facilitate the manipulation of ideas and the making of value judgements. The use of words, whether confined to inner thought responses or expressed in speech, was developed through situational events.

Encouraging the patient to externalise his ideas in speech was fundamental to Freud's psychoanalytic system. This basic objective of his method seemed a similarly important role-play expectation. Role-play offers patients a suitable vehicle for both the narration of experience and the handling and expression of ideas. Primarily the role-play encounter requires a verbal response but because it is an inter-reactionary situation it also allows for more associated physical action stimulation and response than

does the psychoanalyst's couch. Role-play can provide contextual appropriateness for expression in both speech and action; action being the dimension not so fully explored in Freud's work.

Freud's contrasting views on the value of patient insight relate significantly to therapeutic aims in the use of role-play. He argued, in his early work, that one of the strengths of his psychoanalysis system of therapy lay in its reliance on patient insight rather than therapist suggestion.

"The analyst was instructed not to directly suggest behavioural changes and not to use his personality to directly influence his patients' verbal productions or behaviour". (1)

Role-play can offer opportunity for the patient to view and possibly assess situational events, behaviours and affects. If this occurs it may or may not alter his perception of circumstances, motivations, feelings or actions. Left to reach his own conclusions the patient may or may not achieve some new awareness. The role-play leader may himself be aware of very different aspects of the situation than is the patient. Although in a position to express his personal opinion, if he shares Freud's early view on insight as quoted above, he will be reluctant to do so. It may be possible for the leader to avoid overt suggestion but set up another role-play situation to extend or qualify the first, in the hope that supplementary experience may produce independent patient understanding or insight.

Freud later modified his adherence to this insight principle, admitting the possible role of suggestion or even persuasion in his therapy.

"We take care of the patient's final independence by employing suggestion in order to get him to accomplish a piece of psychical work which has as its necessary result a permanent improvement in his physical functioning". (2)

Rather than completely miss the opportunity to utilise revealed events and behaviours in subsequent discussion of implications and suggested changes, which may produce a desirable improvement in patient functioning, the role-play leader may decide to add his own comment in a bid to hasten patient

(1) Seymour Fisher and Roger P. Greenbert, The Scientific Credibility of Freud's Theories and Therapy, Harvester Press, 1977, p.362

(2) Freud, Complete Works, Strachey, J. (Ed.), Vol.12, p.106.

insight.

The leader's personal fulcrum position on this balance between suggestion and insight, as expressed in Freud's opposing views, is one which each leader or therapist must decide for himself.

Associated with Freud's views on insight is his implication that those individuals most open to looking at themselves would be the most suitable for psychotherapy. Much investigation has subsequently been done to assess the prognostic value of insight for therapeutic gain. Eskey, Linn, Childres, Hankoff, Rayner and Hahn⁽¹⁾ being just some of the names involved in such studies. Results are inconsistent but literature reviewed by Fisher and Greenberg in association with their assessment of Freud's theories and therapy generally supports his opinion:

".... a patient's initial predisposition toward self-exploration would appear to have prognostic value". (2)

Perhaps even more significant to any form of psychotherapy is Freud's belief that the patient most likely to benefit from treatment or therapy is the one who acknowledges his illness and wants to be cured.

"He must find the courage to direct his attention to the phenomena of his illness". (3)

Freud's remark on 'courage' presupposes the patient's ability to attend to situational events and his own subjective responses, and to think about

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- (1) (a) A. Eskey, Insight and Prognosis, Journal of Clinical Psychology, 14, 1958, pp.426-429.
 (b) E. L. Linn, Relevance of Psychotic Patients' Insight to Their Prognosis, Archives of General Psychiatry, 13, 1965, pp.424-428.
 (c) R. T. Childers, Jr., Prognostic Significance of Insight in Schizophrenia, American Journal of Psychiatry, 119, 1962, pp.361-362.
 (d) L. D. Hankoff, Englehardt, Freeman, Mann and Margolis, Denial of Illness in Schizophrenic Outpatients: Effects of Psychopharmacological Treatment, Archives of General Psychiatry 3, 1960, pp.105-112.
 (e) E. H. Raynor and H. Hahn, Assessment for Psychotherapy: A Pilot Study of Psychological Test Indicators of Success and Failure in Treatment. British Journal of Medical Psychology 27, 1964, pp.331-342.
- (2) Fisher and Greenberg, op.cit., p.377.
 (3) Freud, Complete Works, Strachey, J. (Ed.), Vol.12, p.152.

them logically. There could be role-play value on both scores, promoting the recall and reconstruction of events surrounding problematic behaviour and encouraging as high a degree of accuracy and honesty in the reporting of those events as possible.

This requires that the atmosphere and attitudes within the role-play group should not inhibit a patient's honesty but should encourage his truthful disclosure of facts no matter what the implications may be with regard to his own personality or competence.

When reviewing the goals in Freud's therapy, Ford and Urban said "The purpose of analysis is not to free the individual from the conflicts of living". (1)

In presenting role-play to patients as a 'safe area' of simulated situations in which past behaviours can be reconsidered and present and possible future behaviours can be explored, the leader may need to make it clear to participants that they are not being offered a panacea for all ills. Freud insisted that people who thought advice and guidance concerning conduct in life were basic elements of his psychoanalysis were misinformed. Similarly, through out the direction of role-play events, the leader may need repeatedly to point out that the activities are designed to allow experiences via which "we want nothing better than that the patient should find his own solutions for himself". (2)

Although finding 'his own solutions' through Freud's advocated techniques, may have involved his patients in the discovery and reconciliations of the contradictory influences of innate urges and conscious, thoughtful control of behaviour which may be related to environmental circumstances, he did not suggest that these situational events were instigators of behavioural responses. Freud considered man's behaviour to be predominantly the product of instinctual energies of sex or aggression (or associated, sublimated

(1) Ford and Urban, op.cit., p.162.

(2) Freud. A General Introduction of Psychoanalysis, Garden City Pub. Co., 1943, p.376.

drive) pursuing self-gratification but subject to modification by environmental factors.

The role-play leader will need to look beyond the theory and therapy of Freud to find much emphasis on the role of situational events in the determination of behaviour. It was the post Freudian thinking of ego-analysts such as Hartmann and Rapaport which began a tendency to demote the role of innate urges in normal behavioural development and balance this with a greater degree of influence attributable to environmental events.

Freud's theories of innate psychological energies as prime elicitors of human behaviour, were challenged by supporters of an interpersonal relationships alternative such as Harry Stack Sullivan.

"One never observes such impulses and drives. What one does observe is a situation 'integrated' by two or more people, and manifesting certain recurring kinds of behaviour". (1)

Sullivan advocated the use of the therapist-patient interview situation to explore these 'integrated' situations which were part of the patient's history. He stressed the importance of the influence of family relationships and later encounters with influential adults and peers, in affecting the patient's current interpersonal behaviours. Bringing these to awareness was one of his main objectives, though techniques for doing so he believed must be flexible and appropriate to the specific patient and situation.

This reminder, that no one method is necessarily ideal for all patients is important for the role-play leader. Even to what extent the therapist relies on a patient to work solutions out for himself or alternatively offers advice may well depend on the therapist's perceptions of a patient's ability or willingness to think through the events of his life and future implications.

Sullivan is as ambiguous as Freud saying:

"The task of both patient and therapist is to work toward uncovering those factors which are concerned in the person's recurrent mistakes, and which lead to his taking ineffective and inappropriate action. There is no necessity to do more". (2)

(1) Harry S. Sullivan, Conceptions of Modern Psychiatry, William Alanson White Psychiatric Foundation, 1947, p.245.

(2) Sullivan. The Psychiatric Interview, New York; Norton, 1954, pp.238-239.

Yet in the same volume Sullivan talks of a "prescription of action"⁽¹⁾ -

"a course of events in which the interviewee might engage and which, in the interviewer's opinion, in view of the data accumulated, would improve his chances of success and satisfaction in life".

Regardless of the leader's personal decision on whether or not to recommend future action for the patient, Sullivan's emphasis on an inquiry into the influence of personal relationships, past and present, particularly family and marital relationships, remains very significant to role-play aims and decisions.

One much lesser recommendation of Sullivan illustrates a detail of procedure which may be picked up by a therapist. He suggests that the continuing long-term effect of the therapy may need to be reinforced by positive evaluation by the patient, i.e. he must be able to see benefit in the activities, the time and effort must result in some perceived "pay off". The use of a non-role-play technique, such as a direct enquiry into the value of the sessions, as assessed by the patients, may improve their effectiveness. Giving the therapy this boost, then becomes a technique criterion.

Although Sullivan and other supporters of an interpersonal view of human development such as Otto Rank did not believe man was the pawn of involuntary innate forces, neither did they accept that external conditions were the sole influence on human behaviour. Individual characteristics of temperament and cognitive approach to a situation they believed to be important to outcome of response.

Rank emphasised the element of choice in any situation and the concept of will as a guiding force. He stressed the view that some people have difficulty making decisions, are apprehensive about new experiences, and are reticent and unwilling to oppose the opinions of others, seeming dependent and unable to assume responsibility. He drew similar attention to the other extremes of people who could not accept authority, rejected rules and the

(1) Sullivan, op.cit., p.212.

demands of their society, and made excessive demands for their own rights or wishes to be observed.

My experience of role-play with children and with chronic, institutionalised patients repeatedly focused on topics related to the resolving, or almost as importantly, the drawing of attention to imbalance between self-will and the recognition or regard for the feelings, wishes or rights of others, or for the social requirements of the environment. If adjustment to the realities of social contacts is an important goal of the rehabilitation experience, role-play could help to illustrate, and prompt people to examine, the contrasting aspects of social situations and could pose questions such as - when is it appropriate or effective to assert an independent decision, possibly to the extent of requiring some environmental change, and when is it appropriate and effective to accept a social norm or perhaps adjust one's own behaviour and attitudes to accommodate the will or needs of others?

This of course raises the issue of moral or value judgements, social acceptability and who sets the standards. Just as role-play of itself will not resolve problems but may be just one way of opening up a problematic situation to elicit experience about solutions from the group of people present, so in my view no one individual can presume, or be expected to decide, right and wrong. A group leader may at times need to remind himself and others in the group that he is not there to sit in judgement but rather to present the facts from which judgements may be made.

Rank drew attention to the behaviour of other people as an important modifying influence. Bringing this interactionary process and its effects, to the awareness of his patients and encouraging more purposive attitudes was an important part of his therapy.

He held the view that many neurotic symptoms arose from excessive self-criticism, saying that among the neurotic's habitual thoughts were those:-

"representing an extreme judgement, a condemnation of himself"⁽¹⁾

(1) Otto Rank, Will Therapy and Trust and Reality, N.Y., Alfred Knopf, 1945, p.193.

Redressing this balance in the judgement of self and other people was seen by Rank as a key to behavioural change.

Similarly, Alfred Adler's methods encouraged people to rid themselves of their feelings of inferiority. In this area of establishing self-reliant attitudes there is considerable overlap of opinion between Rank and Adler. Positive orientation to events and encounters, and the development of assertive behaviour seems an appropriate role-play aim for many patients on the threshold of more independent living.

It was Adler who emphasised the significance in human development of "goal directed" behaviour. He stressed the importance to the individual of thoughts about future events and the setting of believable goals. He viewed the anticipatory stage, of estimating results of certain outcomes of action in terms of future satisfactions, as very influential in the selection of behaviours. It may be helpful to use role-play to stimulate some patient interest in, and positive move towards, an anticipated outcome or realistic goal beyond ward life.

Other areas of overlap in opinion in the theories and practices of Rank and Adler seem relevant to the objectives set at the commencement of a role-play project in a rehabilitation unit.

Both believed in the empathetic identification of the therapist with the feelings and motivations of the patient in order to improve his understanding of reported facts.

"The therapist has to be able to take the role of the other and approximate in his own responses those which seem to be occurring to the patient" (1)

being Ford and Urban's interpretation of Adler's requirement in a therapist.

"Rank, as well, stressed the person's integrating powers and the necessity for understanding the client's feelings and potentialities". (2)

(1) Ford and Urban, op.cit., p.355.

(2) Brammer and Sostrum, op.cit., p.40.

Should putting oneself 'in the shoes' of a patient be considered a worthwhile aid to the leader's understanding of patient experience or behaviour, it should be possible to use role-play methods to approach this type of identification.

Rank and Adler again both suggested that there must inevitably be some approximation in any attempt to share or perceive the experience of another. Adler implied that the therapist may need to infer or guess, from the patient's own reporting of events and from his responses in the session, what his internalised responses (feelings) might be. The patient might not be able or willing to express his feelings verbally or describe events accurately in role-play sessions. The leader may therefore find that not only in efforts to understand the feelings which prompt observable behaviour but also in forming any impressions of past behaviour and associated circumstances, a degree of intuitive guessing may be required. Guided by such inferences, the leader may be able to clarify or verify the motivations or events eliciting behaviour by further role-play. Such amplification may improve his own awareness, that of concerned observers, or that of the patient himself.

The role-play leader frequently acts intuitively to use his methods in what he believes to be an appropriate way to benefit participants. Later he may discover that the action which he felt was right at the time can be substantiated in some recognised theory of psychotherapy.

Seeking support for his own experience, the leader may tend to take a positive rather than a critical look at associated psychological theories and treatments and select from them ideas which are congruent with his own. Although aware of differences in psychotherapy and of their contrary implications in his own work, common elements in therapy systems become more convincing indicators of possible aims for him.

Ideas common to Rank and Adler have already been mentioned but other concepts of Rank in particular, seem to anticipate more recently developed positions on the learning and unlearning of disordered behaviour and may

indicate guidelines to effective role-play practices.

Rank believed that the relationship between therapist and patient could both reflect the patient's responses in other interpersonal events outside the therapy session, and by dealing with responses as they occurred, could be used to encourage appropriate response patterns, first in the therapy situation, but subsequently in similar encounters outside therapy. It was essentially concerned with behaviour as it occurred in the present. Unlike Freud and Sullivan, Rank did not believe that knowledge of causal factors helped to promote improved behaviours - on the contrary, he argued that it allowed the patient to deny responsibility for present behaviour. Present behaviour, he suggested, should be viewed by the patient in relation to his social environment, involving appraisal and anticipation of outcome. Similarly, George Kelly in his personal constructs theory, suggested that man continually predicts his responses and tests these responses against the environment and vice versa.

Kelly proposed that:

"Essentially, abnormal behaviour is seen as an inability to understand and anticipate reality He does not have the appropriate constructs by which to judge events accurately". (1)

Role-play situations can be used to supplement reality, aiming to represent conditions and reactions as they may occur in the patient's 'real' world.

The leader, by setting up believable role-play situations, can provide the patient with a realistic background against which to try out his 'constructs'. The patient is then offered the chance to work out a hypothesis, where consequences are only imaginary and alternatives may need consideration. Kelly himself suggested using make-believe to approach truth, and as a way of coping with threat.

"The point that needs emphasis, it seems to me, is that the hypothesis serves to make an unrealistic conclusion tenable, or tenable for a sufficient period of time for the person

(1) George Kelly, in John Medcof and John Roth, Approaches to Psychology, Open University Press, 1979, p.271.

to pursue its implications as if it were true. The fact that it is regarded as a hypothesis, and as a hypothesis only, has great psychological importance in man, for it enables him to break through his moment of threat. It is after all, only make-believe". (1)

This idea of the individual being able to cope in make-believe with conditions which, in reality, could provoke anxiety does echo the previously considered use of simulated situations to induce 'signal anxiety', as described by Freud, to allay extreme real tensions. Such theories suggest there could be value, in role-play, of the handling of emotions and of encouraging improved cognitive functioning in emotive circumstances.

Appropriateness of behaviour was central to Kelly's fixed-role therapy, in which the patient was asked to act like a fixed-role sketch which represented the type of person the patient would like to be. The sketch was devised by a team of clinical psychologists from relevant data supplied by the patient and was designed to be a beneficial role model for the patient.

A decision to employ this 'fixed-role' type of strategy in either a prolonged, detailed programme, as described in Kelly's writings, or even in a much briefer investigation into a patient's desired self-image, would obviously greatly affect the choice of suitable role-play techniques.

Kelly, Rank and Adler, in their individual approaches to psychotherapy, were all concerned with behaviour as it occurs in the present and were only interested in past events and responses as indicators of changes which may benefit the patient in the future. The use of role-play in accord with their therapies would not be focused on the discovery of possible repressed causes of inappropriate behaviour.

Kelly and Adler seemed to regard psychotherapy as a process to change outlook; to influence attitudes to various aspects of life. Role-play, to accommodate their theories, would be a planning medium in which to establish models and goals.

Rank was far more directly concerned with patterns of behavioural

(1) George Kelly, 'The Language of Hypothesis: Man's Psychological Instrument', in Clinical Psychology and Personality. ~~Selected~~ Papers of George Kelly, Ed. B. Maher, Wiley & Sons, 1969, p.152.

responses; with actual performance or functioning in the here and now. His emphasis was on ways of affecting that functioning so that it more satisfactorily led to the patient's desired models or goals. He concentrated on the means not the end. Similarly role-play, if influenced by Rank's therapy, would be used to expose and, where advantageous, modify behaviour, so that patients may cope to their greater satisfaction in the future.

In the above case, the criteria which govern leader decisions may well arise from a behavioural learning approach rather than a psychoanalytic, insight approach to therapy.

Behaviourists suggest that:

"The symptom is the disorder. No underlying, unconscious causes are involved". (1)

Behaviourists explain abnormal behaviour in terms of maladaptive sequences which are acquired due to the reinforcement of inappropriate behaviours or the non-reinforcement of appropriate behaviour sequences.

If a role-play leader is guided by this assumption, he will aim to affect symptoms directly.

The amount of fore-knowledge available to a role-play leader in a hospital unit on how each member of the group has related to any chosen topic is extremely variable. The leader may need to rely heavily on hospital personnel for sufficient initial information about patient history to guide the selection of relevant topics, and the handling of the interpersonal situations which might arise (both in and out of role-play activities).

Retrospective information about behaviour, whether reported verbally by hospital staff or appearing in a patient's medical notes, tends to be generalised. Even when specific incidents are reported they are subject to the interpretation of the reporter. Details of past experience and actions provided by the patient himself may equally be affected by his opinion of himself and the image he wishes to present to the world.

It may be therefore that background information about patients (even if available) can only indicate general trends in behaviour to indicate suitable

(1) Medcof and Roth, op.cit., p.264.

topics or starting points, and that predominantly the role-play leader will be working with patients as they are; working in fact from the symptom end of the illness continuum.

Measures designed to eliminate the symptoms of abnormal behaviour and others to induce the formation of more appropriate, adaptive sequences give rise to many types of behaviour therapy.

The theoretical bases of behavioural learning were in most instances investigated initially in experiments with animals. From the application to man of suggested learning principles emerging from the observation and manipulation of animals, the ever-expanding field of behaviour therapy has developed.

Behaviour therapy is defined by Eysenck as:-

"the attempt to alter human behaviour and emotion in a beneficial manner according to the laws of modern learning theory". (1)

Richard and Barbara Lanyon's definition reads:-

".... behaviour therapy involves primarily the application of principles derived from research in the psychology of learning to the alleviation of human suffering and the enhancement of human functioning". (2)

Advocates of the use of behaviour therapy continually emphasise the importance of a specific knowledge of individual patients and their problems if the process is to succeed. Regardless of the strategies to be employed, their effectiveness appears to require individual planning to meet particular needs and the setting of individual goals. Effectiveness may also be relative to the degree of control over the patients' environment which is possible. As behaviour and circumstances change the strategies also may need to be revised.

Should a role-play leader decide to use role-play techniques in a structured programme of behaviour therapy, planned to benefit an individual

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- (1) Hans Jurgen Eysenck. The Nature of Behaviour Therapy, Experiments in Behaviour Therapy; Pergamon Press, 1964, p.1.
 - (2) Richard I. Lanyon and Barbara J. Lanyon. Behavioural Assessment and Decision-making: The Design Strategies for Therapeutic Behaviour Change in M. Philip Feldman and Anne Broadhurst Theoretical and Experimental Bases of Behaviour Therapies, Wiley and Sons Ltd., 1976, p.289.

patient, clear guides to design suggested by R. and B. Lanyon indicate that criteria to influence technique selection may arise from:-

- the need to observe and define behavioural problems, i.e. the conditions under which they occur; their frequency and their consequences
- the assessment of available resources, i.e. establishing the capacity of the patient for self-observation, self-regulation and imagery skills, and the potential effectiveness of the techniques as reinforcers
- the need to gain the fullest possible co-operation of the patient and his agreement on what end products can be realistically achieved.

This would obviously involve a very specialised use of role-play and such a programme would need to be devised and implemented in close conjunction with hospital doctors and ward staff. As consistent reinforcement is so important a part of behavioural change projects, the reaction of all role-play group members (staff or fellow patients) would need to be regulated. For maximum effectiveness it may be necessary to extend environmental control far beyond the actual role-play sessions. This degree of interference with patient activities and the normal functioning of a rehabilitation unit may not be possible or acceptable.

If the full process of a behavioural learning programme, using role-play as a means of behaviour modification, is not a recommended or a workable procedure, a more general application of 'principles derived from research in the psychology of learning' may still affect role-play practice.

As previously stated, measures designed and found effective in the promotion of behavioural change include both behaviour elimination methods and behaviour formation methods.

Two elimination methods, which may have role-play implications are 'flooding' and 'desensitisation'.

Flooding is a technique, which in animal experimentation has proved effective in the elimination (sometimes called 'extinction'), of both active

and passive avoidance responses.

Flooding techniques include such procedures as involving the subject in so much physical and mental activity at the time of confrontation with the feared stimuli that the time for considering avoidance is reduced to a minimum, or introducing some method of blocking the avoidance response while maintaining the subject's tolerance of the feared stimuli, or even removing the subject's escape route from the feared circumstances altogether. In human psychotherapy such methods have been used in the treatment of phobias and such conditions as alcoholism and anorexia nervosa. Flooding procedures suggested by Morrie Baum are said to involve:

".... modelling and observation where the patient observes the therapist approaching and in contact with the object of the phobia". (1)

If role-play was to be used to try to modify a patient's handicapping affective responses to help him to cope with fears or anxieties, or to eliminate compulsive behaviours, the leader may decide on a situation involving the patient's direct encounter with conditions said to promote anxiety, or he may choose to promote the patient's observation of someone else dealing with the feared stimulus, using himself or another group member as the third party model.

Although experiments are inconclusive there does seem to be some evidence to suggest that shorter, distributed flooding experiences are slightly superior to prolonged, massed flooding in that they lead to faster extinction. The optimum duration and frequency of role-play flooding activities may therefore become decision criteria.

Desensitisation also involves exposure to feared circumstances in controlled conditions. It is rather more complex than flooding in that it usually includes a carefully programmed build-up of prior exposure to circumstances associated with the main fear but perhaps less intensely

(1) Morrie Baum. Instrumental learning: Comparative Study in Feldman and Broadhurst, op.cit., p.115.

experienced. Role-play developed in this way, through progressive episodes leading the patient toward coping favourably with his anxious encounters, imposes a pattern of approach and content on the leader.

Reciprocal inhibition - Joseph Wolpe's theory which underlies the operation of desensitisation, was based on the assumption that it was possible to associate a response antagonistic to the response to be eliminated with events which had previously elicited that inappropriate behaviour. Wolpe suggested that if the old, unwanted response was to occur less frequently and the new more desirable response was to be progressively more evident, in the learning stages the response to be learned must be more strongly experienced than the one to be eliminated.

The role-play leader may therefore decide to proceed in the belief that the pleasures and satisfactions of joining in role-play activities should, in the early stages, far outweigh any anxieties evoked. This may have its effect on the choice of topic and any pressure imposed on participants. Possibly only when positive feelings about role-play involvement and benefits have been established, should any topics or procedures about which patients are in the least apprehensive be approached.

In the use of both desensitisation and flooding procedures, the chances of eliminating an avoidance response are said to be increased by keeping the subject in calm, rather than an agitated state, prior to and during exposure to the feared object or situation.

Behavioural learning techniques, as a therapy for man, have often been applied in conjunction with hypnosis. Joseph Wolpe himself used hypnosis and muscle relaxation techniques in his treatment. Such extremes may be inappropriate in role-play sessions but it may be beneficial to use techniques intended to induce physical, muscle relaxation before and/or between the tense moments of role-play experiences. The reduction of patient apprehension, by providing a secure, supportive atmosphere seems even more important.

The value of a supportive environment is frequently emphasised by behavioural therapists. Reinforcement of appropriate behaviours by

environmental factors links elimination methods with the formation of new, more desirable behaviours.

The principle of selective positive reinforcement (the basis of Skinner's operant conditioning procedures) is essentially the provision of rewards for desirable behaviours and the withholding of them for undesirable behaviours.

A controlled environment was a prerequisite of Skinner's theoretical and experimental analysis of animal behaviour. C. B. Ferster, in using Skinner's work as a framework for his paper on changing the behaviour of psychiatric patients, acknowledges the unlikelihood of total control of a patient's everyday environment but suggests that only partial manipulation of a patient's actual environmental events may greatly help in maintaining new adequate performance.

Tangible reinforcers, such as money, gifts, or tokens both exchanged for material reward or privilege, may seem too much like bribery for a leader or hospital staff to approve their use. C. B. Ferster ranks social approval highly as an effective reinforcer. He adds this description:-

"social approval, for example, refers to a high disposition to supply favourable consequences to a wide range of behaviours of the individual; and conversely, a low disposition to arrange punishments". (1)

The role-play leader throughout a session and any other social contact with patients is at least able to control his own disposition to the supply of favour or punishment in response to a patient's actions and may also be able to directly or indirectly influence the response of fellow patients and staff. There are ways of showing approval or disapproval and for the leader, such means may be deemed techniques. Ferster has no doubt about which is preferable - approval or sanction.

(1) Charles B. Ferster. Reinforcement and Punishment in the Control of Human Behaviour by Social Agencies, in Eysenck, op.cit., p.190.

"The role of positive reinforcement and its corollaries in determining behaviour is emphasised over aversive control". (1)

The values of praise and encouragement are unlikely to be new to anyone transferring the use of learning aids from the classroom to the rehabilitation ward. Their effectiveness can only operate if the activities arranged permit the success to warrant the reward. So that tasks set in the early stages should be within the range of patient ability and identification. The leader needs to present:-

".... a program which allows for more adaptive behaviours to emerge so that reinforcement can be provided". (2)

Trying to ensure this type of suitability is bound to influence leader decision and become a selection criterion. Ferster points out the significance of the possible history of environmental response common to many psychiatric patients.

"Many psychiatric patients or potentially psychiatric patients may be characterized as having repertoires whose performances are not producing the reinforcements of the world; because too much behaviour is being punished; because nearly all of the individual's behaviour is maintained by avoiding aversive consequences rather than producing positive effects; or a combination of all of these". (3)

Ferster envisaged benefit for patients in group therapy in which they could use each other, under the direction of a therapist, to develop skills necessary in normal social practice. In such a group, reinforcement may come from the patients themselves as well as from the leader.

The observation of selective positive reinforcement applied to other members of a role-play therapy group, both in the context of their role-play enactment and as a result of it, may have an affect beyond the actual recipient. Role-play performers, by accident or design, become models and the response of others to them becomes a supplement to the observation of what they actually do.

(1) Ferster in Eysenck, Op.cit., p.189.

(2) Medcof and Roth. Op.cit., p.269.

(3) Ferster in Eysenck. Op.Cit., p.191.

Advocates of the use of deliberately designed modelling to teach new behaviours recognise the importance of reinforcement of the model. Its effectiveness in the behavioural modification of the observer is commented on in many studies, from the early work of Miller and Dollard,⁽¹⁾ to the more recent projects of Hersen, Kadzin, Bellack and Turner.⁽²⁾

A role-play leader may need to plan his work to allow such secondary reinforcement to occur.

Hensen, Kadzin, Bellack and Turner's 1979 report, on the modelling of assertive, independent behaviour, is one of many to appear in recent years. Evidence from these suggests that modelling is capable of promoting assertive behaviour in "subjects who are socially overinhibited".⁽³⁾

There is also a consistent view, that 'practice', 'rehearsal' or 'role-playing' used in conjunction with modelling is likely to boost its effect.

Appropriate use of observation of, and participation in, therapeutic modelling may effect both a role-play leader's long-term planning and spontaneous, face-to-face decisions.

Establishing independent behaviour, whatever the 'set of practices' chosen to promote this end, emerges as a commonly recommended therapeutic goal. Perhaps the most radical view of personal growth and an individualistic approach to life, is expressed by the humanists. Their existential ideals bring independent decision and will to the forefront of therapeutic aims.

The humanist movement seems to see mental illness as thwarted growth and the humanist approach to therapy is one of removing impediments which prevent the development of a fully functioning individual.

A fully functioning individual according to humanist criteria would be one who is able to appraise and evaluate their own experience in relation to their total environment. Their decisions and behaviour would stem from their

(1) Neal E. Miller and John Dollard, Social Learning and Imitation. Yale University Press, Newhaven, 1941.

(2) Michael Hersen, Alan E. Kadzin, Alan S. Berlack and Samuel M. Turner. The effects of Live Modelling, Covert Modelling and Research on Assertiveness in Psychiatric Patients. Behaviour Research and Therapy, Vol.17, No.4, 1979.

(3) Feldman and Broadhurst. Op.cit., p.210.

personal judgements and mental health would result from the satisfactory integration of individual will and the world in which they exercise that will.

Rank's concept of 'will' extended beyond Adler's will-to-power and Freud's innate drive, to a more humanistic view of:-

".... an autonomous organizing force in the individual which does not represent any particular biological impulse or social drive but constitutes the creative expression of a total personality and distinguishes one individual from another. This individual will, as the united and balancing force between impulses and inhibition, is the decisive psychological factor in human behaviour". (1)

The use of role-play to aid the rehabilitation of psychiatric patients may for some be primarily concerned with experiencing or re-establishing 'an autonomous organizing force', while for others the need may be seen as affording an opportunity for individual appraisal of self-will and its effect, as perceived in social situations which may be based on specific real incidents or merely hypothetical. The humanist approach to therapy is concerned with the individual's perceptions of his environment; with his sensing of the way things appear to be.

Rogarian theory takes account of the important role of environmental reinforcement and the need for positive regard. When an individual becomes aware that others are responding to him with positive affect, i.e. smiles, approval, affection, it produces in him the positive effect of satisfaction.

"His evaluative judgments of his own behaviour - all of which he can attend to and think about - will rely primarily on the direct awareness of whether it leads to positive or negative affect rather than on whether others dislike it". (2)

The above quotation raises two points for the role-play leader, firstly, that a patient may need prompting and practice to 'attend to and think about' his evaluative judgements, and, secondly, that a patient with an adamant sense of inferiority may need to be continually encouraged to evaluate his own functioning according to the direct response of his peers to him - not according to what he believes their opinions of him to be.

(1) Otto Rank. Beyond Psychology. Dover Pub., p.50.

(2) Ford and Urban. Op.cit., p.413.

Two of the most prominent humanists, Carl Rogers and Abraham Maslow, shared the opinion that whether a problem lay within the individual or in the environment the attitude that one could not change the present state was unacceptable. Striving to remove the obstacles and resolve the problem required a clear look at both self and environmental circumstances. Reconciling an individual to himself did not mean doing nothing but only establishing the present reality from which to work for a change for the better, within the individual, or within the environment.

Psychotherapy in humanistic style, as envisaged again by Otto Rank, was concerned with self-acceptance and positivity in attitude.

".... psychotherapy can only be based on an individualistic psychology, that is, should strive to adjust the individual to himself, which means enable him to accept himself. Such self-acceptance, regardless of the "milieu" does not imply resignation, it rather signifies a new start, making it possible for the individual to do the best with himself in and with his environment".

Role-play used accordingly would therefore be aimed at revealing to the patient his own attitudes and problems and using this base to begin a search for solutions and improvements.

A role-play encounter may therefore be designed to draw attention to the fact that, (a) there is a problem (not to be side-stepped,) (b) to effect solutions may be within the scope of the individual himself, (c) working out those solutions may involve an honest look at the patient's experience and behaviour, and an examination of all pertinent surrounding factors. The role-play leader in setting up a role-play situation to meet any of the above criteria, may not necessarily do so with a single purpose. Aims continually overlap and one piece of role-play may simultaneously reveal many aspects of a problem. Which aspect of any role-play situation is followed up is likely to depend on a perception of need.

If action is based on Rogerian thinking, the paramount need at any point in a therapy session would be that of the patient, and Rogers would

(1) Rank. Op.cit., p.51.

further recommend that that need was as perceived by the patient, also that the patient himself should largely determine the goals and hence the action in the therapy.

At the least such a degree of 'client centeredness' requires much rapport between patient and leader, and a wish to encourage discussion of feelings, events and aims becomes yet another decision criterion. Pursued to an even greater degree, the client centered attitude of a therapist, or role-play leader, may require him to relinquish leadership and hand the responsibility for directing events over to the patient himself.

Acceptance by a patient of some degree of responsibility for decisions and direction in a role-play session may become an important part of the therapy process.

When the concept of responsibility for self is taken even further in encouraging the patient not only to exercise his choice in his decisions and actions but also to acknowledge his own responsibility, one is bringing into the psychotherapy process one of the main principles of existentialist thinking.

It does not seem possible, from literary sources, to label any set of practices as 'the existential method'. Indeed, techniques in existential-type psychotherapy seem obscure and are possibly irrelevant as the approach is concerned not with methods but with attitudes.

More than in any of the previously discussed types of therapy or counselling, existential psychotherapy is concerned with applying and sharing a philosophy. It embraces the humanistic, phenomenological approach to patients (or clients - the name which seems in accord with the tone of the relationship with the therapist and is acceptable whether the process is part of a medical programme or not). It emphasises the importance of discovering the way things appear to the individual, and of developing strategies according to the patient's perception of the situation. It sets out to facilitate and develop awareness in current experience and is likely to move away from problem solving to an aim of allowing the individual opportunities for self-discovery and self-functioning through which he may

experience the reality of his own existence, hopefully recognising his responsibility for the decisions and effects of that existence.

The means of achieving the therapeutic experience as advocated by the existentialistic practitioners seem to be subordinate to the nature of the client/therapist relationship itself. What the qualities within that relationship ideally should be is not specifically defined but it is repeatedly suggested that the therapist should not view his client simply as an object to be analysed but as an individual to be understood as he exists inside. It is inferred that not only does a close, empathetic identification with clients improve the effectiveness of the techniques used by the therapist, but that it may, in itself, be a therapeutic element in treatment.

"The fundamental contribution of existential therapy is its understanding of man as being the existence of this particular being sitting opposite the therapist". (1)

Rollo May⁽²⁾ itemises some of the emphases which characterise existential approaches to therapy. The laying of similar emphases in the direction of a role-play session would reflect an existential orientation in the establishing of criteria for technique selection.

The emphasis would be on:

1. Versatile and flexible techniques to meet the individual's needs at that moment in his history.
2. Credibility being given to some psychoanalytical theory involving procedures such as repression, resistance and transference, but in relation to the patient's immediate life.
3. A prime concern with the 'here and now' situations of the patient's life and a therapist who viewed the patient as a being to be understood - not an object to be analysed.
4. A therapist who did not allow focus on behaviour mechanisms to impede the development of a personalised relationship with the patient.

(1) W. Van Duser. The theory and practice of existential analysis. Amer. Jour. of Psychotherapy. 1957, 11. pp.310-322 in Cecil H. Patterson. Theories of Counselling and Psychotherapy, 1973 (Harper and Row), p.418.

(2) Rollo May. Contributions to existential psychotherapy. Ed. May, E., Angel, D., Ellenberg, H. F., N. York. Basic Books, 1958, pp.37-91 in Patterson. Op.cit., p.421.

5. The aim in therapy that the patient should experience his existence as real, i.e. that he should become aware of his potentialities and be able to act on them. Therapy should proceed not by telling or even showing the patient that which he has failed to realise, or the future alternatives that may come to exist, but by trying to facilitate his experience of these in as radical a way as possible.
6. The commitment of the patient to his own responsibilities in decision and action.

The techniques used by existential psychotherapists seem to have been similar to those employed in other systems of psychotherapy. What does differ is not the method but the intention. Binswanger and Frankl are two psychotherapists who at times used psychoanalysis techniques, not for the purpose of analysing present behaviour in the light of the past, but rather to increase the awareness of therapist and client in the 'here and now'.

Frankl in his own work developed and defined two specific techniques; 'paradoxical intention' and 'de-reflection'. These appear very similar to Wolpe's de-conditioning techniques but the end product, as seen by Frankl was not simply a newly-conditional response to a particular set of circumstances but the patients' acknowledgement of his part in the choice of action which became his response.

"The patient shall objectivise his neurosis by distancing himself from his symptoms the patient shall call on man's spiritual capacity to resist, and by his inner freedom to choose a specific attitude in any given situation". (1)

When considering existential philosophy the ideas contributed by Frankl seem particularly significant and warrant special consideration by anyone contemplating a form of group therapy which will encourage discussion. Should the issue which are central to Frankl's theory be raised in therapy its director would need to establish his attitude to them, either spontaneously in situ, or as part of his anticipatory frame of reference.

(1) Viktor, E. Frankl . Seminar in logotherapy conducted at Harvard University Summer School 1961 in Patterson, op.cit., p.451.

Frankl called his theory and practice 'logotherapy'. It was concerned mainly with the aspects of man's existence touched on in the above quotation.

- (1) Man's inner freedom and responsibility
- (2) Man's spiritual capacity

Frankl's philosophy grew mainly from his experiences in concentration camps. He was impressed by man's efforts to preserve independence of mind and to help others rather than self even in terrible conditions.

"The sort of person the prisoner became was the result of an inner decision, and not the result of camp influence alone. Fundamentally, therefore, any man can, even under such circumstances, decide what shall become of him" (1)

Such a conviction of the possibility of counteracting environmental influence may be very relevant when working with people with current or recent experience of living in any kind of institution.

Frankl suggested that 'inner freedom' was not only freedom 'from' but freedom 'to' something - from which developed the concept of commitment to one's responsibilities.

Frankl's philosophy included an acknowledgment of a spiritual dimension in life, from which conscience in man was derived. He also acknowledged possible commitment to religion and extends the range of man's responsibility, to himself, to his conscience, or to his God.

"Logotherapy tries to make the patient fully aware of his own responsibilities; and therefore it must leave him the option for what, to what or to whom, he understands himself to be responsible". (2)

Frankl maintains that in therapy philosophical/spiritual problems cannot be avoided. Should such issues arise they cannot, or should not, be side-stepped by focusing on pathological roots or consequences. His view is that psychotherapy is exceeding its scope in dealing with such problems and that

- (1) Frankl Man's Search for Meaning (rev.ed.), N.York: Washington Square Press, 1963, pp.105-106 in Patterson, op.cit., p.430.
- (2) Frankl, op.cit., p.173 in Patterson, op.cit., p.431.

'logotherapy' must supplement psychotherapy. He acknowledges that in practice the two cannot be separated.

It seems feasible that in a therapy that is open to the investigation of a wide range of life experiences which are of interest and concern to patients, philosophical/spiritual questions are likely to be presented and whether the therapist feels he is operating in the area of psychotherapy or logotherapy is largely irrelevant. What is important is the way in which he deals with such questions. It faces the therapist with his own decision on how much he could, should or would associate or divorce his personal views from discussion, and of course, whether he would encourage discussion to run at all.

Summary of criteria for technique selection

According to FREUD's Psychoanalysis theory the need may be:

1. To use role-play to establish the patient's responses to relevant stimuli - in the present simulated situation.
2. To stimulate patient recall and illustration of past responses, in real experience, to various stimuli.
3. To attempt to modify response to a stimuli in a role-play situation.
4. To bring the nature of his responses to the awareness of the patient himself or to that of people concerned with his treatment.
5. To draw attention to the stimuli which can evoke certain responses.
6. To draw attention to the consequences of certain responses.
7. To attempt to reveal original sources of conflict or concern which may account for unexplained 'negative affects' (repressed responses).
8. To offer a rehearsal ground for the handling of anxiety and developing appropriate behaviours to relieve the tension created.
9. To stimulate a milder 'signal anxiety', without real consequences and avoid a future 'traumatic' experience.
10. Affording the opportunity for patients to handle emotions in a 'safe' 'controlled' context - particularly negative affects such as anxiety.

11. Preventing the creation of so much tension or disturbance of a patient that he absents himself mentally or physically from the therapy session.
12. To indicate the source of antecedent tension or the resultant symptoms.
13. (Attempting to "discover the unconscious in mental life" - possibly already covered in 4 and 7).
14. To use role-play to externalise inner 'preconscious' responses in a speech or action form.
15. To establish simulated situational events that will encourage the use and development of speech.
16. To encourage the practice of organising thoughts or speech logically to promote the manipulation of ideas and the consideration of new and alternative responses (problem solving).
17. To encourage communication and the narration of experience.
18. To provide an appropriate context for expressive speech and/or actions.
19. To afford the opportunity for patients to assess for himself situational events and his own behaviour in relation to that event.
20. To provide a qualifying experience to extend or confirm a previous set of circumstances or responses in the hope of advancing some new understanding or 'insight'.
21. To bring facts to the attention of a patient in order not to miss relevancies of role-play responses i.e. implications.
22. To encourage a positive attitude to treatment or recovery.
23. To encourage the recall, and accurate and honest presentation of events to the group.
24. To create an atmosphere which does not inhibit truthful disclosure.
25. To confirm the potential but also the limitations of the role-play experience.

SULLIVAN's - Interpersonal - (Cognitive and emotive) approach may lay emphasis on:

26. Establishing the important, influential relationships in patient's history.

27. Revealing the significance of interpersonal events and attitudes which seem to indicate a source of inappropriate patient behaviour.
28. Suggesting a course of action to improve patient's success and satisfaction.
29. Direct enquiry into the value of the role-play sessions.

RANK and ADLER's self deterministic principles and therapy recommendations may suggest the value of:

30. Encouraging self-deterministic attitudes via:-
31. The presentation and examination of the facts of a situation, drawing attention to the degree of assertiveness within that situation.
32. Promoting any desirable change in a patient's degree of assertiveness - possibly practising this adjusted attitude.
33. Sharing the responsibility of establishing values and making judgements with group.
34. Encouraging the making of decisions and the patient's positive orientation toward current and future encounters.
35. Stimulating ambition and the setting of goals.
36. Seeking to use role-play to identify more closely with a patient's experience or similarly encouraging another group member to do so.
37. Verifying an 'intuitive guess' in order to proceed appropriately.
38. The need to establish or confirm in 'present action' generalised, reported attitudes or behaviour.

KELLY's - constructs theory may suggest:

39. Establishing present attitudes and behaviours, supplementing reality with role-play.
40. Encouraging the patient to predict the effects of future behaviours.
41. Trying out predictions - hypothetically.
42. Encouraging cognitive control in emotive circumstances.
43. Discovering the type of person the patient would like to be - ('fixed role').

44. Exploring desirable behaviour in a variety of situations typical of 'fix role image'.

BEHAVIOURIST approaches to therapy may require:

45. Investigation into an individual patient's problems - conditions, frequency and consequences, etc.
46. Assessing resources - a patient's capacity for self-evaluation, use of imagery, etc.
47. Reaching agreement with a patient on realistic therapy goals and techniques.
48. Observing the effectiveness of a specific technique.
49. Placing a patient in an imaginary feared situation with the distraction of imposed physical or mental activity to minimise the opportunity of avoidance.
50. Facing the patient with feared situation and blocking avoidance.
51. Present the patient with a model of the leader or some other group member, coping with the patient's feared situation.
52. Setting up short, intermittent anxiety provoking incidents.
53. 'Experimenting' with duration and frequency of exposure to feared stimuli.
54. Setting up a role-play situation which relates to and anticipates contact with feared circumstances.
55. Ensuring that the role-play topic and technique chosen hold more pleasure than apprehension for the patient.
56. Encouraging patient relaxation and security.
57. Reinforcing appropriate behaviour.
58. Allowing the experience of praiseworthy behaviour.
59. Modelling adaptive behaviour.
60. Reinforcing a model.
61. Practising adaptive behaviours.

HUMANIST approaches to therapy may accommodate the need:

62. To encourage the development of an autonomous, organising capacity and self-reliant functioning.

63. To allow a patient's appraisal (evaluative judgment) of his own behaviour and its effects, as evident in a real situation or a hypothetical role-play situation.
64. To encourage the patient to take more notice of the direct responses of others to him and to speculate less about what he thinks others think of him.
65. To develop the patient's ability to view his experiences and behaviour critically and accept this as a reality.
66. To help him develop the ability to isolate his own problems or decide areas of possible improvement.
67. To encourage him to work out ways of increasing his own success and satisfaction.
68. To give him the opportunity to test and observe the effects of any changes in his own attitudes or behaviours, in a variety of social situations of his own choice at his own instigation.
69. To allow the discussion of individual progress or use of future strategies.

EXISTENTIALIST attitudes may suggest the need:

70. To improve the possibility of the therapist being able to perceive things as they are perceived by the patient.
71. To encourage the willingness of a patient to share his "inner world" with the therapist (associated with the building of trust and confidentiality in the relationship).
72. To extend his range of experience of what his world is, and has the potential of being.
73. To help establish some patient-awareness and acknowledgement of his responsibilities to and for himself.
74. To encourage patient consideration of for what, to what or to whom he is responsible.
75. To encourage patient consideration of the implications of the withdrawal of the restrictions and support of an institutionalised environment.

76. To allow the consideration of any dimension of man's existence that the patient may choose e.g. man's spiritual nature or his moral responsibilities.

So far I have attempted to summarise the major approaches to psychotherapy with a view to indicating the influences which they might variously have on the selection of role-play methods, techniques and expectations.

Firstly, I have discussed relevant elements in various identifiable approaches to the promotion of sound mental health and adequate social functioning, which could play some part in determining the attitudes and actions of a role-play group leader. From these implications I have subsequently tried to elicit quite specific criteria which, should they feature prominently in the setting of goals or the handling of situations, would suggest a possible trend towards a recognisable approach to psychotherapy.

Many of the systems discussed were practised and developed as patient/therapist interview types of individual psychotherapy. The suggestion made in the study is that the attitudes and therapy means involved may be equally relevant in the practice of group role-play.

Corsini refers to psychotherapy as:

".... a learning process which can occur autonomously as in self-therapy, in a dyadic relationship between patient and therapist, or in a group situation with a therapist and six to twelve patients". (1)

Role-play as therapy usually requires the interaction of two or more people and is unlikely to be a direct part of autonomous self-therapy. Role-play may be viewed as a suitable aid in the dyadic or group therapy situation when the person controlling the strategies could perhaps be described as a role-play 'director'. As it was a group therapy situation which was envisaged in the unit concerned in the study, it is more appropriate to refer to a role-play group 'leader', for in addition to the actual direction of the use

(1) Raymond J. Corsini, Roleplaying in Psychotherapy, Aldine Pub.Co., 1966, p.1

of role-play techniques, the leader of the group is also responsible for the overall functioning of the group. The non-role-play aspects of the group's functioning may be as important to therapy as the techniques themselves and are also subject to the handling of the group leader.

A role-play leader may be reluctant to accept the title of 'therapist' but once he begins to use his 'set of practices' to aid patient recovery he places himself in the position of a therapist and it is difficult in comparative discussion not to equate the two roles.

Like a therapist, the role-play leader may reveal his own philosophical or theoretical persuasions in his handling of his techniques and opportunities.

How clear a line toward any identifiable type of psychotherapy a leader's direction takes may vary with the individual practitioner and the stage of development of his individual way of working. He may have to explore methods and needs in the refining of the manner and means which currently work for him.

Clearly there is great diversity in concepts related to the nature and nurture of man and in the counselling or psychotherapy practices from which he may benefit.

There appears to be agreement in all approaches to psychotherapy on man's susceptibility to change and there is a shared recognition that the presence of disordered, disturbed, maladaptive behaviours, are painful and detrimental to the patient and that an attempt to change this state is justified and desirable.

The importance of the future is also generally acknowledged in therapy. From schools of operant conditioning to existentialism there is a shared view that behaviour is not entirely dependent on the past but is related to future expectations and consequences.

The greatest divergence in attitudes and techniques to produce psychotherapeutic change is perhaps between these schools of behaviour therapy and existentialism. Behaviour therapy appears to be objective, impersonal and reliant on techniques, while the existential approach is seen as subjective,

personal and concerned more with the relationship between patient and therapist than with techniques.

Existentialists will emphasise man's right to freedom of choice while behaviourists will argue that there cannot be any freedom if man is bound by his conditioned maladaptive behaviours and that reconditioning may be the best way to free him from these constraints.

In Patterson's review of psychotherapy theories, the view expressed is that:-

".... the trouble with the behaviour therapy or conditioning approach is not that it is wrong, but that it is incomplete as a description or theory of the nature of man and of his behaviour and its modification There can be no question about the existence of conditioning, about the fact that man is a reactive being who can be conditioned and reconditioned. But man is more than this. He is also an active being, an initiator of action. His behaviour influences his environment, as well as being influenced by his environment". (1)

Somewhere along this attitude and approach continuum each therapist - or role-play leader, will need to develop his own personal therapeutic process.

A study of past projects involving the use of role-play in therapy would show a diversity of aim and practice which illustrates the kinds of choices before a leader embarking on his own use of role-play in psychotherapy.

Three examples of role-play therapy exponents have been chosen to illustrate:-

A. The leader's expectation of the practices,

(2) The incorporation of various approaches to psychotherapy into the use of role-play to promote sound mental health and adequate social functioning.

One of the most psychoanalytically orientated applications of role-play was in the psychodrama of N. A. Polanski and E. B. Harkins.

In projects which were elements in hospital treatment Polanski and Harkins used their techniques basically to facilitate:-

(1) Patterson, Op.cit., p.532.

- (1) Affect discharge - self-disclosure in a safe environment.
- (2) Clarification - (a) Conscious material being seen in a new way by the patient
(b) Enlightenment of the therapist.
- (3) Interpretation by the therapist in pointing out significances as he sees them.
- (4) Insight - repressed material becoming conscious.
- (5) Identification of unintegrated and internalised objects - i.e. relationships which may have been repressed to form the origins of conflicts as analysed by the therapist.
- (6) Transitory regression - e.g. the reliving of past success to build present confidence, thereby undercutting feelings of failure.

Techniques were designed to encourage free association and expression of ideas and non-role-play discussion which was important to interpretation.

Exploration of personal relationships was concerned with display and explanation of the patient's early reactions to people rather than the development of personality traits through social interaction. The emphasis, as in psychoanalysis, was on the discovery and awareness the repressed causes of behavioural problems.

The much earlier work of Moreno, who pioneered the development of psychodrama and sociodrama, covered a wider range of approaches and practices than Polanski and Harkins.

Moreno as described by Greenberg is:

".... neither a neo-Freudian nor a behaviourist, but rather a psychological explorer whose postulates and the system he has devised from them place him somewhere between the two orientations". (1)

The principles involved in Moreno's psychodrama do suggest his amenability to a variety of approaches to psychotherapy.

(1) Ira A. Greenberg. Psychodrama, Souvenir Press 1975, p.11.

Moreno recommended the use of role-play techniques to help develop individual spontaneity:-

".... some degree of adequacy to a new situation or a degree of novelty to an old situation". (1)

Moreno's spontaneity exercises which were part of both his psycho and socio-drama encouraged creative, physical and verbal action. He suggested training and measurement of both the time taken to produce an action response, and of adequacy in dealing with prescribed situations by recording the mode and appropriateness of that response. His methods do seem to involve behaviouristic attitudes to behaviour modification to achieve more prompt effective functioning. He did, however, seem more interested in promoting an adequate or new reaction determined by the patient, rather than a conditioned effect devised by the therapist.

The situations in which the patients participated in Moreno's psychodrama encounters were designed to occur in what was the 'here and now' of patient experience. By working with circumstances as if they were occurring in present experience, concerned with present attitudes, was very much in accord with Sullivan's approach to psychotherapy. Although psychodrama and sociodrama were individually orientated to meet individual needs, they were inter-personal. As in Sullivan's theory attention was drawn to the roles and individual plays with reference to the roles significant others play, and the importance of this factor in determining personality.

Greenberg summarises the difference between Moreno's Psychodrama and Sociodrama, both of which involved the working out of interpersonal relationships:

"In both psychodrama and sociodrama, role-playing and acting out are important to the patient, but in the former the protagonist reacts to the persons in the roles of individuals who are meaningful to him, while in the latter, he reacts to person in roles of group symbols or stereotypes". (2)

(1) J. L. Moreno, Group Psychotherapy: A Symposium, Beacon N.Y., Beacon House, 1945, p.XII.

(2) Greenberg, op.cit., p.15.

Moreno's role-play investigation of interpersonal events was frequently aimed at revealing the unconscious and achieving insight. The psychoanalytic style objectives, he hoped may occur with the cathartic impact of the moment of involvement in the role-play or in subsequent discussion.

In discussion with patients, following role-play, Moreno advocated self-acceptance in a way which may ally his thinking with the humanistic phenomenological outlook in counselling.

His belief in the value of the reciprocal process of tele:

".... a mutual exchange of empathy and appreciation" (1)

occurring between patient and the role-play leader, again allies Moreno's ideas with a humanistic attitude to the therapy relationship.

Although the long-term objectives of psychodrama and the role-play it involved, as recommended by Moreno, may have a bias toward psychoanalysis, as he seemed to share certain attitudes ranging from behaviourist to humanist, some strategies may have been employed to meet selected aims from these contrasting approaches to therapy.

The use of role-play in drama therapy which aimed more definitely at the phenomenological/humanistic ideals of allowing the patient's identification of his own problems and their solutions, and at the development of man's potential and right to choose his own future, was advocated strongly by Peter Slade. He saw drama therapy as a process of stimulating imaginative creative drama through which the participant could predict future desirable behaviour. The past may have featured in the acting out of what might have been, but he concentrated predominantly on what lay ahead of the participant.

Slade stressed the importance of individual expression, style and values. His purpose was not the discovery of role-conflict or the influence of 'significant others', but the promotion of new ideas and appropriate behaviours. He was not concerned with drama and associated role-play as an aid to psychoanalysis but with drama as the "doing" i.e. "struggling" through which

(1) Greenberg. Audience in action through Psychodrama, Group Psychotherapy, June/Sept., 1964, Vol.XVII, p.110.

"we are enabled to discover the doing of life". (1)

Slade saw drama as an acceptable form of projected and personal play:

".... there is the practical everyday life on one side and the inner dream world on the other". (2)

The 'practical everyday life' he hoped to benefit by developing graded situations of social drama in which personal problems, however small, could be tackled - even basic achievements such as crossing the road.

"For some of us a small thing is a great thing. Achievement is a question of degree". (3)

Social skills were developed in the "preparation for life" or "personal problem" plays - analogous with projected play.

But Peter Slade did not see drama-therapy as only the discovery and eradication of problems - least of all the problems imposed for acting out by the leader or therapist. Episodes including problem solving he thought to be only a small part of drama-therapy's scope as an "aid to becoming a person".

The "inner dream world" Slade suggested could be expressed in dance - an element of personal play which he frequently advocated as part of his therapy process, but also in the acting out of imagined incidents and stories which may initially seem unrelated to illness.

"Not only may a person discover their personal style through improvised dance in the realm of personal play, which may one day prove a very important factor as the compliment to psychotherapy, but by "being" hundreds of different characters in different scenes and situations it is possible to discover certain truths about yourself by a discarding of character-roles that you finally perceive you are not". (4)

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- (1) Peter Slade. Drama therapy as an aid to becoming a person. The Guild of Pastoral Psychology. June 1959, p.21.
 (2) Peter Slade. Experience of Spontaneity. Longmans, 1968, p.228.
 (3) Slade. Op.cit., p.187.
 (4) Slade. Op.cit., p.21.

Slade's improvised drama was a vehicle for "being" and "doing". It involved the exploration of roles and role interaction which became a speculative way of discovering a way of behaving. Discussion of the "doing" and its implications was not as important in Slade's drama therapy as the active involvement, which is perhaps why he suggested it as being complementary to more general psychotherapy practice.

The criteria which influence a role-play leader's use of the techniques which comprise the form of psychodrama he chooses to operate will vary with his view of the purpose of that psychodrama. Some of the variations in purpose and application have been briefly illustrated in the three approaches described above.

Yablonsky, summarises this distinction of purpose when he describes the theme of his own writing as:-

"Psychodrama as a happening or as a productive experience (his italics) rather than exclusively as a therapeutic method, even though a significant side effect of psychodrama is its therapeutic value". (1)

Whether the drama enactment and role-play are seen as the predominant, most time-consuming part of a therapy group activity, with therapeutic value as only "a significant side effect", or whether the involvement in the drama is viewed as an aid and stimulant to further discussion and counselling, will depend on the purpose of the therapy process, and the brief, persuasions, abilities and personality of the group leader.

When Corsini talks of role-play in therapy he expresses this view of feasible flexibility in its use.

"Role-play since it is only a technique can be used by any therapist regardless of his theoretical orientation, and it has been employed by psychoanalysts - by Adlerians -, by Rogerians -, as well as by eclectics". (2)

(1) Lewis Yablonsky, Psychodrama. Basic Books, New York, 1976, p.4.

(2) Raymond J. Corsini, Role-playing in Psychotherapy. Aldine Pub.Co., 1966, p.5.

The comparative outline of the work of Polanski and Harkins, Moreno and Slade does show that although these differing approaches to role-play in what they may choose to call psychodrama or drama therapy may be biased toward a particular type of psychotherapy, this does not mean their exclusive adherence to the theory and practice of any one particular system. There is evidence in them all of a varying degree of eclecticism.

English and English describe eclecticism as:-

"the selection and orderly combination of compatible features from diverse sources sometimes from incompatible theories and systems". (1)

As a group leader begins to develop his own uses of role-play to suit his own objectives and personal style he may well be guided by 'compatible features from diverse sources'. The acceptance of certain theoretical concepts in psychotherapy need not presuppose the acceptance of the theory in its entirety, nor does it necessarily require the use of all of the therapy practices associated with that particular theory.

The integration of pertinent facts from several sources into the frame of reference which is likely to determine role-play practice and group strategies is perhaps paralleled in psychotherapy by an eclectic psychotherapy system similar to that of F. C. Thorne.

Thorne does not offer any single theory of personality development or psychotherapy. He maintained, however, that his eclectic view was not a hodge podge of disconnected facts, unrelated to sound structure, but rather an integration of theories and methods to meet specific or individual needs.

Thorne's assessment of individual need was based on observation and discussion of current behaviour and on details of individual patient history much of which he obtained from the patient himself. Therapy measures were individually prescribed and practised. He suggested that although patient

(1) H. B. English and A. C. English. A comprehensive dictionary of psychological and psychoanalytical terms in Patterson, op.cit., p.460.

history may provide the therapist with some background patient experience, he should primarily be concerned with the patient before him, as he is, and should not approach the face-to-face therapy situation with too many preconceived ideas of anticipated problems.

The role-play therapist with a prospective group therapy meeting in mind may not feel that he is able to embark on therapy with quite such a blank sheet of patient need before him. If his enquiry into the types of mental illness expected to be most common to the diagnoses of group members, suggests a similarity of symptoms and a possible similarity of causal factors and experience, then he may feel that there is some common ground of therapy experience which could benefit several participants. This will require him to investigate what is 'typical' in both the causes and effects of the illnesses concerned.

When working with the rehabilitation group of psychiatric patients the role-play leader may opt for an eclectic approach to therapy, not only to meet individual patient needs, but also to try to overcome specific types of handicapping behaviour or to alleviate the types of residual symptoms of mental illness or hospitalisation which he anticipates may be shared by some, if not all, of the patients in the group.

The role-play group leader's investigation into the types of illness which many of the group members may have experienced influences:-

B. The leader's expectation of the participants.

Criteria affecting role-play methods and the selection of techniques, derived from the above section of influence in the leader's 'frame of reference', are discussed in the following chapter.

CHAPTER II

THE ROLE-PLAY LEADER'S FRAME OF REFERENCE;

B. The leader's expectation of the participants

CHAPTER II

The role-play leader's frame of reference.

- B. Criteria governing the selection of role-play techniques employed in a rehabilitation programme of adult psychiatric patients arising from the leader's expectation of the participants.

Before a role-play leader is faced with the individual backgrounds, needs and wants of selected patients, his initial 'frame of reference' for decision-making may take account of possible common factors in the experience of many of the group members if they have known like diagnosis, treatment and hospital environment. An investigation into what may be typical in patient background and current behaviour may suggest criteria to guide the leader's decisions, according to the particular kinds of help, other than medical, economic, educational and spiritual that adult psychiatric patients seem to need.

B. The leader's expectation of the participants

The particular kinds of help, other than medical, economic, educational and spiritual that adult psychiatric patients seem to need.

As previously stated the role-play group in the rehabilitation unit at the psychiatric hospital was formed on the recommendation of the consultant psychiatrist responsible for the setting up of the unit, following her observation of role-play groups comprised of short-medium stay patients, held in the main hospital unit, and those conducted by myself on a long-stay ward with chronic schizophrenic, institutionalised ladies.

Therefore my first discussion of the particular kinds of help from which the group members could be expected to benefit was with the said consultant, who was concerned with the day to day treatment and welfare of patients in the newly formed unit.

Before I could make any decision about the suitability of my 'set of practices' to help in rehabilitation, I needed to assess the general needs likely to be experienced by people in the transitional period between hospital ward life and home, following mental illness and treatment. At an early stage, prior to the selection of specific patients to be included in the group, this assessment of possible needs gave rise to some criteria to guide the planning of aims and strategies to meet them. Many of these criteria, although based on generalisations, did remain relevant and were part of the background to decision making, even when the consideration of individual problems and behaviours was added.

The first impressions of likely needs of the patients to participate in the group meetings were derived from:-

- (1) The advice of the patients' consultant psychiatrist.
- (2) The leader's understanding, at that time, of the patient's possible states of health and behaviour, based on enquiry into likely backgrounds of illness treatment and hospitalisation.

1. The derivation of criteria governing the selection of role-play techniques from the advice of the patients' consultant psychiatrist

The patients thought most likely to form the rehabilitation role-play group at South View were expected to be medium to long stay. Their time in hospital was expected to have varied from one to ten years. Some may have had spells of discharge, relapse and readmission. The consultant in rehabilitation envisaged that most of the patients to be asked to join the group would at some time have displayed behaviour which had been described as schizophrenic and that the majority would, at the time of their entry into the unit, be diagnosed as chronic schizophrenics.

Her description in a paper on "Role-play with Chronic Schizophrenics", written a few months before the unit opened, concisely covers the aspects of the illness explained and discussed prior to the formation of the new role-play group.

"Chronic schizophrenics suffer from both the effects of illness and institutionalisation. In many schizophrenics the acute and disturbing symptoms of schizophrenia are controlled and they are no longer overtly deluded, hallucinated, violent or aggressive but the symptoms of residual schizophrenia and institutionalisation are the most difficult to treat. Here the main features are lack of spontaneity and motivation, slowness and apathy, restricted and stereo-type pattern of movement and thought. There is a blunting of emotional responses and diminished awareness of self. Attention and concentration are limited and verbal communication may be non-existent, negativistic, monosyllabic or show frank thought disorder.

Once the patient is relegated to a long-stay ward her contact with normal individuals is reduced, she may have become isolated from near relatives and receive no visitors. Her only excursions from the hospital may be hospital trips and as her contact with the outside world diminishes lack of stimulation enhances her schizophrenic withdrawal and she may become afraid to leave the hospital or even her ward. Her only conversation may be with a doctor or nurse whom she regards as figures of authority to whom she must give a 'correct response'". (1)

The above paragraphs illustrate the consultant's opinion that the symptoms of residual schizophrenia and institutionalisation are so enmeshed after a lengthy spell of treatment and hospital life, that it is perhaps futile, if not impossible, to try to separate them. It is this combined debilitating effect which goes to make the patient what he is, that has to be overcome.

The above extract on the features of behaviour frequently associated with chronic schizophrenics described a state which many of the people to be in the role-play group would have come some way to overcoming already, hence their proposed suitability for rehabilitation.

If role-play was then to help such patients re-establish themselves successfully in living situations outside hospital it had to aim at offering opportunities for them to further eradicate the handicapping effects of illness and institutionalisation and to experience and consider alternative behaviours which may be more appropriate and/or effective.

(1) Merrica D. M. Goodall. Role-play with Chronic Schizophrenics, 18th May, 1976.

More specific criteria arising from some of the kinds of help which role-play may offer are implicit in the aforementioned report, i.e. that role-play should offer:

- a series of situations where dormant motor and language skills can be restimulated and practised
- opportunities for varying emotional expression
- opportunities to improve attention, concentration and spontaneity
- situations to encourage problem solving
- situations to encourage the taking of responsibility
- a more neutral approach in leadership from a person who is not part of the hospital establishment, or directly involved with ward administration
- a relaxed and less inhibiting atmosphere for the sharing of experience

The last two criteria are particularly significant for they mark a recognition by a senior member of hospital staff that patients may benefit from communication with personnel from outside the hospital situation. Her last remark on the value of a non-inhibiting atmosphere seems relevant to her earlier quoted comment on the patient's anxiety about the 'correct response' she feels she must give to authority figures. Role-play has the advantage over 'real life experience' in this respect; that it can provide an experimental workshop in which to try out responses without real consequences. Should such responses evoke criticism the group leader has some degree of control of if, how, or how much of it, the participant can be expected to take without it having an adverse effect on his courage or inclination to venture further responses.

2. The derivation of criteria governing the selection of role-play techniques from the leader's understanding of the patients' possible states of health and behaviour based on an enquiry into likely backgrounds of illness, treatment and hospitalisation

If a role-play leader is of the persuasion that therapy begins from 'where the patient is' and is only concerned with defining and clarifying that

starting point, developing and extending what he is and looking forward to what he might become, the circumstances which may have precipitated that patient's present state of 'being' will not be thought, by the leader, to be terribly relevant or worth pursuing. If, on the other hand, a leader thinks there may be an advantage in therapy of investigating past relationships or areas of behaviour in which patients may have experienced problems; if, in fact, psychoanalysis and the relevance of past experience to present and future behaviour, features at all in his plans to help people deal with residual illness effects, he is likely to feel there is need for him to establish a picture of illness background which is considered typical. Such investigation may prove helpful to a role-play leader as it provides some beginnings; some kinds of experience which may be of common interest, appeal, difficulty, gratification and help to patients sharing a common illness label and living environment.

Role-play 'openers' which may be initiated on the strength of only the general knowledge of the leader or on a general consensus of group opinion can become specific and personalised by the subsequent contribution of relevant individual experience.

Criteria stemming from the effects of schizophrenia and institutionalisation have been dealt with to a large extent through the consultant's descriptions of symptoms and the needs of patients.

This section is intended primarily to establish possible circumstances frequently associated with causal factors of the two conditions. These can more easily be distinguished, at least in theory, than the combined symptoms.

My own understanding of precipitating factors thought by medical authorities to be related to schizophrenia and institutionalisation, dated from enquiry into causes preparatory to working with an earlier group of chronic schizophrenics and had changed little since that time.

(a) The causes and effects of original mental illness
Schizophrenia

The term 'schizophrenia' would appear to cover a variety of mental states.

Beccle in his manual on psychiatry for student nurses says:-

"Schizophrenia is regarded as a group of all sorts of unclassifiable mental diseases which show a splitting of the mind to a gross degree". (1)

My preparatory discussions with the consultant psychiatrist suggested that it is not unusual for patients to display both schizophrenic tendencies and signs of manic-depressive psychosis. This view is also expressed by

D. Russell Davis:

"Indeed it is not uncommon for the examination of a patient to reveal manic-depressive, schizophrenia and neurotic symptoms co-existing". (2)

My discussions further suggested that opinions on causation had changed little since the publication of D. Russell Davis' study of Psychopathology in 1957. At that time whether the occurrence of schizophrenia or manic-depressive psychosis was inherent or due to environmental inducement seemed debatable. Davis' statistics, though strongly supportive of the genetic influence were not conclusive. He observed:

"For neither disorder has it yet become possible to draw definite conclusions, but most authorities agree that genetical factors play some part in aetiology; they differ in degree of importance they attach to genetic factors". (3)

But Russell Davis also remarked:

"The external causes of mental disorder are thought by psychopathologists to be in the family environment especially and pathogenic traditions and pathogenic attitudes, it may be argued, run in families as strongly as pathogenic genes". (4)

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- (1) Harold C. Beccle. Psychiatry Theory and Practice for Students and Nurses. Faber and Faber, London 1946, p.181.
 (2) D. Russell Davis. An Introduction to Psychopathology, OUP 1957, p.79,
 (3) D. Russell Davis. Op.cit., p.72.
 (4) Ibid, p.65.

Whether mental disorders are attributable to predominantly genetic causes or whether maladaptive behaviours are produced when genetic vulnerability is compounded by pathogenic attitudes and responses in early experiences, there seems to be evidence to support the view that it is the family environment which frequently puts people 'at risk' of developing psychotic diseases.

"The histories of schizophrenic patients show that they have been more or less incapable of forming personal relationships throughout childhood and subsequently. The origins of this incapacity lie in the difficulties which patients have experienced in their relationships with their parents; these relationships are the source of severe and disabling anxiety. Not only have they failed to learn social skills, which would enable them to meet and form friendships with others, but also they have acquired a sense of profound insecurity and inadequacy, which cripples them. At the same time they tend to feel misunderstood". (1)

The above statement may prompt a role-play leader to decide that whether the aim is analysis of past behaviour and experience to make a patient conscious of root causes of his anxieties and inadequacies, whether it is to expand an interpersonal view that we know and are known through our contacts with others, or whether it is simply to compensate in a controlled safe role-play situation for the lack of opportunity in a patient's past and present reality, the exploration of family relationships may be a valuable part of the group's activities. It is an area in which not only insight may occur but through which, in favourable circumstances, confidence can be restored and patients have a chance to express and explain, and perhaps reduce their feeling of being 'misunderstood'.

Avoidance is suggested as a typical schizophrenic solution to painful emotional situations. Evasion quickly lessens tension which in itself tends to reinforce the behaviour in future similar situations. It explains in part the associated onset of schizophrenic behaviours at times of particular stress such as puberty, menstruation, marriage or pregnancy etc.

(1) Ibid, p.208.

Withdrawal, or in more extreme cases, flight into the fantasy of hallucination or neurotic behaviours may be the preferred escape from an anxious reality. Should such evasive measures be thought of as the resorts of insecure, inadequate people to avoid problems of physiological or social change, the responsibility of decision making, or emotional involvement and commitment of interpersonal relationships, there are several implications for role-play direction.

Firstly, role-play could be used to urge confidence and strength of purpose, so that unease may be appeased by positive, decisive action or change in attitude rather than by-passed through a negative avoidance of distasteful circumstances or distressing situations. Subsequently, patients may be encouraged to acknowledge such alternatives and evaluate the short and long-term relief of emotional pressures. The idea that some psychiatric patients may avoid reality by a flight into fantasy could suggest the need for caution in the use of imaginary situations in their therapy.

It would seem important in the use of role-play that the leader should make it absolutely clear when the imaginary role-play episodes begin and end, and that at the end of role-taking each participant is firmly re-established in reality. The choice of subject matter for enactment may need a watchful eye to ensure that at no time does a patient begin to indulge any personal fantasy theme which has been a part of any hallucination or delusion. Such 'no go' areas can usually be discovered from medical histories or hospital personnel. In many instances role-play topics will be far removed from those of patient fantasy as role-play will frequently concentrate on everyday situations akin to reality or be a recreation of some person's real experience. Should this not be the case the imaginary situation to be explored will normally be logically connected to a topic of group interest. However it is conceivable that a leader may at some time need to act to avoid any undesirable excursion into a patient's personal fantasy. Alternatively under strict medical advice and supervision it may help patient or staff to reveal hallucinatory themes

or events as a part of treatment.

As well as helping in the solution of short-term problems, the leader may be hopeful of long-term gain for patients from the continued use of the techniques over a number of sessions.

Davis⁽¹⁾ states the view that we get wise to ourselves through 'converse with others'. If, as may be the case, with a child in an 'at risk' family of high mental disorder potential, 'commerce with others' is misleading alarming or confusing due to the doubts and difficulties of early relationships, his ability to 'get wise' to himself is likely to suffer a severe setback. If this is accepted as part of the possible background of mental disturbance experienced by some members of a role-play group, part of their therapy may be seen as the chance to make the social contacts which in the long-term may help them develop an improved awareness of the world in which they live, the functioning self which is a part of that world and its interaction, and the inner self which is the private, unique core of what they sense, feel and are. Instilling the habit of reconciling the possible conflicting demands of self-gratification and social acceptability by facing the issues rather than by avoidance and denial of the conflict, may be a long-term role-play goal. Social experience in the interaction of a wide range of role-play contexts or in the interaction of real group relationships may, over a period of time, help patients develop the strength of personality to assert themselves and require change in affecting circumstances or sufficient flexibility to adapt their own attitudes and policies because it is more appropriate, not because they lack the confidence to do otherwise.

Where illness has impeded the receptive or expressive flow of information between a person and his world, compensating for this lack of opportunity may be an important therapeutic aim.

People who have withdrawn themselves from 'commerce with others' and with everyday life experiences and who for some period in their lives have

(1) Davis. Op.cit., p.210.

cocooned themselves in their private world may have cut off their senses to the input of information about their wider physical and social environment. If they are to be encouraged to renew their interest in what is happening around them it may help to use role-play sessions to re-stimulate the use of all of the senses, but with communication in mind, in particular to devise activities to encourage greater discrimination and awareness through the use of sight, hearing and touch.

Sensing alone need not imply increased awareness. Some interpretation of the received messages is necessary. The translation of experience into words adds the intellectual dimension which could help a person to know his sensing more fully. There could be opportunity in both role-play narration and dialogue for the transfer of thoughts into words and their expression.

Expression in words is not only a sharing of experience but may also be an important means of helping a person clarify that experience for himself. For the chronic schizophrenic who may have experienced thought fragmentation during the more acute phase of illness, the holding together of thoughts in words and their intelligible ordered expression may be a valuable experience which role-play can afford.

The need in rehabilitation to re-stimulate expressive language has already been mentioned as arising from the combined inhibiting effects of residual mental illness and prolonged hospitalisation. There may be a need not only to encourage linguistic competence but also confidence in movement and apt communication via both words and gesture. The use of gesture may have become severely inhibited in the depressed or withdrawn patient and exaggerated or inappropriate in the manic or neurotic patient. In either case the result may be the misinterpretation of the observer and patients moving into a wider field of social contacts may benefit from an improved realisation of the importance of body language. A role-play leader may consider that time devoted to the exploration of motoric expression is well spent.

It may also help to break down barriers impeding communication if patients can be induced to overcome any aversion they may feel to the close proximity of others or of actually touching or being touched by someone else. Appropriateness and acceptability of physical contact and nearness in space is perhaps best approached in a lighthearted, non-threatening manner and always with consideration for the sensitivity and privacy of those concerned.

Criteria affecting the selection of role-play techniques and strategies arising from causal factors in patient's original mental illness

The need:

1. To encourage the exploration of family relationships past and present.
2. To relate any feelings associated with any early relationships to such maladaptive tendencies in his own behaviour as the patient may be able to recall.
3. To encourage confidence in present and new relationships.
4. To encourage patients to express their feelings about personal relationships.
5. To allow the handling of emotions associated with inter-personal experience in a safe, supportive atmosphere.
6. To encourage a positive attitude to coping with a variety of social situations.
7. To encourage the discussion of outcome and alternative ways of dealing with circumstances and problems.
8. To indicate to participants the beginning and end of role-play activity.
9. To ensure that a participant is out of any imagined role and is behaving as himself in his real situation.
10. To avoid any theme or situation which may have an adverse effect on rehabilitation.
11. To reveal the content of individual fantasy - only if recommended and overseen by staff responsible for patient treatment and welfare.

12. To allow a patient opportunity to explore social interaction in role-play situations and in real group situations through which he may come to know more about himself, the place and effect of that 'self' in his environment, and the environment itself with its contrasting and complimentary influences.
13. Through the above contacts, in the long-term, to provide experiences through which those involved may develop a greater self-confidence which enables them to strike a balance of assertiveness and flexibility in their attitudes and decisions.

To improve communication by:-

14. Stimulating sensory perception.
15. Encouraging verbal expression of sensory experience and associated feelings.
16. Encouraging the crystallisation of thoughts into words and improving the ability to express them.
17. Drawing attention to body language and gesture as a part of communication.
18. Exploring expressive movement.
19. Encouraging an awareness of appropriate and acceptable physical contact and proximity with others in everyday social situations.

Inhibition and stereotyping of both speech and movement responses, as described by the consultant psychiatrist, do seem to be in part attributable to the self-imposed restrictions of the withdrawn patient. However this impaired expression of ideas or feelings does seem to be more frequently associated with the combined residual effects of illness and the institutionalisation which can occur after long experience of a restricted hospital community. This limitation of behaviour, though possibly originating in illness from a lack of confidence or desire to make any self-revealing statement which might incur further involvement in a situation, seems to be

further compounded by elements of hospital life, where a lack of opportunity, need and perhaps ultimately, ability to respond more spontaneously to an individual set of circumstances, induce even more reticent reactions.

If a role-play leader is to organise experiences to counteract negativistic non-creative attitudes it may help to know the type of conditions in the hospital situation which may have contributed to the development of behaviours referred to as institutionalisation or even 'Institutional Neurosis'.

(b) Causes and effects of institutionalisation
(institutional neurosis)

Again the study of factors likely to contribute to this induced malady are only relevant to a role-play leader who believes it may be worth trying to eliminate a symptom by creating for patients, conditions which are contrary to, or compensatory for, those which may have had a conditioning causal effect on the patient.

Some suggested causal factors are listed by Russell Barton, whose research into the institutionalisation of long-stay patients did influence my own thinking about possible role-play means of alleviating the effects of illness at the time of my planning for the rehabilitation group.

The factors likely to produce institutional neurosis, according to Barton's⁽¹⁾ study are:-

1. Loss of contact with the outside world.
2. Enforced idleness of patients.
3. Bossiness of medical staff.
4. Loss of personal friends, possessions and personal events.
5. Use of drugs.
6. Ward atmosphere.
7. Loss of prospects outside the institution.

Each of the above may suggest criteria to influence the direction of a role-play session.

(1) Russell Barton. Institutional Neurosis. J. Wright & Sons Ltd., Bristol, 2nd edition, 1966.

1. Loss of contact with the outside world

Even at the time of admission to hospital some patients may have lost contact with people and activities outside their immediate domestic environment. The withdrawal effects of their original illness may have narrowed their interest to a concern with only themselves and their daily routine. Patients who already have a tendency to isolate themselves from the demands of social encounter may find that hospital life further reinforces this preference for their own company if they are surrounded by other patients who are similarly disinclined to communicate.

When patients share similar illness and treatment experiences and the same ward routine and occupation there is little that is new to talk to their fellows about. Even patients who have been fully active and sociable up to the time of their hospitalisation may find that as the weeks go by the world outside becomes more and more remote and irrelevant to their current experience. Opportunities to make outside visits may be severely limited by illness restriction or the breakdown of family relationships, which in many cases results from mental illness. Unless there is a supportive family or relative to return to, many patients cannot maintain outside contacts for even short visits even if their medical condition would allow it. Unless or until rehabilitation in some form is a practical possibility there is often nowhere outside the hospital for them to go. Hospital organised trips for suitable candidates may be the only opportunity many patients have of getting away from the hospital campus. On such excursions 'commerce with others' is again largely confined to hospital staff or fellow patients.

As the flow of news from outside declines, so many patients tend to lose interest in local or national events reported on T.V. or in newspapers or magazines. Although watching television may occupy much of their spare time it does not motivate comment or discussion amongst the majority of patients. Rather it gives them further opportunity to sit doing and saying little.

A useful role-play aim may be the re-stimulation of interest in events outside hospital at both the personal and broader interest levels. Working on relevant topics will require the use of recall, reasoning and communication skills which it is hoped will be continued in conversations outside the role-play sessions.

If a person is to be motivated to speak he needs not only the physical mechanisms and meaningful word sounds of spoken language but also an idea and the desire and need to say something. Role-play can be used to supplement real experience and extend the contexts in which ideas, desires and needs may develop and be communicated. For rehabilitation patients the attempt to compensate for loss of contacts outside hospital may require role-play not only to build bridges with the past but also to lead patients to a consideration of future contacts in the world beyond hospital to which it is hoped they will be returning.

2. Enforced idleness of patients

Lack of interest in gaining knowledge of outside events has already been mentioned. Once entrenched in the hospital way of life few patients have any desire to find out via the media. Leisure reading matter concerning home, garden, fashion or car etc. perhaps seems irrelevant to people confined to hospital for long periods.

When living in the outside community becomes more imminent it may be useful for role-play to remind or introduce patients to a variety of leisure pursuits and opportunities which they might have to make for themselves.

Idleness would seem to be a difficult habit to overcome once a patient is content with it. Although some wards may be lacking in stimulation or suitable facilities to encourage patient occupation, in many instances idleness seems to be chosen by the patient rather than enforced by the staff or system. Patients recovering from mental illness tend to be difficult to motivate. Ward staffing can be so sparse that a nurse is so occupied with

ward supervision and attending to the physical welfare of patients that she has little time to be repeatedly trying to induce people to try activity that they shun. If joining in leisure pursuits means moving to another part of the hospital some patients may not be prepared to make the effort. Resistance to hospital social or occupational activities may be due to apathy but it is possible that any type of group activity throws the insecure patient back into the very type of face-to-face encounters with which they find it difficult to cope.

For the short time that a role-play leader is with patients, unlike the busy nurse, she can afford the time to persevere with efforts to involve them and break down the habit of indolence. Should she feel that reticence is caused by lack of confidence she can ease patients into activity and by providing some cushioning against anxiety in role-play experiences, prepare them for real social demands and any associated emotional disturbance.

It is perhaps not the absence of leisure opportunity in hospital which robs patients of activity but the absence of a work or self-sufficiency requirement to get on with some necessary task. The hospital system can so completely take over the care of patient and property that he has no need to even think about the provision or maintenance of physical needs or comforts. While some patients may have jobs in or out of the hospital, they are unlikely to be financially dependent on them.

The handing back of responsibility for self-management and independent living, during rehabilitation, requires that patients regain the confidence and competence to cope with both the planning aspects of looking after themselves and with many practical domestic and self-care skills.

In both decision-making and the acquisition and practice of skills role-play should be able to supplement actual rehabilitation experiences and help to re-orientate patients to doing things for themselves and adopting the discipline of a work habit in domestic chores or prospective employment.

3. Bossiness of staff

When patients enter hospital they expect to be told by staff what they must do. Staff expect patients to respect and accept their authority and the hospital regulations and practices which they represent. The Stanford University Simulated Prison Experiment⁽¹⁾ was perhaps an extreme illustration of the influence of role-rules on behaviour. In the prison simulation, extending over several weeks, subjects role-playing prisoners and guards tended to behave according to the expectations of their allotted roles rather than the dictates of personal judgements.

In a psychiatric hospital throughout the patient's illness and treatment it is understandable that most of his activity should be directed and controlled by medical and welfare staff. But the extent to which ward staff inadvertently eliminate minor personal judgements of patients may exceed what is necessary for their health, security, guidance or treatment, particularly on long-stay wards.

Part of the problem is that there is pressure on nursing staff to maintain ward efficiency and not to waste their own valuable time. They cannot afford to stand and wait for slow patients to do things which they could complete themselves in a fraction of the time. Over-protectiveness can also become a habit and an attitude adopted to all patients regardless of the stage of their illness or individual capacity for initiative or independent decision. Fault also lies with the patient if he is content to go on conforming to the expected role of dependency long after illness symptoms have been controlled and he should be able to make many of his own judgements and decisions.

Role-play may help patients who are on the way to recovery by encouraging them in everyday choices and spontaneity and in the more considered decisions of interpersonal problems which they should be able to deal with

(1) Craig Harey, Curtis Banks and Philip Zimbardo, "Interpersonal Dynamics in a Simulated Prison". International Journal of Criminology and Penology, 1973, 1, pp.69-97, Seminar Press.

themselves but may persistently refer to staff.

It may also be necessary to provide opportunity for patients to discriminate between circumstances in which it would be wise and proper to tackle difficulties themselves and those when it may be necessary to bring the matter to the attention of staff.

It may also be appropriate to use role-play to make patients and staff more aware of each other's attitudes and responsibilities with regard to authority and hospital conditions.

4. Loss of personal friends, possessions and personal events

The loss of personal friends, possessions and events contributes to the depersonalisation which can occur when people live for any length of time in an institution where contact with the outside world is limited and so much of the routine and property are communal. Patients on psychiatric long-stay wards may come to have few friends or relatives to take a specific interest in their individual circumstances and interests, and remember occasions such as birthdays or anniversaries.

If they never go very far from the ward they will not need the accessories of dress and travel which are a part of an independent life-style. Lack of interest may mean that many of them never acquire the variety and number of possessions connected with hobbies and pastimes that a person in an ordinary home would accrue.

Seeking to overcome any erosion of personal identity and individuality which the institutional pattern of living may cause, the role-play teacher may look specifically to techniques involving the observation and recognition of individual appearance, mannerisms, preferences and interests. The long-term effect of interaction which requires personal views, statements, and actions should promote a clearer affirmation of individuality but the leader may feel a need to emphasise this to benefit specific patients.

The leader's own interest in events which are important to individual group members may boost morale and stimulate their even greater enthusiasm for sharing experience. Interest shown by patients in the personal events

and welfare of others may be the beginnings of friendships outside the role-play sessions. The desire and ability to form and sustain friendships may be important to successful rehabilitation.

With regard to possessions it may be possible for role-play activities to restimulate a pride and pleasure in ownership which could be relevant to encouraging a pride in personal appearance and tidiness. Certainly care of personal possessions and respect for the property of others may be significant in both the daily functioning of the rehabilitation community and in the smooth running of any prospective shared living accommodation to which patients may go.

5. The use of drugs

Patient treatments, including drugs, could affect patient behaviour in role-play sessions. Therefore matters arising could present criteria to influence the choice of techniques and the demands they make on patients.

To the layman any deviation from the expected norm of patient response may not be immediately attributed to the effect of medication. It may therefore be very important that a role-play leader be forewarned of any change that could occur due to such treatment. He should then be ready to adapt to the response of the patient, allowing for any variation in attitude or contribution.

It is also possible that patients may wish to express their own feelings about the treatments they have received and this too could affect role-play choices and opportunities created. The presence of the professionals concerned with treatments may be important in the investigation of such topics. Patients may wish to ask questions which only the experts can answer. It may also be appropriate that their doubts and fears should be communicated to staff.

6. Ward atmosphere

On many of the wards in the hospital concerned in this study great effort is made to break away from the traditional, dull uniformity of hospital

decor and furnishing. However, hampered by the structural limitations of old premises and the fact that wards are first and foremost required to be functional with aesthetics a secondary consideration, there may be little in their physical appearance that is stimulating, has personal appeal or reflects the personal tastes of inmates.

There is a little more scope for creating a more particular atmosphere in smaller, specialised rehabilitation quarters but this is usually the province of staff not patients. Accommodation is still shared, few patients even have a separate bedroom and none of it can be called their own. For ex- long- to medium-stay patients any ideas about home-making will be far back in their experience.

Role-play could be considered a useful opportunity to arouse some interest in the planning of a home atmosphere. Encouraging patients to establish the nature of such an atmosphere and the necessary ingredients could provide them with helpful ideas to carry over into eventual home situations.

Much of the inhibiting effect of a hospital existence may be due, not to the uninspiring appearance of the surroundings but to the monotony of the routine. Much of the ward procedure is predictable and undemanding.

The care of staff, the provision of physical needs and the regularity of happenings, make it particularly easy for the patient whose original illness has induced a desire to preserve the status quo, to avoid any spontaneous activity or decision.

Introducing the unexpected and encouraging spontaneous adequate response from patients should help to counteract the effects of taking the easy line to fit in with the familiar pattern of hospital life.

Spontaneity does not necessarily mean a hasty, thoughtless reaction to given circumstances. The emphasis is on the appropriateness of any action taken and on the motivation to begin to do something to deal with the circumstances. This may mean considered planning rather than immediate action.

With patients who are particularly hard to motivate the initial stage of promoting a willingness and desire to 'do' rather than avoid involvement may be a prime objective of the role-play leader.

7. Loss of prospects outside the institution

If a prolonged stay in hospital has resulted in the loss of accommodation and employment outside, and even in estrangement from family ties and responsibilities, it may be important to use role-play to restimulate ambition or commitment in such areas of experience.

Freud suggests that maturity grows through experience of a proper balance of *lieben und arbliter*; love and work. The prospect of regaining either ingredient may seem remote to a rehabilitation patient without marital or family stability or job possibility.

If there are patients in the group who can foresee relevant future encounters in their re-integration into family life, the making of new relationships, or the securing and maintaining of home or job, the anticipation and hypothetical practice of such encounters may help participants. It may be that the future can only be viewed in general terms if specific individual forecasts of events do not emerge from the group. A leader may still consider that there is value in investigating attitudes to future prospects and again with regard to the avoidance tendency of the institutionalised patient, to encourage a positive orientation toward outside opportunities.

Situations for future prediction need to be realistic and it may be more relevant to view the prospect of living in a hostel or group living scheme rather than any unlikely sudden move into private accommodation. The suitability of a proposed 'way out' of hospital for the individual patient and consideration of alternatives and advantages may suggest worthwhile role-play ideas.

Criteria arising from the leader's understanding of factors likely to contribute to Institutional Neurosis

The need:

1. To re-stimulate interest in the outside world by:-
 - (a) encouraging recall of past outside experiences and prediction of future outside experiences in both role-play enactment and discussion
 - (b) exploring and developing patients' views on topics of interest reported by the media.
2. To supplement limited real situations in hospital by providing a variety of imagined contexts to extend scope for communication of ideas, needs and desires, etc.
3. To interest patients in leisure activities and opportunities.
4. To induce positive contributions to role-play group activity by allowing time for patients to 'warm up' to action.
5. To encourage participation by providing a supportive attitude requiring appropriate effort according to individual capacity and confidence.
6. To help in the acquisition of practical skills.
7. To encourage self-sufficiency.
8. To encourage planning for an independent future.
9. To re-establish the discipline and acceptance of the responsibility of work in the performance of domestic chores or in the carrying out of a job.
10. To help patients make everyday choices.
11. To encourage patients to attempt to deal with problems themselves if possible but also to judge when and from whom to seek any necessary help.
12. To make patients and staff aware of each other's responsibilities, attitudes and motivations.
13. To involve patients in activities requiring close observation of each other and the recognition of individual differences and features.

14. To encourage independent statements of opinion and preference.
15. To show the leader's interest in individual members of group.
16. To encourage group member's interest in each other and the building of relationships.
17. To re-stimulate pride and pleasure in personal appearance of the care of personal property.
18. To encourage respect for the property of others.
19. To allow for the effects of medication or other treatment on response.
20. To provide opportunity for patients to reflect on treatment experiences if desirable.
21. To introduce the unexpected.
22. To arouse interest in home-planning.
23. To encourage spontaneity.
24. To provide opportunity for a consideration of appropriateness of response.
25. To encourage 'doing' rather than avoiding.
26. To give experience of possible new personal relationships in new situations.
27. To allow the personal interpretation or development of general themes being explored.
28. To encourage a positive attitude to future opportunities.
29. To investigate future living situations such as hostel, group living scheme, private home, family home and consider suitability of preferred accommodation and the pros and cons of alternatives.

This review of the behaviours commonly associated with residual mental illness and hospitalisation while looking at possible causal factors in patient history, does not necessarily suggest only a retrospective approach to therapy in which patient problems may be lessened by revealing and tackling root causes. The investigation also suggests for a role-play leader more direct approaches to behaviour modification, related to causes,

but not necessarily requiring the patient to be aware of possible connections or involving insight. It also indicates criteria to urge more forward looking strategies, designed to improve functioning and related more to predicted future experience than to the past.

The background criteria which may be integrated into an initial 'frame of reference' to guide a role-play leader in the early stages of a role-play therapy project, may have begun to be formulated even prior to the leader's consideration of the setting and conditions of the specific enterprise concerned.

Other criteria to influence role-play group activity will result from the leader's knowledge of, and response to, the particular establishment and circumstances in which he is to operate. The following chapter is concerned with such details about the working situation and the staff and patients to be involved in the setting-up of the particular role-play venture being examined in this study.

CHAPTER III

THE REHABILITATION UNIT

CHAPTER III

The rehabilitation unit

Criteria related to life in the unit, the expected residents and their adjustment to it.

Criteria related to the setting up of the role-play project and the aims of unit nursing staff.

The use of role-play as a group therapy for patients in a rehabilitation unit implies that the activity is intended to help people to cope with change. In this case the anticipated change being from living in the supportive, controlled environment of a psychiatric ward to living more independently in the outside community. The rehabilitation unit provides a preparation ground in which selected patients may become more familiar with the conditions of their predicted new life styles. Their inclusion in the unit at all would suggest that patients are already moving toward a readiness to live outside or have the potential for doing so. Achieving that rehabilitation potential may depend on their own behaviour in relation to it. It may also involve some modification of behaviour.

The study so far has been concerned with ways in which role-play may incorporate various attitudes and approaches to behaviour modification should this seem likely to improve the individual's effectiveness or satisfaction. It has also included some assessment of the kinds of help which patients may need if they are to deal adequately with the demands and responsibilities of current and future changes in their living circumstances.

A role-play project which is planned as part of a 'round the clock' rehabilitation programme in a unit must compliment the total aims and function of that unit. If the handling of role-play sessions is designed to reflect the aims and policy of unit staff, additional criteria to affect the leader's selection of techniques may arise from this intention.

It is therefore necessary to include in this chapter:

- (a) A description of the South View Rehabilitation Unit and the working situation at the hospital.
 - (b) A description of the type of patients expected to be asked to join the role-play group.
 - (c) Details of the proposed sessions and the role-play project.
 - (d) The philosophy of the unit staff in their daily contacts with patients.
- Together with any additional criteria to affect role-play group activity arising from each of the above.

(a) The Rehabilitation Unit

The South View Rehabilitation Unit was opened in the summer of 1976 as a 'half-way house' in which it was hoped patients would regain some degree of independence and learn to cope with living once again outside the protective atmosphere of the wards of a large psychiatric hospital.

The self-contained unit stands in its own grounds approximately half a mile from the main hospital campus. Initially it was planned to accommodate 15-20 patients who had been carefully selected by medical staff and transferred from the main male and female wards. Although this newly formed residential community was still supervised by nursing staff, initially there were no domestic staff as the shared responsibility for domestic welfare and catering was seen as a very necessary part of the patients' rehabilitation. It was intended that they would share the responsibility of cleaning the premises, shopping and the preparation of meals. As both the planning and performing of such domestic tasks were expected to be unfamiliar to many patients who had been on the ordinary hospital wards for any length of time, the staff anticipated the need to offer guidance, training and help with many of the day-to-day jobs involved.

The staff were not only concerned with the self-sufficiency of patients but also with improving the social competence of each one and preparing them for integration in the outside community.

Criteria related to the patient's move out of hospital have been

detailed in the sections on mental illness and institutionalisation. They can be briefly summarised as the need for patients to increase their self-sufficiency via the acquisition of domestic, self-care and social skills, the need for improved self-confidence and the ability to make independent decisions and the need for them to look positively at the prospect of leaving hospital, the opportunities and responsibilities involved, and their own behaviour in relation to these.

Discussion with unit staff verified the relevance of role-play group activities which may meet the above needs and also mentioned the changes which moving into the unit from a main ward might entail. These presented more precise criteria associated with adjustment to the unit environment itself.

Patients may need:

- to adjust to shared living accommodation
- to learn the unit routine and expectations
- to adjust to unit staff attitudes (which may differ from ward staff attitudes)
- to accept some degree of responsibility for the organisation of the unit
- to consider the purpose and value of a period of rehabilitation

(b) Expected patients

The length of time each patient had been in hospital was expected to range from a few months to a number of years. Several of the anticipated residents had alternated between periods of hospital treatment, discharge after favourable response, subsequent regression, and re-admission.

Their links with people outside the hospital community were few. Not many had been in recent close touch with relatives and very few were expected to have any employment other than in hospital training units where they were engaged in repetitive contract work.

Most of the patients expected to transfer to the unit had at some time

been diagnosed as schizophrenic. The residual symptoms of that illness were likely to be integrated with some degree of institutionalisation. The acute more disturbing symptoms commonly associated with schizophrenia were expected to have been controlled. Hallucinations or delusions were not expected to be a problem. Neither violent or aggressive tendencies, nor severe thought disorder seemed likely in patients considered ready for rehabilitation.

My discussion with the consultant in rehabilitation suggested that the patients selected for the role-play group would possibly display the characteristic reticence and withdrawal which often divorces chronic patients from human contacts and is frequently accompanied by emotional indifference, which was described as "emotional flattening". Other schizophrenic traits such as lack of sustained concentration, apathy, stereotyped behaviour, dislike of change or disturbance of the status quo, were also likely to be apparent in role-play sessions.

The prolonged hospitalisation of patients, sometimes inevitable to allow treatment or because there is nowhere else for them to live, may have induced some of the additional problems of institutional neurosis as described in the previous chapter. Failure to communicate whether due to a chosen aloofness or a lack of confidence could have been further ingrained in an atmosphere where social contacts were few and the daily routine relieved patients of decision-making. Several patients proposed for the role-play venture had been described as isolates; difficult to motivate, with very little initiative.

It was thought that the majority of patients in the unit would need at least three to four months' experience of the more self-reliant life style in the unit before they would be ready to move away from the hospital.

If patients did make favourable progress, the alternative living situations into which they may move seemed to be their earlier personal or family home, a semi-sheltered hostel, a group living scheme or some newly found house or flat.

This information about patients expected in the unit and in the role-play group tended to reinforce the overall picture of patient abilities and requirements already outlined in Chapter II.

Again regard for the demands of a changing life style indicated particularly pertinent criteria.

It seemed that from the time of transference from the ward to the rehabilitation unit, patients were likely to be in situations requiring more and more social contacts. In this widening sphere of experience, unless there was unnatural and undesirable withdrawal, they would be continually meeting people and making themselves known. To help particularly with the initial stages of integration into the community, role-play could give opportunity for patients:

- to exercise communication skills (particularly practices associated with introductions and the opening approaches in conversation)
- to enjoy and gain satisfaction from conversing (possibly a feedback from knowing they had coped well)
- to define and encourage acceptable social behaviours in terms of recognised rituals known as good manners and common courtesies, but with the consideration of reasons for observing or abandoning these.

(c) Proposed role-play sessions

The initial role-play group was expected to include the leader and approximately six patients. The unit nursing staff were invited to attend at any time, either as observers or participants. The consultant was expected to visit and observe at regular intervals.

The sessions were planned to commence within a month of the opening of the unit. The group was to meet in a small sitting room off the main T.V. lounge. The sessions were to be held at weekly intervals, each lasting from approximately 6.30 p.m. to 7.30 p.m.

It was thought that tape recordings of the sessions would help the leader reflect on events and plan future work and that the consultant and staff directly concerned with patient welfare and treatment may find the recordings informative. There was no intention of staff to play every tape but they were all available on request and could be referred to in the discussions of significant events which the leader may feel should be reported to the appropriate staff.

Such recordings were only to be made and used, as described, with the full consent of the patients concerned. This practice was only to start at all if and when the leader thought it would not be detrimental to the therapeutic potential of the meetings.

This of itself presented an additional criterion; familiarising the group members with the tape recorder, a microphone, and with the sound of their own recorded voices.

Familiarising patients with the whole procedure of role-play may affect the choice of activity. It may be necessary to dispel the mystery about what role-play is and demonstrate its form and function. It may be helpful to ease people into their first roles with measures to:

- overcome self consciousness
- promote confidence
- prevent embarrassment
- allow initiatives
- promote group acceptance and involvement
- stimulate and share humour
- provide lighthearted situations
- provide familiar, easy to handle, situations or roles
- demonstrate a particular role-play technique

When patients first come to role-play it must be an agreeable experience with apparent relevance to them. The first few sessions in particular need to be pleasant enough to encourage the patients' return to

future sessions. Patients in a rehabilitation unit have transferred to a freer social setting in which they are requested to attend role-play at the recommendation of their doctor. Their right to refuse to attend must be respected should they reject the opportunity. Similarly, theirs is the right to stop coming to role-play if it is their wish.

As sessions progress, if the benefits become obvious, this should be an additional incentive to ensure continued attendance. Maintaining the willing participation of group members therefore presents other considerations for the leader, such as:-

- the need for work done in the sessions to be seen to be relevant to the patients needs and situation.

Should the work undertaken extend to the exploration of personal relationships and behaviours, the leader needs to remain aware that:

"There are few people who do not mind being reflective about themselves and having their difficulties pointed out". (1)

Although the role-play leader needs to be sensitive at all times to the feelings of contributors, it is in the first few sessions particularly that his actions and attitudes:-

- need to show his own regard for the efforts and feelings of contributors, and also
- need to encourage similar respect in the attitudes of other group members.

(d) The philosophy of unit staff

The charge nurse's statement of his view of his role in the rehabilitation unit (Appendix A) was written for inclusion in this study at the end of the period of role-play sessions being researched here. It was not available at the onset, in this form, to which a role-play leader could possibly refer if he wished to establish complimentary objectives. The ideas and principles

(1) O. Spurgeon English and Gerald H. J. Pearson. Emotional Problems of Living. Allen and Unwin Ltd., 1947, p.402.

contained were however discussed with myself, as role-play leader, as the project progressed.

The summary of patients' problems in the nurse's report suggests relevant topics for role-play. Patients may need to consider:

- | | | |
|-------------------------|---|-----------------------------|
| 1. Domestic problems |) | |
| 2. Work problems |) | Further details of relevant |
| 3. Social problems |) | situations in the report |
| 4. Personal problems |) | Appendix A, pp.183-184 |
| 5. Psychiatric problems |) | |

If the role-play objectives are to be similar to the nurse's intent, the reasons for basing role-play content on any of the above areas may be to aid unit functions (as listed in the report, p.184) which seem to fall into two categories:

A. 1. Assessment of the patients

- B. Those concerned with the gradual withdrawal of support of the hospital system and personnel, with the fostering of independence, i.e.
2. Improvement of patient's level of functioning.
 3. Progressive de-institutionalisation.
 4. Establishing a work routine.
 5. Preparing patients for a life in the community when discharged.

A. 1. Assessment of the patients

This function of the unit raises for the leader the question of the need of someone other than the patient.

The need to observe patient response in either the real interaction of the group members, or in role-play situations which may be intended to reveal likely response in similar real situations, may be to benefit nursing or care staff, doctors or other professionals concerned with welfare, or it may be to help in the role-play leader's own assessment. The leader's observation of response and his conclusions will be an important guide to the choice of useful future activities.

The need to facilitate observation to help in the assessment of patients

may be thought an important role-play criterion. But it may be relevant to note that the same behavioural response may simultaneously have varying significance in the assessment of each observer present e.g. evidence in role-play that a patient does not know how to make a cup of tea, may imply for the nursing assistant that tomorrow she should further instruct the patient in this skill, for the charge nurse or doctor it may be one indication that the patient is not yet ready for rehabilitation, while for the role-play leader it may suggest that the experience of other techniques to improve concentration or confidence could benefit the patient.

It may also be that role-play techniques which allow assessment are not chosen for that sole purpose. Activities which show behaviours thought relevant to assessment may simultaneously be serving one or a combination of the other functions suggested in the nurse's report.

- B. 2. Improvement of patient's level of functioning
- 3. Progressive de-institutionalisation

Furthering the above aims would suggest activities previously mentioned such as improving communication, spontaneity, initiative, self-confidence, independence and the ability to make judgements and decisions.

The charge nurse's list of problems suggests topics suitable for role-play focus. Where the aim is one of the above, concerned with effective functioning, the precise topic chosen need not necessarily be related to the personal experience of every member of the group, nor the details of an activity be confined to real probabilities, e.g. adopting the role of a travel agent, nurse or salesman, may require of the participant skills and qualities which may improve competence in some of the areas of functioning named above, though he or she may be unlikely to have the job concerned.

- 4. Establishing a work routine
- 5. Preparing a patient for life in the community when discharged

Work aimed at fulfilling one of the above functions, concerned with familiarising patients with possible events after discharge, is more likely to be related to individual need and real past, present or prospective experiences.

The leader's decisions on whether content needs to be based on first hand or feasible real experience, may depend therefore on the purpose of the exercise.

The nurse's final remarks on unit policy and function (p.185) refer to the relationship between the nurse and the role-play group leader. Perhaps the most significant factors, as far as criteria to influence the leader's decisions are concerned, are the "full communication" between nurse and leader and "complete confidentiality" of any matters arising in sessions.

The need to make the extent of a leader's communication with staff clear to patients, and of an assurance of complete confidentiality beyond that, unless there is consent from patients for any 'matters arising' to be discussed outside the sessions, may affect the leader's actions and discussions with patients.

The statement of unit aims, as presented in Appendix A, covers factors emerging throughout three to four years of nursing experience in the unit. Not all needs were simultaneously apparent, nor were all associated aims necessarily relevant to the first patients to join the unit and the role-play group. Throughout the history of the unit the membership of the role-play group changed, introducing different needs, problems and behaviours.

The significance of these changes and their relevance to criteria to suggest role-play priorities and techniques are the subject of the following chapter.

CHAPTER IV

THE SIGNIFICANCE OF CHANGES IN THE ROLE-PLAY
GROUP

CHAPTER IV

The significance of changes in the role-play group membership

Criteria governing the selection of role-play techniques to suit specific patient requirements.

Throughout the duration of a role-play project intended to help psychiatric patients, the advice of medical staff responsible for patient treatment is likely to be most valuable. Opinion regarding the type of role-play experience likely to benefit individual patients, suitable topics for group exploration and any problems which might arise, were readily given by the consultant in rehabilitation to help with the particular project being researched in this study.

Relevant information about patient experience, current behaviour or future prospects was discussed, in confidence, prior to each patient's first attendance of a group session and periodically throughout the time that he or she was in the group.

There was no recognised or recommended number of role-play sessions that was thought ideal for all patients. They came to the meetings for as long as was considered suitable for each individual. Deciding factors included the length of their stay in the unit, their response to role-play activities and any benefits which they seemed to derive and their own attitudes to continued attendance.

Consequently the patient membership of the group was fluid. The number of sessions for which the same patients came together varied considerably. There was often overlap of membership as some patients left the unit and new ones were advised to join the group.

During the run of the sessions the type of patient admitted to the unit and recommended for role-play altered, so did their needs and the role-play

priorities. The paper on the unit's function written for inclusion in this study by the Consultant Psychiatrist (Appendix B), describes the variation in the patients for which the unit and the role-play therapy aimed to cater.

Criteria influencing role-play direction to suit specific patient requirements based on the consultant's statement of patient types and on details of individual patient histories and diagnoses

The functions of the Unit and Multi-Disciplinary Team are stated in Appendix A in terms of broad aims which hold good for all types of patient i.e.:

- (1) Assessment
- (2) Improvement of patient functioning
- (3) Discharge into the community

How that Multi-Disciplinary Team, and any therapist called upon to help, met such aims, approached and carried out that task, was not necessarily constant but subject to change according to patient experience, illness symptoms, personal problems and needs arising. The changing nature of these throughout the period of research into role-play sessions is discussed here and related to criteria influencing role-play decisions and technique selection.

This section is illustrated by including notes on individual patients asked to attend role-play sessions. To preserve confidentiality pseudonyms have been given.

The consultant refers to two types of patient:

- (a) Longer stay patients
- (b) Shorter and medium stay patients

(a) Longer stay patients

This group of patients, whose hospitalisation was likely to be from 5 to 40 years comprised mainly chronic schizophrenics with possible associated effects of institutionalisation. The consultant's description of the behavioural consequences of these two conditions again confirmed that the investigation into patient illness and speculation about related needs which has been outlined as part of a role-play leader's preparation for the planning of role-play sessions, and referred to as his 'frame of reference', was

likely to be pertinent to rehabilitative work with such patients. The first patients to move into the unit were long-stay.

The consultant mentions one other important factor to have a bearing on therapy. Her experience suggested that many long-stay patients "fall either in the dull normal or mildly subnormal range of intelligence and are slow learners". (Appendix B).

The intellectual capacity of participants in role-play session obviously has significant effect on the type of activity that is attempted and on the leader's expectation of individual performers. Should the leader pitch these wrongly it may lead to failure, dissatisfaction or frustration.

All factors discussed so far and considered as potential influences on role-play have arisen from what is thought to be typical of patient history, behaviour or prospects. Although mindful of these generalisations a role-play leader is likely to be able to direct the use of his set of practices more purposefully and with greater sensitivity if he is also aware of more specific behaviour of individual patients to be present in the group, and of any related facts in the patient's past or potential future experience. This is one reason why a good liaison between other professionals concerned with patient treatment and welfare is so essential to the effective use of role-play as therapy.

Details of the individual requirements of patients to join the first role-play group were given by their consultant as follows:-

ANDREW

Age: 38 years

Admitted 1973

Requires: Prompting with personal hygiene
Total supervision with finances
Stimulation in every aspect, lazy,
lethargic
Will only do what he is instructed to do.
No initiative.
Supervision with his diet - obesity
Smoking - excessive

Was in group 3 months - discharged

MABELAge: 50 years

Admitted 1959 and 1970

In hospital continually since 1974

Diagnosis:

Chronic Schizophrenia

Requires:

Total supervision with her personal hygiene.
 Instructions on budgeting and decimal currency.
 Observation to stop her from hoarding rubbish -
 cigarettes, packets, sweets, etc.
 Needs correction in her dress sense.
 Is hard of hearing and short sighted.
 Is independent in most aspects.
 Tends to be greedy with food.
 Table manners need supervision.

Was in group 8 months - returned to ward.

CLAREAge: 47 years

Hospitalised 3 years in previous hospital.

In this hospital about 9 months.

Diagnosis:

Schizophrenia

Requires:

Supervision - hygiene - clothes.
 Shy and withdrawn and uncommunicative.

Was in group 8 months - transferred to hostel.

MAY

Age: 48 years
Admitted 1950

Diagnosis: Epileptic, Chronic Schizophrenic

Requires: Correction of speech habits.
Curbing of domineering personality.
Interfering, nosiness and lying.
Help with finances (hoards).
Help with diet (under eats).

Was in group 16 months - transferred to group living scheme.

ARTHUR

Age: 46 years

History of vagrancy and living in other hostels and hospitals.
Admitted to this hospital 8 months before transfer to unit.

Diagnosis: Schizophrenia.

Requires: Prompting in personal hygiene.
Prompting in personal clothing.
Supervision with his diet.
Excessive in the amount of alcohol he drinks.
Anti-social, withdrawn.
Table manners poor.
Lazy, lacks initiative.

Was in group 6 months - discharged.

The patients' requirements fall into 4 categories. Categories 1-3 are behavioural problem areas where some approach to modification of the patient's current behaviour was thought to be a useful role-play aim. Category 4 is somewhat different.

1. Self-care

Inadequate personal hygiene
 Poor supervision of own finances
 Poor supervision of own diet
 Excessive smoking
 Excessive drinking
 Inappropriate dressing
 Hoarding rubbish

2. Anti-social behaviour/personality traits

Hoarding rubbish
 Bad table manners
 Greediness with food
 Lying
 Nosiness and interference
 Domineering behaviour

3. Problems associated with lack of stimulation and withdrawal

Laziness
 Lethargy
 Lack of initiative
 Withdrawal
 Shyness
 Lack of communication

4. Physical disabilities

Poor hearing, sight or speech habits
 Epilepsy

The aims when dealing with physical disabilities were:

- (a) Removing any embarrassment which could cause secondary inhibition or undesirable compensatory behaviour.
- (b) Awareness and reconciliation to any limitations which are unavoidable e.g. safety precautions of epileptics.
- (c) The acceptance and understanding of fellow patients (particularly as they may be living in close social contact with people with such problems).
- (d) Experience to improve faculties if possible e.g.:
 - Improvement of speech habits
 - Improvement of lip reading
 - Improvement of concentration-if associated

When working on problems concerned with physical disabilities such as the above it is almost certain that all patients present will know to whom the topic and exercise are directed. The patients' acknowledgement of the impediment, but with a resolve to minimise its handicapping effect, may be an important part of the role-play function. However, when using role-play to help eradicate specific inappropriate behaviours as in 1, 2, and 3 above, it may be preferable for the sake of group or individual to work on topics with general relevance to several participants and only focus, at a suitable point, on the problem, not the patient, concerned. The leader may hope that if the 'cap fits' the patient who needs it will wear it. This may be particularly necessary when tackling topics such as bad table manners or personal hygiene. The leader's sensitivity to the maintained morale and self respect of patients is essential at all times.

The first group of five long-stay patients met for role-play for the first time on 26th August, 1976. By January, 1979, 93 sessions had been held and 45 different patients had been in the group for varying numbers of sessions. By that time a greater proportion of the patients attending were short to medium stay.

(b) Shorter to medium stay patients

The length of hospitalisation of short to medium stay patients was not easily defined. It ranged from one or two months to one or two years. Patients considered to be in this group also included some with a history of recurring periods in hospital (not necessarily Winterton), the frequency and length of these stays varying considerably between individuals.

There was also likely to be a wider range of diagnostic categories including illnesses with anti-social implications such as problem drinkers, recurrent depressives and personality disorders with associated neurotic reactions and psychoses.

Unlike the chronic long-stay patients the problems of this group tended not to stem from an avoidance of social interaction but from the consequences

of some type of unacceptable or ineffective response to social situations. As described by the consultant some such responses and behaviours became intolerable to hear relatives and presented difficulties when the patients had to cope alone.

Such patients were likely to be quite well in touch with life experiences outside hospital so that, when compared with the long stay patients, more of their perceptions of real experience in the wider environment were available in role-play situations. This would influence role-play aims and possibilities, for short/medium stay patients could approach in role-play, likely situations in the wider society into which the hospital sought to discharge them, with a greater wealth of first hand responses to recall and consider. This may warrant more time being spent on reviewing and assessing past behaviours which relate to current and future encounters than is profitable with long-stay patients with restricted experience outside hospital. However when role-play is used to assist and anticipate discharge into the community, whether it is an entirely new or forgotten community, or whether it is one which is familiar and readily recalled, the aim of using role-play to bring behaviours to the attention of those concerned and the consideration of alternative behaviours and their effects can be equally valid.

As suggested by the consultant, short/medium stay patients were more likely to be in a higher range of intelligence than the longer stay institutionalised patients, though chronic psychosis may also result in a lowering of intellectual capacity. This would suggest that short/medium stay patients would have an increased ability to manipulate ideas and possibly an increased capacity for awareness both in the assessment of their own problems and those of their fellow patients. This again would influence a role-play leader's expectations and direction of a session to use the techniques at his disposal to the best advantage of an individual and/or group.

The consultant's brief reviews of the diagnostic backgrounds and recommended role-play requirements to help in the rehabilitation of six



short/medium stay patients meeting at a later stage in the role-play project, illustrate the needs, problems and concerns of the patients involved.

GERALD

Age: 40 years

Diagnosis:

Recurrent depressive
Anxious, timid person lacking in confidence to cope alone.
Had a broken marriage and more than once had attempted suicide.

Requirements:

To increase his assertiveness and ability to cope with everyday decisions.
To gear him toward a move into a group living scheme.

JIM

Age: 21 years

Diagnosis:

High anxiety schizoid personality.
Shaking at times of severe anxiety.
Natural parents were divorced. Jim was fostered as a child.
Three admissions to hospitals for psychiatric treatment.
One overdose taken two years prior to latest admission to Winterton.

Requirements:

Experience of a stable environment.
Opportunity to deal with new situations.
Experience of situations to help him overcome introversion, if necessary being shown how to mix socially.

LEONARD

Age: 34 years

Diagnosis:

Vulnerable personality with deprived background.
Chronic schizophrenic with depressive episodes.
Isolate becoming anxious and depressed, occasionally drinking to excess.
Fostered as a child. Missed a lot of schooling.
Previous hospital admissions for psychiatric treatment in eighteen months prior to this latest admission to Winterton.
No contact with relatives or friends outside hospital.

Requirements:

To help restore confidence and encourage the making of contacts and friends.
To give opportunity for communication and social skills.
Prepare for group living scheme.

CHRISAge: 31 yearsDiagnosis:

Schizophrenic - recurrent admissions to psychiatric hospitals.

Excessive drinking, several overdoses.

Temper tantrums, avoids crowds.

Head injury.

Father also had had psychiatric treatment in a different hospital.

Requirements:

Experience of social situations in which to display a stable approach to dealing with a variety of circumstances.

Prepare for group living scheme or independent accommodation and work situation.

BRENDAAge: 39 yearsDiagnosis:

Schizophrenic with some illogical thought patterns.

Incoherent and withdrawn at times.

Recurrent overdoses.

Separated, with husband having care of their one child.

Requirements:

Assessment and diagnosis.

Improvement in social skills.

Gearing her to coping again outside hospital and job prospects to be realistically reviewed with reference to her earlier personal problems.

MALCOLMAge: 36 yearsDiagnosis:

Personality problems, affectionless.

Previous suicide attempts.

Adopted as a small child but not told of adoption until adolescence. He had suspected adoption prior to this.

Very possessive attitude to his wife from whom he is now divorced.

Requirements:

Investigation of personal relationships, in particular his attitude to women.

Preparation for return to independence outside hospital and the development of new relationships and new career prospects.

Criteria based on the role-play requirements of this group of short/medium stay patients can be summarised as:-

Their need:

- to experience a secure group environment in which patients may explore a variety of relevant social situations which require effective and appropriate handling not only of the given circumstances, but also the patient's own attitudes and reactions in relation to those circumstances i.e. awareness and handling of self as well as the facts of any given situation.
- to have opportunity for improving communication, self-expression and social competence.
- to prepare for discharge and independence by considering practical issues such as home and self management, job prospects etc. and their attitudes to others outside.

Role-play may also provide diagnostic opportunity for staff in facilitating additional situations for their observation of patient behaviour.

In contrast to the long-stay patients far less emphasis was put on the need to eradicate specific maladaptive behaviours concerned with self-care, antisocial habits or lack of motivation. The consultant's brief was to explore a wide variety of interpersonal situations. Personal relationships and history were thought to be more significant in both cause and recovery from illness and were discussed with staff in more detail than can be given here. It is the doctors and staff responsible for care and treatment of patients who can inform the leader of the advisability and value of role-play to reveal past experience and relationships. Their fuller knowledge of patients should make them better able to judge when retrospective enquiry can aid rehabilitation and when it should be more beneficial to begin where the patient is, and concentrate primarily on current or future experience.

With short/medium-stay patients the preparation to move out of hospital could be related more readily to recall of more recent experience outside which could feature in role-play activities. The relevant experience of partici-

pants was likely to influence not only the content of role-play situations but also the type of activity which could be effectively used.

If role-play was to help in patient recovery it needed to be an adaptable set of practices which could reflect not only patients' needs and experiences but also their abilities.

One of the main differences when working with the shorter stay, less hospitalised patients, was that they could bring problems and topics of concern to them, to the attention of the group. Thus they contributed increasingly to the content and development of role-play sessions. As their confidence and experience increased they could be invited to take over some responsibility for the direction of events. The willingness and wish of the leader to hand over responsibility for leadership with its associated decisions, when appropriate, raised the question of criteria by which to judge the patient's suitability and the likelihood of benefit from a period of leadership. Assuming that there were foreseeable advantages in requiring a patient to direct the group, the official leader's (therapist's) confidence in the wisdom and effectiveness of the move was associated with evidence of the patient's ability to assess relevant factors in a variety of social contexts and to command the attention and respect of other group members. A patient needed to be able to express himself sufficiently well for other people to understand and respond to him and to show that he was willing to undertake the task. Lack of expertise in the handling of role-play techniques was secondary to the ability to direct the thinking of other members in some worthwhile way and to stimulate interest and discussion.

Although patients who have been attending role-play sessions for some time may appreciate the principles involved, discussion may remain for them a more natural medium through which to investigate topics of common interest. A patient who has taken over the direction of a group may not be conversant enough with role-play techniques to capitalise on their use and may need some indication of role-play ways of developing situations - if this seems appropriate and advantageous.

In considering the appropriateness of relinquishing leadership, as related to role-play priorities and effecting criteria associated with the contrasting needs and abilities of patients, the discussion has involved the mention of factors which arose during the course of role-play sessions. In the following chapter further comparison of criteria, as established at the onset of a patient's membership of the group, and as emerging during the course of the sessions attended, will be made. The intention is to assess how far the requirements of one individual patient were met in role-play sessions.

CHAPTER V

THE REQUIREMENTS AND WANTS OF ONE
INDIVIDUAL PATIENT

CHAPTER V

Criteria governing role-play techniques in relation to the requirements and wants of one individual patient

The value of reliable information from doctors or nursing staff to guide a role-play leader has already been emphasised. The advice of staff is particularly useful in the early stages of the leader's association with a patient when it helps to ensure the appropriateness of both the leader's attitudes and the activities in which he chooses to involve the patient. When he gets to know a patient a little better the leader may become aware of areas of difficulty or particular interest which were not mentioned by staff. Role-play itself may reveal anxieties or problem behaviours. Equally it may reveal unexpected aptitudes and abilities.

When working with a patient who appears to be readily able to talk about his difficulties and concerns, the leader may need to guard against the assumption that the topics and situations which the patient says worry him or which he may even suggest working on in role-play, necessarily reflect all of his problems. The leader must not overlook the possibility of conscious or subconscious omissions or a patient's falsely created impressions of what he is or how he behaves.

The leader may have to direct events according to the patient's needs as perceived by the patient himself and/or his doctors and nurses, and according to his own observations of that patient in or out of role or indeed outside of the role-play sessions altogether.

From written observations made at the time of a patient's inclusion in the role-play group, and from tape recordings of some of the sessions, the intention in this section is to trace factors related to one patient's role-play contributions and attitudes to the sessions, and to outline the criteria which affected the leader's decisions and actions in trying to help that patient.

It is important to note that although this review focuses on one individual female patient, she was one of a group with an average membership of eight. The work done in those group sessions had to be planned and directed with the needs of all of those members in mind. Only one session, the last that she attended, was, at her own request, devoted primarily to her requirements.

Maureen

Maureen was the twelfth patient to come for role-play. By the time she joined the group, it was quite well established, 33 sessions having been held. Some of the original patients had left the group so that the average attendance was eight.

During that period she came to 30 sessions.

The consultant's report (Appendix C) was prepared in January 1978, approximately half way through Maureen's time in the rehabilitation unit and in the role-play group. Her background problems and possible role-play requirements were discussed at the onset and throughout her membership of the group.

Requirements suggested in discussion with the consultant when Maureen joined the role-play group

1. Assessment

(a) Discovery of her attitude to:

- home and family
- peer group, particularly the opposite sex
- fellow patients and making friends

(b) Enquiry into adolescent memories, in particular the influence of her schooling, partial sightedness and limited educational progress.

(c) Discovery of her attitudes to past employment, her own awareness of her current skills and job potential, also her attitude to future work.

(d) Assessment of her ability to organise her own affairs and cope with a variety of domestic or social situations.

- (e) Discovery of her attitudes to romance, marriage, babies, with a view to future sexual counselling (by an expert, separate from role-play) "If she asks for it".

2. Improvement of patient functioning

- (a) Supplementing, if possible, any advice or practice of practical skills being developed in the everyday experience of the unit, such as the planning and preparation of meals, care of a home, self-care, hygiene, appropriate appearance and dress.
- (b) Supplementing real experience of a variety of social situations, where necessary trying to increase confidence, competence and pleasure gained from social interaction.
- (c) Establishing a realistic view of the limitations imposed by partial sightedness but seeking to overcome any barriers to independence and confidence.

3. Discharge into the community

- (a) Adding to the development of skills (as in 2), an ambition to be independent and the conviction that hospital life can be left behind.
- (b) Practice in coping with likely outside occurrences.
- (c) Improving her attitude to community workers from whom she may need future support.

Meeting as many of the above requirements as possible within a shared group venture, suggested criteria which could influence the role-play leader's aims and actions with regard to Maureen's rehabilitation.

The following material, taken from the leader's notes and tape recordings of her contributions to role-play sessions, and from notes on the leader's experience of the patient outside those sessions, is presented here as an indication of any influence of the above initial criteria and of any new ones arising during Maureen's membership of the group.

(1) 2.6.77.

ROLE-PLAY

Conclusion of project spanning several weeks in which we had role-played the experiences of a patient on the ward.

Now:

- (a) transfer to the rehab. unit (reassuring a new patient)
- (b) discussing problems with staff
- (c) conversations with person of (1) same sex, (2) opposite sex

NON-ROLE-PLAY

Discussion of role-play content and relevant real experience. Informal chat before session and before tape recorder was switched on. Asking for suggestions of suitable role-play topics for next week.

- need to allow new patients (including Maureen) to observe role-play practice and session format
- to work on a situation which patients would have experienced in common
- to encourage established group members to befriend new ones
- to remind patients that staff are there to help them
- need to encourage amiability between sexes and suggest topics of conversation
- to remind them that sessions are for their use and benefit
- to stimulate conversation

Maureen said she would not speak while the tape recorder was on. She agreed to sit and observe. She spoke one word in discussion "Yes". She would not be involved in role-play - said she "didn't like acting" - when tape was off!

After the session she told me how much she disliked a fellow patient because she "pried into other people's affairs". Said she disliked Spaniards because they were over-familiar. She seems a very private person which possibly relates to her dislike of the tape recorder.

My aim was encouraging her to say anything at all in sessions, allowing her to observe and putting her at ease in conversation with me outside sessions.

9.6.77. Maureen did not come to this session saying she didn't think she wanted to be in the group.

I invited her to observe the following week.

(2) 16.6.77. NON-ROLE-PLAY

Patients were asked if they could remember previous session. Tape played to aid recall.

ROLE-PLAY

"Suitable employment" topic chosen by patients.

- (a) demonstration by patients of one aspect of a past job - teaching skills involved to others in group
- (b) Maureen in semi-role when she showed interest in typing.

NON-ROLE-PLAY

Kim's Game - a memory exercise.

- to show helpful use of tape recorder.
- to allow display of patient expertise in familiar skills and give them responsibility to direct others
- to give opportunity for leader to praise their abilities and raise their status
- to stimulate Maureen's interest in a job related to her training course
- to allow Maureen to show her memory skill
- to give group a break from role-play

Maureen showed interest in jobs of others and was particularly interested in typing as she was attending a clerical course. She spoke in semi-role situation. She discussed her typing progress. She was very good in Kim's game. Said she still didn't like tape recorder.

Kim's game relies partially on vision and Maureen adapted and accepted help from others who described the position of articles to her.

She seemed more relaxed. I said I would not use tape recorder for a while.

Main aim was to interest Maureen enough for her to continue attending sessions and if possible ease her into role-play.

(3) 23.6.77. ROLE-PLAY "Job interview"

- (a) Interview (did not actively involve Maureen)
- (b) Coping with annoying habits of others at work.

NON-ROLE-PLAY

No tape recorder! Free flow of discussion.

- primarily to benefit a patient soon to meet this real situation
- to involve all members (including Maureen) in discussion of an aspect of life outside
- to involve members in interpersonal role situations possibly with attendant anxieties but also practical advice
- follow-up suggested by patients therefore need to develop their ideas
- need to accept Maureen's contributions however small

Was helpful in discussion of interview technique. Made spontaneous suggestions. One small role episode - said she couldn't rouse herself to anger in role-play but admitted to intolerance in real situations.

Maureen was a minor contributor to role-play but joined in general discussion. Showed experience of the job interview situation.

N.B. The patient she dislikes has been transferred to an adjoining unit but still comes to role-play.

<u>Session</u>	<u>Role-play session activities</u>	<u>Criteria</u>	<u>Response</u>	<u>Leader comment</u>
(4) 30.6.77.	<p><u>ROLE-PLAY</u> "Maureen's job as a Nanny" She interviewed leader in role of applicant for position of Nanny for her family.</p> <p><u>NON-ROLE-PLAY</u> Discussion of her real job prospects. Still no tape.</p>	<ul style="list-style-type: none"> - to use very relevant material to get as much voluntary involvement of Maureen as possible - to encourage positive attitudes to future events 	<p>Good role-play by Maureen which covered such topics as - preference for babies or older children, working hours, conditions, wages and discipline. (Asked me if I would ever smack a child - her view is it is acceptable in some circumstances). Discussion of accommodation and living away from her home district.</p>	<p>After the session Maureen told me of her night vigils beside her sick grandfather. Said she would always be patient with someone like that and it was a family responsibility.</p>
(5) 21.7.77.	<p><u>ROLE-PLAY</u> "Shopping and preparing meals" (a) Helping house bound friend. (b) Advising friend who does not eat sensibly.</p> <p><u>NON-ROLE-PLAY</u> No tape</p>	<ul style="list-style-type: none"> - to work on topics of general interest to all - primarily to help some poor ability patients - to involve Maureen in advisory role 	<p>Sympathetic handling of a rather confused low ability patient, advising on appropriate meals.</p>	<p>Maureen showed tolerance in working at a very simple level to help someone else - who incidentally was male.</p>
(6) 29.7.77.	<p>Last session before summer break</p> <p><u>NON-ROLE-PLAY ACTIVITY</u> Asked if anyone objected to tape recorder. Patients asked to explain role-play to new ones and assess any values.</p> <p><u>ROLE PLAY</u> to demonstrate activities (a) Doctor/patient interviews prior to discharge. (b) Leaving hospital - suggested problems.</p>	<p>Several new patients present who may join group in September.</p> <ul style="list-style-type: none"> - to prepare new patients for use of recorder - to assess Maureen's attitude to above - to encourage patients to evaluate any benefits of role-play - to encourage experienced members to set new ones at ease - to observe Maureen and group's response to discharge - to explore relevant situations - to see what patients anticipate difficulties could be out of hospital 	<p>Said she didn't mind tape being on because "I only say what I want other people to hear any way. I've still not said anything important to me!" Said she didn't like records kept or people who spy like social workers. Said break from hospital should be final. Thought role sessions were alright because they were not all acting.</p>	<p>Maureen said in session that the role-play group gave opportunity to talk. She later enlarged on this saying there was more time to say what you thought than to a doctor - they were always busy. Couldn't suggest role situation to demonstrate reasons for disliking social workers as no first hand experience - only hearsay.</p>
(7) 1.9.77.	<p><u>NON-ROLE-PLAY</u> No tape recorder - as new members in group needing secure atmosphere.</p> <p><u>ROLE-PLAY</u> Topics very varied and short to familiarise new patients with techniques and forms</p>	<ul style="list-style-type: none"> - to promote a relaxed atmosphere - to familiarise patients with techniques - to boost confidence - to stimulate communication - to prevent embarrassment - to make an enjoyable start to role-play experience but move gradually to more serious considerations 	<p>No details of development of activities given here as they were almost irrelevant to Maureen.</p> <p>She agreed to stay and watch so she may have indirectly benefitted from events in what was for others a pleasant session with a lot of role work. No attempt was made to persuade Maureen to take a role.</p>	<p>Maureen was heavily sedated and had just returned to the unit from ward care after a threatened suicide which seemed associated with depression and the birth of the baby of one sister and the pregnancy of the other.</p> <p>(In her conversation with me she denied the above reason. Doctor advised against any mention of this subject in role-play).</p>

<u>Session</u>	<u>Role-play session activities</u>	<u>Criteria</u>	<u>Response</u>	<u>Leader comment</u>
(8) 8.9.77.	<p><u>NON-ROLE-PLAY</u></p> <p>Let patients talk their way into an appropriate point to begin role-play. Session taped. Discussion of living situation.</p> <p><u>ROLE-PLAY</u></p> <p>(a) Making conversation with new acquaintance - e.g. at a social, introductions, ordering drinks, etc.</p> <p>(b) Advice on how to get along well in the unit - all to give suggestion.</p> <p>(c) Tackling people about not doing their share of chores.</p> <p>(d) Kitchen duties - cooking skills.</p>	<ul style="list-style-type: none"> - to provide warm-up to role-play until all group assembled - leader's need to cast around for suitable topic - to build on recent real experience - need to put patient in superior, helpful, role - later need to involve distractable patient - need to extend involvement to whole of group - to give opportunity to work on situations occurring in unit - to supplement real experience of 'making apple pie 	<p>Very tolerant of opening work with less able patients.</p> <p>A few contributions to discussion when we were considering unit duties.</p> <p>No role-play.</p>	<p>Said she got on with the patient she previously disliked much better. Thought she did well in role-play sessions. Observing has some effect!</p>
(9) 15.9.77.	<p><u>ROLE-PLAY</u></p> <p>(a) Miming games using everyday activities</p> <p>(b) Domestic activities and instruction in simultaneous cross-talk (Arose from their discussion).</p> <p><u>NON-ROLE-PLAY</u> activities</p> <p>Discussion of school days. Semi-role game about school.</p>	<ul style="list-style-type: none"> - to provide lighthearted warm-up - requiring only non-verbal participation - requiring more than one person to speak at any one time, thereby reducing pressure on the individual (inc. Maureen) - to provide lighthearted conclusion to session - to assess attitudes (inc. Maureen's) 	<p>Made one guess at activity but seemed at ease and interested. Accepted role of instructor and spoke in cross-talk situation then gave verbal instruction on her own. Did not volunteer information about school days. Enjoyed game.</p>	<p>Immediate help in getting patients together for session. Still seems to prefer activity which is not obviously acting.</p>

Session	Role-play session activities	Criteria	Response	Leader comment
(10) 22.9.77.	<p><u>NON-ROLE-PLAY</u></p> <p>Gaming activities moving from non-verbal to verbal.</p> <p><u>ROLE-PLAY</u></p> <p>(a) Simultaneous paired dialogue on choice of topic for $\frac{1}{2}$ min.</p> <p>(b) Variations on above with imposition of some conditions on topic and circumstances</p> <p>(c) Making conversation with someone who is unresponsive</p> <p>(d) Terminating a conversation</p> <p>(e) Alleviating depression of fellow patient</p>	<ul style="list-style-type: none"> - to open with enjoyable activity which seemed popular in last session - patients may feel more secure when more than one person speaks in only semi-role - to build up to fuller role participation which was still not viewed as 'acting' - to illustrate frustration of trying to make conversation with someone who is uncommunicative (a common experience in the unit) - to show a contrasting situation where there is need to deal with an over-talkative person - to follow up using patient's experience - reinforcement with praise for effort 	<p>Joined in games without objection. Maureen joined in pairs activities and discussed role-play experience. Spoke of real experience of avoiding conversation with a person without giving offence. Raised subject of listening to and helping someone who is depressed. Slipped easily into role of advisor, comforting depressed patient. Suggested ways of patient embarking on new activities and going on educational courses.</p>	<p>One may have expected Maureen to be hostile to rather juvenile games - but she was not. More spontaneous, uninhibited expression of views and narration of experience. Other patients praised Maureen's contribution. I was able to thank her for positive effort and helpful advice and attitude.</p>
(11) 6.10.77.	<p>Maureen had been absent the previous week and asked immediately "What did you do last week?" This show of interest led the group to explain and continue the previous week's topic of:</p> <p><u>ROLE-PLAY</u></p> <p>(a) A tired son, home from work.</p> <p>(b) The above situation was used to begin group development of a dream theme. One patient's fantasy about "Desert tribes and the Foreign Legion"</p> <p>(c) The above mentioned cameo episodes including demonstration of skills etc.</p> <p><u>NON-ROLE-PLAY</u></p> <p>Issues from the above dream compared to reality and the family.</p>	<ul style="list-style-type: none"> - to stimulate recall - to provide information requested by Maureen - to give members an opportunity to organise and develop ideas - to enable leader to try a new technique - exploration of a dream theme - to relate fantasy to possible real events - to stimulate judgements and discussion - to conclude session satisfactory 	<p>After initial interest in events she had missed Maureen was only slowly drawn into action of dream improvisation in a semi-role as an advisor. Joined in discussion of relevant family issues. She expressed very adamant opinions about family and home situations. (Not taped)</p>	<p>Single minded in her refusal, in role, to help shield a deserter and said if one left a tribe, regiment or family there should be no readmission allowed. After session she said dream was too "way out" and did not want to act. She did not mind discussing related real events and spoke of her sister's boyfriends.</p>

(12) 13.10.77. NON-ROLE-PLAY
Recall of previous week's work.
ROLE-PLAY - related to above
Short encounters about "compromise"
in marital relationships.

- to use their ideas
- to assess attitudes
- to encourage all (particularly Maureen) to consider alternative actions and outcomes

Said "I would compromise if it suited me". But added that any mellowing of her stance would be due to her feelings for a man, not the ties of marriage.

Much of this week's work was based on the real marital problems of other group members but Maureen did make useful spontaneous comments.

(13) 20.10.77. ROLE-PLAY
Many short episodes about
(a) "avoiding duties", "breaking rules" in variety of situations
(b) relating the above to unit expectations and explaining job of work to new patient.

- in order to relate to previous work
- to explore patient views and stimulate discussion
- to contrast emotive responses and appropriate time to apologise
- patients had opportunity to talk of responsibility to people in the unit and outside, and express attitudes to work

Positive attitudes - some role-play

Touched on approaches to people and to work disciplines.
Still resists too much role-play but many topics relevant and perceptiveness evident in discussion.

(14) 27.10.77. NON-ROLE-PLAY
After previous session patients were asked to write down some topics with which they thought role-play could help.
ROLE-PLAY
All role-play based on these problems with patients concerned.

- in order to hand over initiative to patients and find out what they see their problems to be
- need to work on relevant material accepting their ideas

Maureen gave me an impractical list with facetious topics such as - "learning to ride a bike".
It did include improving her reading and writing.
In session she was not very co-operative, but helped patients' planning.

After session said she spoiled list because she thought it was for staff and did not want to co-operate - apologised.
Commented on inhibiting effect of staff in sessions.
(Second sister had baby following week).

(15) 3.11.77. ROLE-PLAY "Jobs"
(a) Game - everyone in turn guessing job indicated by dialogue with leader.
(b) In pairs working on realistic meetings of people with different jobs.

- to provide lighthearted approach
- to involve every member
- to encourage patient initiative, working with as many as possible in short encounters to stimulate discussion
- to emphasise that there is no intention of hiding the tape recorder or its uses

Reference to use of tape to emphasise that I now intend to go on using it and why but not for purpose of staff spying. If they wanted to attend they could do so.

Doctor did not recommend any direct concentration on 'baby' topic.
Maureen later spoke to me about her feelings of inadequacy because of her interrupted education and poor vision.
Apologised again for spoiled role-play list but said her main problem was poor reading and writing. (List had been neatly written - she is not illiterate).

NON-ROLE-PLAY

Direct reference to uses of tapes

7.11.77. On a visit to the hospital, between sessions, Maureen said that the practical help she needed was to improve her reading and writing. She said that she did not feel she could go to adult literacy classes but would appreciate some tuition if I could manage to spend a few minutes with her after the sessions.
N.B. Maureen was not illiterate. She could write - not too tidily, she read adequately to herself, she could handle money and figures. She seemed to lack confidence, practice and advice. I agreed to spend a little time each week and she said she was pleased because she was used to me. She readily agreed on her first task - A letter to her sister in hospital after birth of baby.

- (a) Several interrelated episodes involving a variety of job roles and discussion
- (b) Deliberate inclusion of "social worker" role
- (c) Extension to involve more people in drama story

- to encourage initiative
- to encourage recall
- to allow praise for role-play efforts thereby influencing observers also
- to encourage communication and co-operation
- to assess Maureen's opinion of the real life role of a social worker
- to encourage patients to identify with the duties and possible motivations of a social worker
- need to involve more of group
- need to relate to patient's personal experience

Not involved at beginning of session but spontaneous help in planning. All group very patient while main work was being done with low ability patient. Clear lead in planning - talked of patient need of social workers. No resistance to role of workmate in social worker's enquiry - people asking questions about ex-patient.

One always hopes that observation of qualities such as consideration and tolerance may have good effect on observer. Maureen less hostile. Other patients talked of help of social workers in real experience. Less derision of their job, function, and personal approach to ex-patients.

(17) 17.11.77. ROLE-PLAY

- (a) Continuation in encounters between people with different job and experience backgrounds
- (b) Suitable jobs and interviews
- (c) Domestic implications of working wife

- to introduce role-play to new members via a topic of general interest
- to encourage conversation between members
- to encourage spontaneity, concentration and co-operation
- to stimulate discussion of problems

Spontaneous involvement. Input of new ideas and acceptance of role. Initiative in role. Most positive contribution to date. Comment on real job prospects.

Remedial reading and writing continues well.

(18) 24.11.77. ROLE-PLAY

- (a) Selling 'social tickets' to casual acquaintances - anxiety
- (b) Door to door selling
- (c) Dealing with salesmen
- (d) Consideration of wise buying
- (e) Situations concerned with budgeting and family co-operation
- (f) Outcomes of carelessness

- to help with practical problem, mentioned by Maureen
- to facilitate a less-confident patient's handling of a situation in role-play which could cause anxiety in reality
- to observe response or advice of other patients
- to continue the theme of 'selling' in relevant situations
- need to consider budgeting when living outside hospital

Brought problem to attention of group. Comment on her own task and encouragement of others in discussion. Speaks freely now. Good inventive role-playing dealing with matters which could arise in family outside.

Maureen is helping prepare for unit social and advising others. Even when not actively involved in taking a role, Maureen pays attention and introduces relevant ideas and opinions.

Maureen gains from presence in group of new male patient who shows ability and application to group activities and role taking.

(19) 1.12.77. NON-ROLE-PLAY

Introduction of topic "carelessness" and regretting incident - involved patients' value judgement and discrimination.

ROLE-PLAY "responsibility"

- (a) 2 groups to work, in leader's absence, on topic stemming from sentence, "If only I'd met him/her as I said I would"
- (b) Group work to be shown to other group and 2 outside visitors

- to provide progression from previous week
- requiring concentration, attention, initiative and judgements
- to encourage discussion of interpersonal problems
- to allow opportunity for patients to work without direction from the official leader
- to observe ability to work together and any natural leaders
- to provide a link with topic responsibility
- to facilitate follow-up
- to link follow-up with Maureen's interest in children and encourage opinions and judgements

Joined in discussion. Maureen was one of the first to open discussion with group and begin organisation when leader left patients to work. She showed ability to direct the sub-group she worked with in both the planning and enactment of their scenario. She showed consideration for other group members. Took key role in 'pretend' 'acting' situations such as she used to avoid and deride. Discussed topics arising freely. Visitors talked among themselves in session. Later Maureen was first to complain of their rudeness.

Maureen chose to work with the patient she had previously disliked - possibly because of her respect for the patient's role-play competence. She was tolerant and involved patients in work who she was likely to have ignored in the past. (Knew tape had been left playing).

Not only studied topic of 'responsibility' but displayed her own in her actions in group.

Leader was able to praise whole group.

NON-ROLE-PLAY

Role-play led to discussion of responsibilities to children. Again asking for value judgement.

patients invited to suggest situations which may cause difficulties or anxieties.

All role-play based on these.

(21) 12.1.78. ROLE-PLAY

- (a) Conversing with a variety of people
- (b) Relationships with ward staff and doctors.

NON-ROLE-PLAY

Much enquiry into their own views of illness, hospitalisation and treatment

- to explore topics suggested by patients about 'going out of hospital'

- to explore topics arising from patient's suggestions of suitable role-play
- requiring patients to identify with duties and motivations of staff
- requiring patients to enquire into their own views of illness and treatment etc.
- to familiarise leader with experiences of patients, their fears and doubts

just a little role-play

Joined in group consideration of patient illness symptoms and staff attitudes to their behaviour.
Patients spoke frankly and confidently about patient/staff relationships - they seemed secure and uninhibited in the session atmosphere.

play the topics were relevant e.g. making new friends and help from social workers.

Sessions at this time were focussing very much on problems of other patients in group and though quiet, Maureen was interested and sympathetic.

(22) 1.2.78. ROLE-PLAY

- (a) Callers at the door such as - workmen, traders, neighbours, religious fanatics

- anticipating patients dealing with such encounters and decisions outside
- to provide simple role situations, good for face-to-face conversation
- openings for discussion etc.
- patients could compare with similar real experience

Refused to be drawn into conversation or action.
First sign of resistance for weeks.
Did stay to observe.

Maureen later said that she did not want to participate while a patient, who tended to monopolise and deviate to inappropriate personal experience, was in group.

(23) 24.2.78. ROLE-PLAY

- (a) Job encounters but also with addition of personal circumstances and role characteristics supplied by patients taking the roles
- (b) School days - situations recalled "Running away from school". Various conversations between parents, headmaster and staff about circumstances of child who ran away.

- to provide practice in coping with interpersonal situations
- requiring initiative in providing fictitious background to role portrayal
- encouraging decisions and opinions in situations relevant after discharge
- to provide openings into discussion
- to stimulate recall and exchange of ideas
- to assess attitudes to schooling and children
- to give Maureen opportunity to express her views in role of mother
- to build Maureen's recalled experience into improvisation

Pleasant, acceptance of activities suggested. Said she would hate to go back to school days.
Readily supplied information about own unhappiness at residential blind school. (Had to leave home at 13).
Spontaneous move into role of mother of runaway child.
Mentioned her own vision problems and her need to go to boarding school - home-sickness.
Also offered suggestions to ease problem.

There was very serious concentration on the problems of a little child away at residential school and conversation continued long after normal session time when patients, including Maureen, began to compare anxieties, needs and ways of alleviating them with those of a patient, isolated from home, family and friends in hospital.

Patients asked if they could continue this discussion at next meeting.

(24) 2.3.78.

No role-play in this session but activities came directly from previous session.

- (a) Patients decided to draw up list of things which may help a home-sick child in boarding school and see if relevant to their own situation in hospital.

- patients wanted to listen to previous week's tape, to plan and talk through ideas
- satisfactory outcome obviously important to them all
- respecting their very earnest approach

Joined in group discussion of attitudes to child and themselves of:-
(a) other people, peers, friends
(b) staff in their establishment.
Also ways of helping themselves.

Topics discussed involved - visitors, maintaining contacts, communicating with outsiders, getting people to mix in unit, putting new patients at ease, approaching staff for help, occupation on ward, social activities, recognition and thanks for help given, praise for doing their best from staff.
"Staff attitudes" suggested for role-play next week.

Maureen was absent from the following session which dealt with staff/patient relationships and attitudes, as she was transferred to an adjoining domestic unit which was designed to foster independent self-care and self-catering.
During this period I continued to see her, at her request, to give reading and writing tuition. She asked to continue in role-play group.

- (25) 30.3.78. ROLE-PLAY - introductions
- (a) Formal - as in interview situation
 - (b) Informal - many situations involving meeting people and renewing acquaintances
 - (c) Job interviews
- done at patient's request
 - relevant after discharge
 - required direct face-to-face communication
 - required initiative
 - raised issue of whether patients should tell outsiders about their illness and admission to a psychiatric hospital
- quiet but short role-play portrayal. Became reluctant in latter stages of session.
- during this session I was working for much of the time with the patient who Maureen disliked. She said after session that the said patient was stupid because she did not always understand role-playing and came out of role to tell of personal experience.
- (26) 6.4.78. ROLE-PLAY
- Various episodes concerned with suitable choice of job.
- done at request of male patient who had applied for one job and wished to consider other alternatives and how to set about enquiry etc.
- Posed one or two pertinent questions to interviewee.
- (27) 13.4.78. ROLE-PLAY "The best present I ever had".
- Work done in pairs.
- (The rest of this session was concerned with the needs of others following Maureen's walkout).
- was intended as an opener - a light hearted beginning to the consideration of attitudes to earning and spending
- The patient who was the current focus of Maureen's disapproval arrived late. As soon as she arrived Maureen excused herself and walked out in the middle of the first role exercise.
- Maureen's actions had disturbed other members; in particular the person with whom she was working at the time. Restoring her partner's morale became a criteria in rest of session. I later spoke to Maureen about her lack of consideration for others when angry, which contrasted with her kindness and help displayed with patients in previous sessions. She said she had been "full of hell" for a number of reasons - including relationships with peers and staff.
- (28) 20.4.78. NON-ROLE-PLAY
- As two new patients were present the experienced members of group were asked to explain role-play to them.
- ROLE-PLAY
- "Dealing with the unexpected"
- (a) Phone messages for staff or patients not able to take calls.
 - (b) Use of phone call box, dealing with cut off calls.
 - (c) Patients asked to suggest calls which they may have to make. Suggested - calling doctor; informing unit when late back from leave because of missing last bus; phoning for a taxi; phoning benefit office, etc.
- to familiarise new patients with procedures
 - to assess the other patients' view of what is done in sessions and why
 - requiring initiative
 - to provide discussion of appropriate action and unit practice
 - involved use of surnames of staff and patients. They did not know many of these
 - required spontaneity, appropriateness, confidence, memory
 - all such occurrences could be relevant to those going out
 - it was a positive forward looking activity for those nearing discharge, such as Maureen
 - stimulated discussion of problematic situations about which patients could advise each other
- While patients were assembling for session Maureen was the first to speak, making general conversation without hint or comment on previous week's walkout.
- She was the first one to begin an explanation of role-play to new patients and later spoke freely of personal experience with other patients.
- When asked to take call said "Is it alright if I don't write anything down? I can't see".
- She was not anxious but acceptive of this limitation and coped well with phone message.
- More role-play in this session than in previous week. Willing and confident.
- Maureen and the patient she refused to work with both present. No sign of antagonism.
- Maureen had confidence to correct me about ambulance procedure, this was acknowledged.
- She was very helpful and showed a lot of good sense and ability to cope with unexpected circumstances.
- Possibly more willing to be involved because we were dealing with the handling of practical circumstances - coping with events, rather than coping with people or revealing interpersonal relationships.

<u>Session</u>	<u>Role-play session activities</u>	<u>Criteria</u>	<u>Response</u>	<u>Leader comment</u>
(29) 27.4.78.	<p><u>NON-ROLE-PLAY</u></p> <p>Recall of an earlier session in which 'failure to keep appointment' was topic - linked with this week's role-play.</p> <p><u>ROLE-PLAY</u></p> <p>(a) Patients asked to role-play a patient declining to do someone a favour - but with good reason</p> <p>(b) Use of Maureen moving to another chair to illustrate another situation where action may be justified but misunderstood</p> <p>(c) Asked to role-play a situation in which explaining why they were moving away from someone was thought to be appropriate</p> <p>(d) Refusal to help a neighbour who asks a favour - 'minding baby'.</p> <p><u>NON-ROLE-PLAY</u></p> <p>Discussion of any reason which may induce Maureen to change her mind about allowing her brother's dog in her house.</p> <p><u>ROLE-PLAY</u></p> <p>(e) Patients asked to think of and role-play the asking of a favour - address request to leader</p>	<ul style="list-style-type: none"> - to provide a lead into new role-play topic of hasty judgement without possession of facts - required long term recall - required spontaneous involvement of individual patients - prompted discussion of alternatives and value judgements - to utilise real spontaneous act to develop topic and stimulate discussion of how misunderstandings can arise <ul style="list-style-type: none"> - requiring patients to reflect on their own behaviours and the need to consider their effects on others - role situation involved justification of actions therefore require judgement - provided natural follow-up to "doing someone a favour" based on Maureen's real family experience - looking for further development of theme - leader's illustration of alternative behaviours required patient's decisions and opinions - leader's deliberate refusal, in role, was abrupt and aggressive to stimulate response 	<p>Joined in initial discussion and did not object to focus on her action or discussion of her motives.</p> <p>Joined in discussion of reasons why refusal to mind baby may be justified. Brought up subject of looking after her own house and her refusal to let her brother bring his dog there. Could think of a couple of exceptions - therefore less adamant attitude.</p> <p>Many patients recognised the difference in manner of refusal to help and could suggest underlying reasons.</p>	<p>The theme planned was 'not judging without full possession of facts and the possible effects of hearsay on the reactions of others'. It was planned with Maureen in mind as she was still hasty in judgement and carried tales.</p> <p>This early work on not giving offence to others was explored generally by all but should have been significant to Maureen.</p>

<u>Session</u>	<u>Role-play session activities</u>	<u>Criteria</u>	<u>Response</u>	<u>Leader comment</u>
(29)(contd.)	<p><u>NON-ROLE-PLAY</u></p> <p>Maureen asked to justify the remark which she said sounded like her - led to general discussion of the borrowing habit</p> <p><u>ROLE-PLAY</u></p> <p>(f) Nasty refusal to lend a cigarette to fellow patient</p> <p>(g) Derogatory remarks about character in above role situation which may be made behind his back</p> <p>(h) Leader's spontaneous request in role to borrow shampoo from Maureen</p> <p><u>NON-ROLE-PLAY</u></p> <p>Discussion of related real experience.</p> <p><u>ROLE-PLAY</u></p> <p>(i) One patient remarking to another - "You don't want to go to that role-play thing - it's a load of rubbish".</p>	<ul style="list-style-type: none"> - Maureen was required to assess and comment on her own behaviour - to allow natural development of patient's ideas - situation intended to stimulate discussion of hasty judgements and subsequent justification of someone else's actions - leader's spontaneous, 'in role', statement was intended to catapult Maureen into response and the role-play situation - allowing time to talk but at times focusing attention on the 'hearsay' issues <p>- this attitude intended to provoke comment from two new male patients</p>	<p>When retort of leader in role was abrupt and aggressive Maureen said - "It sounds like me that".</p> <p>When asked to justify the refusal and manner said - "I don't borrow and I don't lend - under no circumstances!"</p> <p>Immediate uncompromising refusal to lend by Maureen.</p> <p>She was critical of others who were afraid to say no.</p> <p>Maureen was first to say remarks such as, "Oh, I know her, she's always after cigarettes", did go ahead of them.</p> <p>One new patient immediately said that he had just made a similar remark to his colleague before coming to this their first session. He based his opinion on attendance of another role-play group.</p> <p>Maureen and others offered ways of using role-play to benefit them most.</p>	<p>Able at this point to bring in topic of 'giving someone a bad name'.</p> <p>This was a very lively session and patients were particularly motivated by reference to persistent borrowers, relating many stories of patients who were renowned for this behaviour. This gave opportunity to turn thinking to experience of tales and a reputation preceding someone in the hospital environment. They could give examples of a hearsay and when it should and should not be believed.</p> <p>Maureen took me aside during session and asked for part of the tape, where she got angry in role, to be erased. "In case the doctor thinks I really am like that".</p> <p>I reassured her about the doctor's interpretation but it does contrast with her early resistance to identifying with any emotive role situation - even if response was only simulated - 'acted'.</p>

(j) One patient remarking to another "You don't want to have anything to do with social workers. They don't do any good. They only ask a lot of questions".

- again to provoke response because there was a social worker present

Again discussion of help from social workers, with the social worker present. Maureen said, "When I leave here I will probably have a social worker coming to my house". "If she's alright and I like her I will let her in. If I don't, I won't." "It will be someone else to talk to, different company". "I used to be suspicious of social workers". "A girl told me what her social worker did and I thought, I'm having nothing to do with them". "Since I've come down here I've seen some and I think they're alright". "Some might be awful but you don't need to have anything to do with them".

The comprehensive discussion about the functions of social workers and personal experiences of patients receiving help from them may have helped to mellow Maureen's attitude to them. At least she admitted that her earlier suspicions were based on what she had heard about them, not on her own first hand experience of them.

Again there was opportunity to thank patients for positive contribution to the sessions.

After this session Maureen asked if the following week could be used to help her "See herself as others see her". It was decided, after consulting her doctor, to devote the role-play meeting to this request.

NON-ROLE-PLAY

Lengthy final discussion of the patients' views of the role of a social worker.

(30) 4.5.78. This session was planned to meet Maureen's request to see the image that others have of her. She was expecting to leave the hospital, possibly to live in her own council house. Having discussed Maureen's good and less commendable qualities with the doctor and nurses responsible for her rehabilitation it was decided that the group leader should role-play various reactions, attitudes and ways of communicating, some of which the leader may think to be typical of Maureen. It was to be left to the group and Maureen to decide which portrayal personified her behaviour. It was agreed at this stage in her rehabilitation that it was particularly important for the whole experience to be constructive and that although her request in itself invited criticism, care was needed to ensure that although the image was honestly presented, it was not a blow to morale. It seemed particularly important to conclude with emphasis on the many good qualities which had been observed by many of those present, 2 staff members were to be present and had agreed to play any roles necessary in the initial stages of the session.

ROLE-PLAY

(a) Three ways of reacting to a suggestion, from a friend, of updating her image by changing such things as hairstyle or dress.

- (1) Indecisive, choices influenced by others.
- (2) Eager to try different styles.
- (3) Inflexible, not to be swayed by fashion or the opinions of other people. Aggressively adamant and suspicious of motives.

- Maureen had no interest in fashion trends preferring to wear plain trousers or short straight skirts with dark or neutral coloured sweaters. Her long, straight hair was usually worn loose giving a rather immature appearance.

Maureen saw something of herself in (1) and (3) but in discussion she decided that (3) was more typical. The group members similarly agreed. Maureen said, "Ask the others to say what they think first or they will just agree with me".

It was important that the group and Maureen formed their opinions without the leader imposing a definite image at first.

In conversation after a session Maureen had previously mentioned her concern about the ease with which she could influence others and manipulate patients and even staff at times. She was here deliberately resisting this natural urge and ability to impose her will and opinions on others.

(b) In a role-play scene, pre-arranged with staff, the leader attempted as faithful a role portrayal of Maureen as possible. The short episode included some of Maureen's good and bad qualities - as seen by the leader and agreed by staff who were present - e.g. efficiency, trustworthiness, honesty, helpfulness, initiative and blunt criticism of others and intolerance of their weaknesses or inefficiencies, hastiness to judge by hearsay and repeat such tales to others.

NON-ROLE-PLAY

Maureen was asked to confirm or dispute the aspects of behaviour said to be typical of herself. Other patients were also asked to comment on the role-play and compare it with their own experience of her.

Discussion of other qualities (not apparent in role episode) was encouraged.

The conclusion was supportive to Maureen and more light hearted.

- this was what she had asked for including both good and bad qualities the leader tried to contrast extremes which had been observed in Maureen's attitudes and reactions but also to provide many discussion points for the group and Maureen herself.
- she had opportunity to answer any challenge contained in the role-play and make explicit anything which was implicit in the role-play
- the leader wished the total picture of Maureen as she presented to others to include the experiences and impressions of her fellow patients - they had the day-to-day contacts to draw on
- Discussion points posed problems requiring examination of values and related personal decisions

She invited group members to comment on her behaviour. She did contradict some of the impressions of typical reactions suggested in the role-play.

She also was honest in admitting to some of the less flattering qualities shown, trying to justify some.

She coped very well with being in the 'hot seat' and having people enquire into her motives, reactions and attitudes.

Very different to her first guarded remarks in the early sessions.

Speaks freely and does not comment on the obvious use of the tape recorder or the possibility of other people hearing the tapes.

At times differences of opinion were expressed about how Maureen would be likely to behave. These gave opportunity for Maureen to add her own comment and also focus on alternatives.

There was much agreement about her good qualities and her fellow patients and staff expressed their appreciation of these.

As we concluded the session Maureen was asked if she was satisfied with the events and wished to comment. She said that she was glad that she had gone through such a session though she had been nervous.

When it was suggested that a similar experience may benefit others she said:- "It depends on who you are going to ask. Someone - it might hurt them too much but I didn't care if I got hurt. I really wanted to know the truth. Some people - it might be bad for them. It would also depend on whether the doctor thought it was right".

Because the recordings of the above sessions, 29 and 30, contain much evidence of techniques selected to meet the 'needs in helping to deal with patients' specific problems', they are included as part of the taped evidence relevant to the identification and selection of techniques in Chapter 6. The same extracts can be referred to as illustration of the session activities and Maureen's involvement as described above.
TAPE H.108-H.595.

Reviewing role-play session activities and the topics covered in them, the leader identifying his objectives (as noted immediately after each session), enables him to see to what extent he is catering for individual need, within a group situation.

Looking back at Maureen's original requirements and comparing these with what was done in the sessions she attended, it can be seen that meeting some of the requirements was at times approached through group activity, intended to have benefits for many people. Many of the criteria identified were relevant to the requirements of several group members, including Maureen. No member was actively involved in all role-play and non-role-play activity, they were all 'observers' at some time. It was hoped that although participation was at times indirect, in this way, it might still be influential where relevant to need.

Attempting to meet multiple needs may involve many criteria in the leader's choice of one shared experience for patients e.g. an exercise designed to aid the communication skills of one patient may also be aimed at encouraging tolerance in another.

There were some sessions in which activities and the leader's actions were based primarily on the leader's wish to pay particular attention to Maureen's problems and behaviours. The study includes more detail of the events and determining factors involved on these occasions. Had the study been centred on another patient, other occasions, covered briefly here because of their minimal relevance to Maureen, would have been analysed in far more detail.

It is perhaps inevitable when role-play is used in a group therapy enterprise, that not all of a patient's requirements will be attended to in the group's meetings. How far the role-play sessions were able to approach Maureen's needs is now reviewed.

Requirements approached in role-play sessions1. Assessment

All of the assessment points were touched upon with the main influence on the leader's decisions coming from enquiring into her attitudes to school, overcoming the handicapping effect of her partial sightedness, and encouraging a positive attitude to future employment. Much of the work on attitudes to peers and making friends was spread over a number of sessions and varied group activities, including role encounters and non-role-play involvement with other people. Only oblique reference was made to romance or boyfriends (other people's not her own). No mention was made in sessions of attitudes to sex or any ensuing problems. It had been suggested by her doctor that any advice on sexual matters should be a private follow-up to evidence of need, should it be revealed in role-play and then "only if she asks for it". Maureen expressed very few opinions in sessions about relationships between the sexes. She made no mention of the sexual act or sexual attractions but she did not show any evidence of associated anxiety. The topic was not discussed in the sessions she attended. Another reason for this omission was the leader's opinion that it was inappropriate for many of the other group members. Some were of low intellectual capacity and would have been excluded from any discussions of sexual topics, others seemed naive and without any relevant experience from which to comment on sex or associated emotional involvement. More importantly discussion of sexual problems, possibly linked to marital break-up was not thought to be helpful at the current stage in the rehabilitation of certain other patients in the group.

In deciding which criteria should sway the balance and effect some line of action in role-play sessions the leader needs to consider the implication of minority benefit, majority interest and identification with the topic, and any possible adverse effect - even if only on one member of the group.

2. Improvement of patient functioning

Practical skills and social competence and interaction were brought into session activities whenever possible, often with the mutual benefit of all participants in view.

Maureen's attitudes to her partial sightedness and independence were covered in role-play and in practically fulfilling the requirements of other activities such as games and group direction. Some handing over of leadership was done to help improve the self-confidence of those, who like Maureen, would act positively and accept responsibility. It is important to discuss here Maureen's request for help with reading and writing and the leader/patient relationship outside role-play sessions.

Firstly, I am of the opinion that her request for help with writing was genuine and possibly related to her feelings of inadequacy because of limited attainment at school. Her clerical course involved letter writing etc. and she asked for advice on such practical tasks. She also seemed to need reassurance of her ability. At the time she joined the group she suggested that it was this kind of practical help she needed, not role-play. It was only much later that she acknowledged the relevance of role-play activities to her needs.

I also found that it was possible to use the letter-writing to approach topics which she would probably not have tolerated in a group role-play situation i.e. associated with her sisters' pregnancies and babies. I suggest that if role-play had been used in an individual therapy context, there may have been role-play ways of achieving a similar end.

It is perhaps significant that as Maureen's understanding and trust in my motives as a leader developed so did her willingness to become involved in the events of role-play sessions.

Although she asked for individual attention she did not seem resentful of similar leader attention being given to other members of the group. Her lack of co-operation seemed to be associated with her lack of respect and tolerance for people whose habits or incompetence annoyed her, or with her family relationships.

A leader may need to guard against the adverse effect of becoming too involved with any one particular patient. Conversely, actions to reassure a patient of the leader's integrity and improve the trust in the relationship may influence the patient's acceptance of the practices used in therapy. Criteria to influence the leader could arise from either of the above types of circumstance.

3. Discharge into the community

Much of the role-play and discussion was forward-looking to focus on discharge and coping outside hospital. Maureen was often to the fore of such discussion. The attitudes of patients to social workers, from whom they may need future support, were explored with Maureen particularly in mind.

Analysis of the events in role-play sessions shows that influencing factors arose from patient requirements not foreseen when the patient first joined the group. Some of these were concerned with Maureen's reactions to role-play and the group sessions themselves. Others emerged from behaviours, interests or wants revealed during the course of the sessions.

They were:

1. The need for Maureen and other new members to familiarise themselves with the role-play practices; learning what was involved and how they may be expected to work.
2. The need to encourage involvement (a) by promoting response, (b) by making the patient feel secure.
3. The need to create a congenial atmosphere.
4. The need to encourage relaxation in group company and co-operation with members - tolerance of group membership.
5. The need to explore the effectiveness of the role-play techniques and assess attitudes to their use - tolerance of the 'drama-game'.

6. The need to assess the patient's attitude to staff.
7. Facilitating the consideration of alternative behaviours, their appropriateness, fairness or effectiveness.
8. The need to meet the patient's own request to see herself as others see her.

It appears that while the original needs were concerned with patient problems, most of the newly emerging needs were associated with creating favourable conditions for role-play to take place and with the patients' security within the group. Some new problems (i.e. questionably inappropriate behaviours), were presented and their assessment and possible solution also affected leader decisions and group activities.

The individual case study seems to confirm three dimensions in criteria affecting the selection of techniques used in role-play sessions. These have already been suggested in previous chapters but are here refined to:

- A. The needs that are prerequisites for role-enactment.
- B. The degree to which a patient/patients needs to be secure/insecure.
- C. The needs of patients in relation to specific problems:- (1) The need to find a suitable topic; (2) The need to discover diagnostic factors relating to specific problems; (3) The needs in helping to deal with patients' problems.

The investigation into criteria in the case study involved some description of activities in role-play sessions. These were stated mainly in broad terms to indicate the topics covered and their relevance to the criteria said to be influential. There was no attempt to fully define the techniques used, though in some instances in giving sufficient detail to relate role-play and non-role-play content to criteria, the 'practices'; the techniques employed, were outlined.

The thesis moves next to what was stated in the Introduction as the associated aim, that of identifying the techniques selected to meet criteria

in categories A, B and C above, considering the reasons for their selection at the particular time they were employed and indicating some possible alternatives.

CHAPTER VI

THE IDENTIFICATION, CATEGORISATION AND
SELECTION OF ROLE-PLAY TECHNIQUES

CHAPTER 6

The identification, categorisation and selection of role-play techniques

The individual case investigation featured in the previous chapter illustrated the degree to which role-play activities were relevant to one person's needs and it contrasted needs, as originally perceived by hospital staff and the role-play group leader prior to commencement of role-play, with other unanticipated needs, of which the leader only became aware as the patient's attendance of sessions progressed.

The case study also drew attention to the compromise which may be necessary as far as the relevance of the topic and type of activity is concerned. Role-play, as practised in the South View Rehabilitation Unit, was not individual therapy, but essentially a group experience. While many areas of requirement seemed common to almost all participants, there were others which more specifically related to the particular problems or behaviours of individual patients. This may therefore require a leader to create a balance of participation and pertinence of content if the group is to flourish and perform its helping function.

The three dimensions in criteria suggested here arose from the above individual study and are presented as one way of categorising criteria governing technique selection in role-play - according to the type of requirement concerned, i.e.

- (A) The needs that are prerequisites for role-enactment.
- (B) The degree to which a patient/patients needs to be secure/insecure.
- (C) The needs of patients in relation to specific problems:- (1) The need to find a suitable topic; (2) The need to discover diagnostic factors relating to specific problems; (3) The needs in helping to deal with patients' problems.

In linking the above criteria with the techniques used in particular

role-play sessions there is also implicit classification of the techniques involved. The intention here is to identify the techniques associated with criteria (A), (B) and (C), giving the reasons for their selection at the time they were employed.

In all, during the research period, 45 patients passed through the group's membership and 93 role-play sessions, each approximately one hour long, were held. Most of each session was tape-recorded. From this great amount of recorded material, edited extracts have been transferred to the four tapes; sides lettered A-H, submitted with the thesis.

In order to make the dimensions of the study manageable and to preserve some continuity, the sessions used in this analysis are those attended by the patient in the previous case study, particular reference being made to her part in sessions. However, in order to expand the coverage of techniques as used throughout the whole research period, the analysis in categories (A) to (B) also includes alternative examples of techniques which were employed to meet similar needs in different circumstances. In category (C) the investigation takes account of problems related to all patients present.

TECHNIQUES THAT ARE PREREQUISITES FOR ROLE-ENACTMENT

The aim under category A is to identify the techniques which were concerned with presenting and promoting role-play group sessions as an integral part of the patient's rehabilitation programme.

Included here are techniques concerned with patients getting to know and accept role-play (the 'drama game') as a useful experience for them, to be practised within a group. The criteria for technique selection can be defined as:-

1. The need to create a congenial atmosphere.
2. The need for patients to tolerate the practices (i.e. the 'drama game').
3. The need for patients to tolerate group membership.

Techniques concerned with the patient in the study

Other examples or alternatives in different circumstances

Particular reasons for choice

THE NEED TO CREATE A CONGENIAL ATMOSPHERE

Choice of appropriate room for role-play meetings i.e. at the time of the beginning of the study the group met in rehab. unit recreation room

- for earlier sessions, prior to study period, the venue had been a small lounge

- it was associated with relaxing activities
- it was away from the staff office, the noise of TV, kitchen chores and food smells etc.
- there was enough space to move around if necessary
- the lounge used for initial meetings was a small, quiet room with an intimate atmosphere fitting to the needs of the first small groups of long-stay patients - but as the group expanded it became too small and restricted any role-play work requiring movement away from chairs
- the recreation room proved cold, lofty and impersonal
- there were interruptions from patients not in the group passing through to their dormitory as on TAPE A001-008
- the patients tried the dining room and they preferred it

role-play sessions were later moved to the dining room

TAPE A001

Illustrates disturbance of background noise; outside patients calling to each other; door creaking; hollow sounding, impersonal room. Extract also illustrates scene in which patients utilised and moved furniture. TAPE A054.

leader greeting patients as they join the group and talking informally

role play content involving welcoming

TAPE A008, A014, A022.

informal coming together of group and person chat with members. Short role-play episode to begin session which includes 'greeting'.

TAPE A037-086

encouraging talk with patients, and between them, about events outside session

(a) about hospital life

TAPE A117-144

e.g. (2) Maureen's chat with others about selling raffle tickets

TAPE A087-117

e.g. (1) Talk about forthcoming garden fete - an event in the hospital calendar

- patients often sit together in silence
- they tend not to make the effort to greet each other or even comment on others coming into the room or sitting beside them.
- for Maureen's observation.
- Maureen was not involved in the role-play but participants became models whose behaviour could stimulate discussion
- to stimulate discussion of mutual interests as on TAPE A108 - hoping for carry over to real experience outside sessions
- to demonstrate leader's willingness to listen to them
- allowing Maureen to discuss with others her attitude to selling raffle tickets to other patients and staff, using this topic to begin role-play. TAPE A145-179.
- early discussion often gives a lead into relevant role-play

(b) reminiscence and recall of interests prior to hospital
TAPE A179-300

Examples:- (1) Going on holiday TAPE A179-198
(2) Sleeping rough TAPE A198-300

- patients encouraged to talk to each other TAPE A187
- other patients join in and identify with experience TAPES A203, A250, A271, A264.
- can utilise their enthusiasms, specialist knowledge or unique experience in areas unfamiliar to the leader, who becomes a listener.

Techniques concerned with the patient in the studyOther examples or alternatives in different circumstancesParticular reasons for choiceCreating a congenial atmosphere (contd.)

;) current interests and further prospects. TAPE A301-340.
e.g. Maureen's retraining scheme

- at this time Maureen was apprehensive about speaking if tape recorder was on or taking roles. Main aim with her here, as with many new or reticent patients, was to motivate involvement of some kind, even if only in discussion about personal interests or skills
- admiration of others and leader positively reinforces contribution
- a closed, intimate, confidential formation
- conducive to face-to-face communication
- convenient for patients to change seats if necessary for role-play activity
- circle is good to come back to for discussion after any significant seating change for role-play
- to get away from teacher/pupil image
- can be an indicator, occurring naturally or contrived by the leader, of his/her wish for patients to similarly relax or pay keen attention
- returning to the relaxed position may be one of the signs which says 'end of role-play' or 'change of mood'.
- relieves tension if any anxiety exists
- sets mood of approach to role-play when topic not serious
- laughter is a unifying shared experience
- can be a warm-up activity to stimulate attention, concentration, laughter, etc.
- may involve interpersonal contacts i.e. physical contact and tolerance of ideas of others
- can use easy skills (verbal or non-verbal)
- can give opportunity for patients to direct others
- can be a relaxed activity to begin or end with
- can ease tensions or change mood
- can allow simultaneous involvement of all members
- can be analogous to and linked with some more significant real situation

sitting in a circle to hold session

leader part of that circle

- can be contrasted with more formal pose in roles or may vary naturally with the leader's own reactions to events

leader sitting in relaxed way at beginning of session and when appropriate during session

leader smiling i.e. laughing with patients
e.g. TAPES A358, C021, C164, E316

use of a light-hearted gaming approach to make believe

TAPE A340-417
e.g. (1) Kim's Game with group including Maureen

- Kim's game idea. TAPE A340 - was chosen with initial dual-purpose (a) to present opportunity for Maureen to display memory skill but also cope with honesty about limited vision; (b) to see if the male patient who said memory pursuits were absolutely beyond him, could be shown to be underestimating his own ability (which he commonly did)? improving his morale.

Techniques concerned with the patient in the studyCreating a congenial atmosphere (contd.)

TAPE A418-526

- e.g. (2) Guessing activity from a commentary on mimed action

'Warm up' by asking patients to recall previous sessions, possibly using tape to confirm and expand

initially suggesting roles and situations which are easy for patients to handle, e.g. (1) Maureen played role of mother interviewing leader in role of applicant for position of nanny for her children

leader accepting and respecting patients' ideas and contributions.

- e.g. (1) Building on Maureen's interest in selling raffle tickets

TAPE A410-179.

Other examples or alternatives in different circumstances

e.g. (2) Making conversation at breakfast time
Dialogue between new patient (Eileen) and more experienced patient (Mary). TAPE A526-575.

- e.g. (2) Patients interest in garden fete as on TAPE A117.

Particular reasons for choice

Other reasons for choice and advantages in practice were:-

- it developed naturally from knowledge of typing keyboard TAPE A331-340
- related to recalled party spirit and relaxation, therefore appropriate as session neared an end
- group were involved in helping leader collecting objects
- patients helped and encouraged each other
- leader needed assistance with timing, therefore patient volunteered to be responsible
- absolute silence at time of concentration and memorising (even observed by restless patients)
- joint effort in contributing answers
- Maureen spoke of poor vision without embarrassment
- many opportunities for leader and members to praise efforts

TAPE A418-526

- involved many previously mentioned factors but additionally required:- simple non-verbal activity
- isolation of sound and sight and perception via sensing and interpretation
- direct communication between patients
- interest in activities of others
- patient in control
- to improve memory i.e. patient functioning
- gives patients early opportunity to contribute
- playing recording can be quite entertaining (though may also create tension)
- can present a lead into new work
- Maureen had worked as a nanny and was familiar with relevant interview questions
- leader was in the 'hot seat', Maureen controlled the content and was confident about the procedure
- she could relate to her own real situation which gave the role experience credibility in her eyes
- also revealed some of her attitudes and opinions
- could be related to her future employment
- simple everyday activity to be 'talked through' with some assistance from leader's direction, but with few conditions imposed by leader or situation itself. TAPE A532, A541.

- to increase patient satisfaction from knowing they have influenced events.
- to reinforce effort
- to encourage similar respect and tolerance one patient to another

Techniques concerned with the patient in the studyOther examples or alternatives in different circumstancesParticular reasons for choice2 THE NEED FOR PATIENTS TO TOLERATE THE PRACTICES (i.e. THE DRAMA GAME)a) Introducing the practices by:-

basising role-play on a continued topic of interest from previous week, but within that context:- demonstrating the taking of roles in simple forms
leader and patients taking roles varying in status

e.g. (1) Long term topic had been creating, over a period of several sessions; a fictitious patient whose passage through the illness/recovery experience and the hospital system, was developed through role situations.
The final stage suggested here was transference to Rehabilitation Unit.

TAPE B001-034.

- guaranteed a quick start into role-play because of the interest of established members in the topic
- gave the established members opportunity to conclude their project satisfactorily
- allowed new patients opportunity to observe some usual role-play practices in action
- the leader's willingness to be dependent on patients at times, both in the kind and interpretation of the roles she adopts, and in her need and wish to seek their guidance on role portrayal and role-play situations, TAPE B001-021, B022 - broke the rigidity of the director/directed relationship with patients. New patients could observe this means of patients influencing role-play activity.
- Maureen had agreed to watch role-play but not to join in as she did not like 'acting'. Her observation of role-play, used to present ideas and stimulate discussion of matters which were very real to patients (herself included) was likely to be important to her future tolerance of the practices
- it was hoped that new members would be encouraged by the role playing successes of the experienced members of the group
- experienced members were able to be supportive in role-play with new participants.

allowing observation of inter-related role-play and discussion discussion of role-play events and their relevance to patient reality keeping role-play and discussion pertinent to new patient experience while still relating it to the main theme of a 'fictitious patient'

Some role-play episodes were
(a) Breaking the news of an imminent transfer to the unit, using role reversal in that a patient plays the staff nurse and the leader played the fictitious patient. TAPE B004-021.

(b) Conversation at breakfast time as on TAPE A526-575.

gradually involving willing new patients in role-play
allowing new members to observe the successes of the experienced ones in role situations - therefore initially using confident players in roles which they can be expected to handle well
TAPE B004

asking patients to recall and explain role-play to newcomers

e.g. (1) TAPE B035-054
Brief recall by other patients of long term project being pursued when Maureen first joined the group

- stimulates recall and conversation
- may reveal attitudes to role-play and sessions and topics which were significant to patients
- recall of earlier role-play work may present opportunity for leader to link practices with practical help in dealing with patients problems

e.g. (2) TAPE B055-085
A resume of role-play activities often several weeks attendance in group (instigated by Maureen)

e.g. TAPE B086-101
Doctor/patient interview prior to discharge (repeat of earlier episode)

- repeat of a role-play episode of the previous week helped boost the confidence of the participants and was a useful starter for further development of the situation TAPE B101.
- new patients may join in discussion as TAPE B104
- again follow-up discussion may reveal attitudes and needs TAPE B112-126
- future attendance of patients may depend on how meaningful activities are to them
- patients who are reluctant to take roles at this stage may join in discussion as Maureen's advice TAPE B126-131.
Involvement, even if only on the fringe, was always being encouraged.

repeating a previous role-play success (as observed by Maureen)

relating content to more immediate need

allowing discussion of content to follow

Techniques concerned with the patient in the studyOther examples or alternativesParticular reasons for choiceIntroducing the practices (contd.)

leader explaining some of the theory and purpose in the use of role-play, prior to putting it into practice
e.g. TAPE B132-146

- use of short role episodes
e.g. (1) Simultaneous dialogue pairing experienced members with new members of group. "Complaints to a shop assistant". TAPE B147-189.

e.g. (2) Adjusting and responding to imposed role-play conditions and situations TAPE B190-353

- some brief explanation might help if several members are unfamiliar with a leader's ways or aims of using role-play
- to help patients respond as appropriately and willingly as possible to what is asked of them in role-play
- no long term project needed to be considered
- opportunity for experienced role-play participants to work with and support newcomers in role situations
- simultaneous dialogue was intended to encourage new members to speak under cover of other voices TAPE B147-153
- simple 'shopping' situation not only demonstrated a role-play form in practice but also could be used to show how such drama, make believe techniques were relevant to possible real patient experience. TAPE B174.
- new patients David and Marjorie could be encouraged to talk about their first role contributions TAPE B153 TAPE B158 and discussion geared to future encounters outside hospital TAPE B174-189.
- required volunteers, therefore demonstrated patient willingness to try a role-play practice TAPE B206, B252
- situations were directly related to real matters which might arise in hospital
- patients are sometimes noticeably slow in responding to the requirements of a situation
- required spontaneous adjustment to factors being imposed by leader in role but also allowed patients some influence of how role episode developed. TAPES B215, B256, B302.
- again leader needed to ask for patient guidance on accuracy and plausibility of situation. TAPES B232, B247.
- experienced patients could advise new ones in the follow-up discussion of hospital life and unit procedure. TAPE B240
- 'bike' incident. TAPE B256. Moved emphasis from general to specific personal problems and discussion nurtured advice from other patients. TAPE B284.
- 'untidiness' episode was based on patients real trait and was a topic requested by nursing staff. TAPE B300.
- general discussion encouraged to avoid any personal embarrassment. TAPES B327-353.
- patients tend to have few leisure activities so it is foolish to clash with the few which do exist if this is avoidable. Patients may have favourite TV programmes and not allowing role-play to prevent popular viewing may help keep up attendance of sessions.
- patients who have been on the wards for a long time are often conditioned to doing as they are told. Letting them know that attendance of role-play sessions is recommended but not obligatory gives them a choice - making choices may be considered part of rehabilitation

b) Acceptance of the practices by:-

arranging time and duration of role-play sessions to fit in with the majority of patient commitments and leisure activities
making it clear to patients that attendance is voluntary and there will be no coercion
e.g. TAPE B354-372.

Techniques concerned with the patient in the studyOther examples or alternativesParticular reasons for choiceAcceptance of the practices (contd.)

asking experienced patients or staff to assess role-play value
TAFE B354-372, G563-599

Dispelling the mystery of role-play practices

Keeping content relevant to real needs and problems (as observed by Maureen)

e.g. 1 TAPE B373-582.

Comparing activities to the patients' views of beneficial topics and expected real situations

(a) Short imagined conversations between patient and sister she will be living with
TAFE B416-451.

(b) semi-role in that group imagined themselves in another's future situation
TAFE B457-479, B480-567.

variety in the type of activity (practice) suggested e.g. Topic "Communication"

(a) Chinese whispers
TAFE C134-170

(b) Talking for 30 seconds
TAFE C171-206

(c) Talking without verbal reinforcement from partner
TAFE C206-224

(d) Imposing topic "Buying something new" extending to 2 minutes
TAFE C225-241

allowing follow-up discussions to evolve and relate role-play practices to personal experience
TAFE C242

e.g. 2 TAPE C001-133

- using an analogous situation to approach a real problem - "repeated lateness for work"

(a) Patient with real problem put in role of factory boss criticising employees lateness (role reversal situation)
TAFE C005-016

(b) Above patient and others discussing implications of lateness of fictitious employee and relatedness to real problem. With some short role episodes. TAPE C016-133.

- the right of refusal to attend also suggests that members coming regularly do so because they want to. TAPE 354, 365.

- new members are perhaps more likely to accept practices approved by others.

- removing any apprehension about the unknown, false hope of a cure-all panacea, or cynicism about inexplicable 'acting' is very much related to presentation of the practices as described in the previous section (a)

- the practices needed to emerge as a practical help toward rehabilitation and were more likely to be accepted by many patients (particularly those resistant to 'acting' such as Maureen) if their usefulness and relevance could be experienced and observed as TAPE B416-451, B567-582.

- acceptance of patients' ideas as in e.g. 1 tape B373 gives them a reassuring degree of control over content

- whether role-play represents a predicted real encounter or occurs in an analogous situation it can lead to the patient concerned discussing the real problem with others e.g. TAPES B451, C021.

- role-play participation, observation or discussion of implications, may help the patients clarify needs, suggest solutions to problems and begin to help and advise each other

- Maureen was involved in only a little role-play but made useful suggestions in discussion

- to maintain interest and concentration

- to gain the attention and involvement of patients in early non-role-play practices before progressing to role-play encounters

- patients were immediately involved in discussing game (Maureen joined in description and direction)

- game invited close physical proximity, concentration and shared laughter

- talking in pairs for 30 seconds involved simultaneous relaxed speech under cover of other voices, choice of partner (following lighthearted group involvement), choice of topic, choice of order of talking. Such organisation of itself required communication between patients

- patients paying attention to fulfilling conditions imposed by leader in a non-real, gaming atmosphere was intended to prevent anxiety over starting or continuing conversation

- simulating the lack of reinforcement in conversation reflected a fairly common real situation on the ward

- patient's ease in dealing with an imposed topic and a longer length of time to talk demonstrated to them that sustaining a conversation was not too difficult a task

- patients were encouraged to contrast circumstances surrounding conversations. Maureen's willingness to address the group was particularly being nurtured. TAPE C242.

Techniques concerned with the patient in the studyAcceptance of the practices (contd.)

"hearing depressive patient"

) Leader role-playing with patient in depressive role. TAPE C321-342.

) Leader role-playing with self in depressive role, imposing role of helper on Maureen. TAPE C352-403.

clarifying in discussion the implications of matters arising in role-play which may affect patients' lives. TAPE C404-449

the inclusion of staff as observers and role-play participants

letting patients know of their doctor's recommendation that they attend for role-play

(Observed by Maureen)

Other examples or alternatives

e.g. 1. Staff reassurance of patients TAPE C460-569

Reassurance of confidentiality TAPE C492

e.g. 2. Staff approach in role to patients

(a) TAPE C574-596
"aggressive"

(b) TAPE D001-039
"sympathetic"

- issuing a direct challenge to new sceptical members to justify cautioning a prospective role-play attender with: "You don't want to go there (i.e. role-play), it's a load of rubbish". TAPE D040-083.

Patients asked to tell of any hearsay criticisms of role-play, repeated without first hand experience of actual practices.

Particular reasons for choice

- leader role-playing to assess attitudes of depressive patient - as presented by a fellow patient TAPE C321-342
- Maureen was offered a role to which she might respond readily - that of helper-adviser in a situation based on her own experience TAPE C352-403

- requiring patients to think seriously about positive attitudes to alleviate difficulties
- capitalising on a high level of concentration at the end of a very varied session
- taking opportunity to praise contributions (particularly Maureen). TAPE C404-449.

- staff approval of the practices should help dispel any patient doubts (N.B. on one occasion Maureen had however remarked on the inhibiting effect of staff presence. This adverse effect therefore also needs consideration).
- staff may know more about everyday rehab. unit life and expectations. TAPE C502
- staff may know what manner of approach is appropriate with a patient as well as the facts of the situation
- staff should be sufficiently aware of patient temperament and self-confidence to know how much aggression in role they can cope with, e.g. TAPE C580-593.

- staff can be supportive to patients in role
- seeing staff accept the challenge of a role should be encouraging to patients
- role-play may raise issues which can profitably be discussed between staff and patient. This may be viewed as a valuable opportunity by both staff and patients. TAPE D035.
- obvious co-operation between nursing staff and role-play leader should legitimise practices in patients' view
- staff playing role leaves leader free to help patient in role-playing. TAPE D024.
- the known approval of doctors responsible for rehabilitation programmes should encourage the patients' acceptance of role-play as an aid to recovery

- this 'warning off' role-play was pronounced by the leader in the role of a sceptical patient as part of a follow-up to a theme of judging by hearsay
- it was intended to surface any doubts and invite discussion but it was also hoped that it would stimulate some defence of practices from more experienced members - including Maureen (who did in fact suggest that role-play be increased to twice a week)
- again was used to link practices with help for patients. Obscure practices had meant little to them.

Techniques concerned with the patient in the studyOther examples or alternativesParticular reasons for choiceAcceptance of the practices (contd.)

- satisfactorily concluding a session
by:-
- assessing outcome and implications with patients
 - ending with a good piece of role-play
 - praising contributions
 - inviting good humour and laughter
 - allowing patients to talk out session between themselves
 - planning possible future activities
 - setting some task to be done before next session

These ways of ending a session are obviously relevant to patient satisfaction from their experience of past role-play sessions.

These strategies require and anticipate a commitment to attending future sessions.

Other techniques to promote acceptance of role-play practices are related to, and will be included in, the section on patient security.

THE NEED FOR PATIENTS TO TOLERATE GROUP MEMBERSHIP

any techniques mentioned under 'congenial atmosphere' which cause patients to associate coming to group sessions with interesting and pleasurable activities

any techniques mentioned under 'tolerance of the drama game' which may help make group involvement valuable to patients and/or promote their awareness of benefits

the inclusion of gaming activities

the discussion of shared interests and problems

the leader's frankness about who has access to recordings of sessions

leader's frankness about content of sessions which may be discussed with staff.
S TAPE C492.

leader's respect for patients' confidences and sensitivities in treating their concerns seriously

- patients may have few other interests apart from the all too common pastime of sitting in the lounge watching TV.
- if the role-play activities are interesting and enjoyable they may be a welcome change from the above routine.
- some patients may be encouraged to attend not primarily for enjoyment, but because they believe the experience is good for them. Many patients are isolates and may be more likely to tolerate contacts imposed by session activities if they can appreciate the relevance of the practices to their particular needs.
- games can be an acceptable vehicle for face to face interaction, physical contacts and the tolerance of the ideas of others
- patients may welcome the group sessions as a rare opportunity to talk over mutual concerns. They may have little contact with each other outside sessions.
- the patient's knowledge of how much and what type of information about them may be passed on to medical or care staff could produce some initial anxiety; however, in the long-term patients may be more likely to be honest in their revelations about themselves if they have an honest and trusting relationship with the leader.
- from an ethical point of view such honesty may be fundamental to the leader's relationship with both staff and patients and a chosen condition of his therapy work.
- patients need to know that their disclosures will not be dismissed flippantly in sessions or talked of disrespectfully with other patients or staff.
- the patients' confidence in their relationship with the group leader is likely to have a bearing on their overall tolerance of the group experience

Techniques concerned with the patient in the studyOther examples or alternativesParticular reasons for choicePermeance of group (contd.)

the leader's use of role-play practices or control in discussion to prevent the disruptive effects of over-dominant or inappropriate participation TAPE D085-120

the leader's similar actions to preserve the status and opportunity of quieter members e.g. TAPE D100-113

semi-role shared by two patients, giving advice about an anticipated real situation TAPE D100-119

non-role-play techniques were -

- to insist in discussion on members keeping to topic TAPE D089

- to divert an over-excited vociferous member into more controlled consideration of the situation in hand TAPE D091

non-verbal indicators as controls on the conversations of others are as natural part of role-play encounters and associated group discussion, as they are of any everyday conversations. A leader's actions such as nodding or shaking the head, raising an eyebrow or use of hand movements may be used to encourage or restrain and are therefore included here as techniques.

leader leaving the room while patients prepare role-play to be shown on return. TAPE D121-358

although patients may have developed ideas without the group leader some may need support from the leader and help to achieve a satisfactory end-product and draw conclusions. TAPE D175-240.

other groups may not need any assistance but may still need to be encouraged to make judgements. TAPE D240-358.

any measures which allow patients some say in what happens in sessions i.e. accepting their ideas:-
(a) given verbally in session
(b) written and handed to leader between sessions

- a leader may need to keep a balance of involvement in both role-play and discussion. This may necessitate the restraint of over-dominant members (staff or patients) and, quite deliberate attempts to increase the opportunities and efforts of those less confident, less able or less inclined to contribute.

- patients will soon tire of meetings if they don't get a chance to speak or if any one member persistently monopolises events

- e.g. of alternative role-play control could be:-
- terminating a role-play episode
- extending role to group involvement
- putting dominant person in a subservient role
- reversing roles

- at this stage Maureen was one of the patients who needed to be drawn into discussion. Asking her to advise or reassure other patients was one of the most successful ways of doing this. TAPE D095, D115.

- e.g. of alternative non-role-play ways of controlling involvement could be:-
- leader selecting desirable ideas to be developed
- leader addressing questions to, or asking opinion of selected members

- to produce results in the leader's absence the group needed to draw on their own ideas and rely on each other
- if left to work alone there is opportunity for patients to function as a group and it is possible that from within that group new leaders will emerge
- there was not only opportunity but need for direct discussion between members (not people in turn addressing the recognised leader)
- Maureen had shown signs of ability to organise other people. She had also been less hostile to 'acting out' situations in role-play. This leader's absence gave her the chance to direct others and help them develop ideas into role-play ways of expressing these ideas
- how patients behave when left alone with a role-play task may produce evidence of behaviour to help staff from a diagnostic point of view, or to guide the official leader in assessing attitudes to role-play

- patients may be more keen to join group activities if they feel they have some influence on what happens
- patients may prefer to write down ideas between sessions because
(a) they are too shy to offer them in session
(b) they may prefer to suggest topics anonymously
(c) they may need time to think of relevant matters
(d) some relevant situations may only arise between sessions

Techniques concerned with the patient in the study

Other examples or alternatives

Particular reasons for choice

Tolerance of group (contd.)

allowing patients some opportunity to organise events in sessions e.g. developing ideas in small groups - possibly working simultaneously

- handing over some responsibility for directing role-play to suitable patients TAPE D359
- (in the above situation) providing support for a temporary patient/director

- if patients appear to have confidence to address the group and sufficient experience of role-play practices to implement them, it may be useful when they are nearing discharge from hospital to try to foster independence by allowing them opportunity to direct some of the group's activities
- although patients may feel ready and willing to have a go at role-play direction they may still need support and guidance in their early attempts
- in the instance included here the most difficult task for the volunteer temporary leader was to translate the ideas presented to him into role-play e.g. converting a projected view of a possible situation which might occur outside hospital into the 'here and now' of a role-play encounter in the session. TAPE D397, D487-521.
- support from the official leader was intended to help increase the whole group's satisfaction with their end product as well as to safeguard the morale of the temporary patient/director

at times bringing together patients who do not get on well as TAPE D240-358

- at times pairing patients known to respond well to each other as TAPE A037

- pairing patients known to react favourably to each other may increase the prospects of success in early role-play efforts - early satisfactions may help continued tolerance
- contacts in role-play appeared to help overcome some personal antagonisms e.g. role interaction coupled with observed good role-play and praise for a patient Maureen initially claimed to dislike, possibly contributed to her increased respect for the said patient at a later date.
- patients (including Maureen) can respond well to feeling they are helping someone else.

pairing competent people with less confident TAPE D240-358

placing patient in advisory role to help another. TAPE D095, C480.

allowing patients to choose who they will work with TAPE D143-156, C171

- making the choice to work with another patient should at least require patients to think of some of the qualities of their chosen partner and reasons for wanting to share the experience with that particular person, at best it may be the beginning of a friendly relationship
- in addition to reinforcing efforts of members praise may increase the respect of observers
- patients may not interact with many of the other unit residents. Communication in the sessions may continue and develop in real life unit situations the effects may come full circle and later strengthen group relationships.

raising contributions TAPE C404, D220, D357

varying pairings and groupings

welcoming and addressing members as a group
 leader informing patients of any likely absence or alteration in sessions TAPE A022
 raising group effort
 thanking members for attending

- e.g. TAPE B457

putting patients in the roles and situations of others
 encouraging patients to suggest ways of resolving the problems of others

- e.g. TAPE C101

simulating the experience of others

- e.g. TAPE C329

- encouraging responsibility to the group

- encouraging identification with the problems of others

In Section A the reasons for the leader's choice of practice in a particular set of circumstances often imply a 'mini-criterion' to be considered under the umbrella of a broader statement of need.

For example, the broad criterion may be the 'need to create a congenial atmosphere' but in employing the technique of choosing an appropriate room in which to hold sessions, one mini-criterion was the need to find somewhere associated with relaxation, away from work or staff formality. When the technique was to deliberately change the room the mini-criteria were to get away from interruptions and to allow patients their preference.

Similarly, while being mindful of a broad need, to promote tolerance of the 'drama game', in choosing to introduce role play via continued topic, the leader was narrowing his objective to meet a mini-criterion of making a quick start into the use of the practices in order to establish and maintain the interest of group members.

The reasons for the selection of techniques show that their use was often multi-purposed and also indicate why certain criteria were paramount at a particular instance in a role play session, e.g. while the technique of making it clear to patients that attendance at role play was voluntary, was intended to promote acceptance of the practices, as it assured patients that no pressure would be brought to bear if they did not come to role play, it also offered them choice. The need for patients to make their own choices and not rely on being told what to do was a very important criterion in the context of the total rehabilitation programme, and therefore it was an important one to accommodate whenever appropriate in role play activities.

Throughout role play sessions, therefore, the leader is faced with multiple choices in the selection of important criteria upon which to act and the almost simultaneous selection of a technique to meet that requirement. The reason for a technique being preferred may well be because the leader aims to satisfy more than one need in its use.

Techniques related to the degree to which patients/a patient may need to be secure/insecure.

Many techniques already outlined as measures to promote a congenial, acceptive atmosphere, and the patient's tolerance of 'drama game' practices in a group situation are concerned with putting the patient at ease and making him/her secure enough to allow positive constructive responses. In the sessions attended by the patient in the case study, other strategies can be identified which were more specifically related to promoting patient security.

The analysis of techniques that might be selected to promote patient security suggested that it may be achieved through content, structure, or the leader's response. In reviewing the said techniques, each has been categorised to indicate these distinctions - content (C), structure (S), leader's response (R). Some techniques involve elements of more than one of the above means and in cases of such overlap more than one category has been indicated.

PROMOTING SECURITY

Techniques concerned with the patient in the study

- patient being allowed to observe the role-playing successes of others
- burden of role-playing being carried by the leader and other patients
- role-play content including the reassurance of one patient by another
- leader asking patients for direction on how to play a role
- leader taking a role of lower status than that taken by patient
- leader appearing vulnerable and insecure in role
- early content topics seeming remote from patients' problems
- acceptance of minor contributions reinforced verbally or by nodding, smiling, etc.
- All of the above techniques were evident in Maureen's first session. TAPE B001-034, A526-575.
- reassurance about the use of the tape recorder (Following this session Maureen said she did not want to continue in group. She did not attend the next week. But she agreed to return to observe for one more time).
- Leader discussing session and any resistance to practices with patient in private
- explanation of a less threatening use of the recorder e.g. (1) to aid recall of previous session and lead into new work TAPE E010-018

Other examples or alternatives

Maureen took no active part but observed this role-playing with other patients

- done here to benefit the role participant in this session but later used similarly with Maureen. TAPE C352-403.

Again Maureen was only involved as an observer

- patients may be apprehensive about the keeping of information about them - on tape or written. After the period of this study the group were asked to complete a questionnaire designed to help in an assessment of group dynamics. This also caused some concern and a leader needs to consider if such practices are good therapy.

e.g. (2) deliberate use as a radio microphone in the context of role-play situation. TAPE E019-030. "Sports commentary game"

Particular reasons for choice

- perhaps they will see it as a less formidable experience than they anticipated; also the observed satisfaction of others may encourage their efforts
- no pressure initially on newcomers
- the content in this particular episode also related to any apprehension which patients may have felt when first transferred from ward to rehab. unit
- in asking for guidance the leader makes the patients the experts
- raising patient status
- patients may reassure themselves and others present in their advice and comfort for leader's role character
- patients will be less inclined to worry about what may happen in sessions if the topics do not seem likely to focus on them or expose their problems
- even though only watching a patient may be influenced by the reinforcement and praise given to active role players who become models in the role-play experience
- Maureen had said at the beginning of the session that she would not speak while the tape recorder was on. She had observed the role-playing and listened to discussions without making any voluntary comment. Leader addressing a question directly to her was intended to draw her into conversation but also to see if her attitude to the recording had relaxed a little. Her refusal to speak was brief and adamant. TAPE E001-009. She was a very private person who disliked any records of her behaviour being kept. When, after several weeks, patients were asked to write down any topics they would like considered in role-play sessions, Maureen spoilt her paper by making silly suggestions. At this stage she did not want there to be any tangible evidence of any matters which seriously concerned her.
- putting patient at ease with leader outside sessions if she is reluctant to express any opinions in sessions
- this simple approach in the use of the microphone as a commentator (e.g. (2) TAPE E024 was taken with a group of fairly institutionalised patients - more sophistication may have to be built into the situation to satisfy patients with wider experience or higher intellect

Techniques concerned with the patient in the studyPromoting security (contd.)

- removal of threat of tape altogether (several sessions were not recorded)
- leader asking if anyone objects to the tape recorder

- encouraging patients' expertise in a skill well within patient's scope e.g. taking an easy role or contribution to discussion as in Maureen's case recall of a typewriter keyboard.
as TAPE A315

- praise for a non-acting skill (as in Kim's game already illustrated)

- patient being asked to take a supportive role to help a less able patient. (Not recorded).
"Advising a friend who does not eat sensibly".

- patient asked to take a semi-role such as expressing an opinion from within an imagined situation.
"Helping a house bound friend".
(Not recorded).

- sharing a role or semi-role (as above) where more than one patient adds ideas to role-play character's dialogue (briefly done by Maureen)
TAPE as D095-120.

The above principle was sometimes extended still further with other patients to involve the whole group (as described opposite)

- short role episodes at first

- patient allowed to choose what to do

- leader's acceptance of ideas

- simple miming activities, possibly from the security of a chair

Other examples or alternatives

S - patients combining in a group role in which his/her responses need only be contributory. TAPE E031-112.

Particular reasons for choice

- Maureen had been drawn into guarded conversation and games while tape recorder was on. She refused to take any roles while it was in use therefore recording was suspended to see if this was any inducement to her agreeing to participate in role-play.

- leader's main aim at this stage was to set at ease, interest and satisfy the patient enough for her to continue coming to sessions. The intention was to encourage her to join in in any mutually acceptable, relevant way.

- reinforcing effort

- in private discussion with the leader, the patient had spoken sympathetically about her care of her grandfather and of her general concern for the elderly or less able. The patient she advised in role was a rather confused chronic schizophrenic who tended to neglect himself

- asking for only semi-role involvement was less like acting to this patient, opposed to the 'drama game'. (In this instance the technique was used more to encourage her acceptance of the practices than to improve her security. Similar measures could be used to ease those unfamiliar with role-play into the use of imagined situations).

- group roles require only shared responsibility involve the supportive ideas of others and may produce less feeling of individual exposure or vulnerability

- asking for contributions round a group gives everyone opportunity to speak. Those lacking confidence may be encouraged to add a little to the proceedings because everyone else has done so in their turn - they may therefore be motivated by expectation - of leader and group

- brief periods of role-play focus should mean only brief tension but quick reinforcement with praise and satisfaction etc.

- choice may improve security in that it can relieve the patient of imposed content or performance requirements that he cannot handle.

N.B. But, as it puts the onus of decision on the patient, it may increase tension, particularly if he/she fears criticism. If security is the aim the leader will need to support patients' choices, or the patients' morale if a suggestion is rejected.

- some patients may be more confident of expressing ideas in simple action than they are of putting them into words. They may feel more secure sitting down than standing up.

Techniques concerned with the patient in the studyPromoting security (contd.)

- simple miming activities, possibly from the security of a chair (contd.)

- leader checking a patient's understanding of what is required, and giving guidance before he/she embarks on a role

- simultaneous cross-talk in role-play portrayal or in the direction of others. TAPE E113-206

- the 'expert' in the instruction of others

- asking for volunteers to instruct

- leader allowing patient to avoid disturbing content

- leader diverting the focus, either in role or discussion, from content which might hurt or embarrass a patient. This could be achieved by:-

- changing the topic
- changing the nature of the activity
- changing the role-play participants
- the leader taking over a role

Other examples or alternatives

r - leader's quieter voice with a timid patient as TAPE D001-039

rS - leader holding a pause to allow a patient thinking time as TAPE B505-517

C - giving a movement direction as a lead into beginning of dialogue as TAPE A539, E243

Particular reasons for choice

- should the leader wish to develop activity toward emphasis on non-verbal expression and confidence in movement, he/she may choose to encourage patients out of their chairs and into various movement experiences. Where the therapy is to centre primarily around verbal exchange, some non-verbal activities may still be considered appropriate to compliment verbal skills, or because they are an integral significant part of the total communication of a role-play situation, e.g. posture and mannerisms as indicators of emotions - such as anxiety in an interview situation

- to reduce harassment

- preventing misinterpretation or, if necessary, qualifying instruction may save a patient embarrassment or the feeling of having 'done it wrong'

- simultaneous dialogue, as described in the section on introducing the practices, throws less limelight on individuals who may speak more confidently under cover of other voices. The further development here, of separating two instructors from their pupils so that each simultaneously directs their group across the talk of the other, also presented the need to speak up and be assertive to succeed

- the technique of requiring some type of expertise to create or develop a role-play situation can be used in many ways. In the content of the taped episode E113-206, it was useful to help promote the assertiveness and communication skill of the two instructors (Maureen being one of these). If the patients were to feel secure in the central role of instructor, it was necessary for the topics to be well within their scope and experience. N.B. Although this particular 'expert instructor' activity could have value for the instructors concerned, the wider general aim was to use the whole 'cross-talk' experience to encourage some awareness and identification of the group members with the hearing problem of one member. As illustrated here role-play practices are often multi-purpose

- avoidance of content which might cause patient anxiety may be judged necessary to prevent a patient avoiding sessions altogether or blocking thoughts on the topic
- the leader allowing, or even himself practising, avoidance of a topic, may be done to protect a patient from embarrassment or any counter-productive outcome of insecurity, but avoidance may also be related to the leader's own insecurity or competence in the handling of patients' responses. Doctors or nurses may advise against specific topics with certain patients. A lack of adequate information to guide the leader's decisions and enable him to cope advantageously with the patients' reactions may prompt avoidance or postponement of a topic. N.B. (Any emphasis on childlessness, although possibly related to problems was not recommended by Maureen's doctor).

Techniques concerned with the patient
in the study

Promoting security (contd.)

- an oblique approach to a sensitive subject

- e.g. (3) paralleling patient's real experiences in a fictitious character, putting patient in a role which will allow her to re-identify with past feelings and express them.
TAPE E377-406, F013-036

- asking others to identify with the patient's possible past circumstances and feelings and suggest ways of helping

- reassuring patient that feelings and action were understandable and normal. TAPE F036-120

e.g. (4) leader role-playing alternative attitudes and reactions to a given set of circumstances and leaving the group members and patients concerned to decide which attitudes would be expected from the said patient.
TAPE H241-378

- giving patient opportunity in discussion to dispute or justify what is thought to be their typical behaviour in real situations
TAPE H345-561

- praising patient for putting herself 'at risk' in role (not taped)

- leader drawing attention to and asking fellow patients to assess a participant's commendable qualities TAPE H556, H563

- giving patient opportunity to comment on the handling of session TAPE H568

Other examples or alternatives

- r - the leader supporting a patient let down or embarrassed by any unforeseen occurrence in the role-play session by:-
- r - reassuring in discussion
- C - putting patient at ease in a role associated with his own future prospects
- r - leader praising role-playing
- CS - extending into semi-role to display knowledge and expertise
- S - keeping him central to action

C e.g. (1) initially focussing attention on another requirement such as picking up clues about the situation rather than the personal problem.
TAPE B215, B256, B302.
CS e.g. (2) use of analogy
TAPE C001-133, E113-206

Particular reasons for choice

- Maureen was annoyed by circumstances outside the session and walked out while partnering a gentleman in a role dialogue. Reassuring him and improving his morale by giving him opportunities to do well in the session became important.

TAPE E207-319

- patient may be embarrassed or hostile if approached directly

- the confusion of the simultaneous dialogue as on tape became analogous to the blurring of sound which can be experienced by some deaf people. The member of the group who was partially hearing later spoke without self-consciousness about his problems
TAPE E320-334

- Maureen spoke of her need of special education and also her unhappiness at boarding school. Via the role of the mother she explained childhood experiences which possibly reflected her own.
TAPE E335-406, F001-092.

(Patients later went on to compare the situation of the child in the imagined situation with their own in hospital, illustrating in further role-play situations).
TAPE F093-120.

- by offering alternative behaviours the leader can suggest ways in which a patient might react but group members who also know the patient can judge and comment according to personal experience

These techniques relate particularly to events in session devoted to behaviour of one individual patient detailed in category C3

- if the patients have the opportunity to explain and discuss their behaviour they may find the whole experience is less threatening

- praise for the courage of patients who offer to risk the exposure of their behaviour, even if not all is favourable, reassures them of the leader's respect

- it seems particularly important to end with the positive and good aspect of behaviour if there has been analysis involving the bad and indifferent elements

The patient's successful handling of many of the situations likely to occur after his/her discharge into the community may depend on his/her ability to tolerate anxiety/insecurity while responding appropriately. Practice in coping with insecurity may therefore be an important part of rehabilitation. Just as role-play events can be designed to foster security, similarly insecurity in role-play sessions can be promoted through content, structure, or leader's response.

B.2. Promoting insecurity

e.g. Via content

- content being pertinent to patient's problems (this can be increasingly arranged as patient's experience progresses)
- leader or other participant in dominant role
- in-role criticism of patient
- disputing patient's opinion in discussion
- challenging authority in role
- leader's high expectation of ability in role enactment
- absence of support in sustaining role dialogue
- patient being asked to play an unfamiliar role requiring initiative and inventiveness
- plunging a patient into a role situation without talk-in or warm-up (could also be classed as a structural ploy)
- direct focus on an individual problem
- asking patients for value judgements in role or discussion

e.g. Via structure

- putting patient in central role
- longer periods of role-play. (As experience of patients increases they may be expected to sustain and develop role-play situations further without the feedback of such frequent leader reinforcement)
- role imposed by leader
- role requiring patients to move from the security of their seats
- obvious tape recording of role-play sessions
- responsibility for organisation given to patient
- leader's withdrawal from a group activity
- no prompting from leader about role requirements (could also be classed as content)

e.g. Via leader's response

- no supportive words or gestures from the leader
- sceptical reaction to patient's contribution (could be verbal or non-verbal expression) challenging the patient's view
- aggressive tone use by leader to patient in or out of role
- no positive verbal reinforcement given (praise etc.)

C. Techniques to meet the needs of patients in relation to specific problems

The examination of techniques related to patients' problems includes not only measures designed to help patients deal with their difficulties but also the practices which were concerned with establishing possible subject areas for role-play, suggesting activities which were appropriate to patient experience, interest and need. Also of particular importance were the techniques used to reveal behaviours and/or facts related to incidents, situations or reactions considered by staff or the patients themselves, to present problems.

The criteria headings in Category C are therefore:

1. The need to find a suitable topic
2. The need to discover diagnostic factors related to specific problems.
3. The needs in helping to deal with patient problems.

C1. The need to find a suitable topic

Techniques used in study sessions

- asking patients for suggestions of suitable role-play topics
- discussing previous week's events occurring outside role-play sessions and choosing suitable topics
- encouraging patients' recall of experience, e.g. before hospitalisation, at the time of referral, treatment or transfer to rehabilitation unit
- discussing prospects of discharge and living out of hospital
- allowing patients to talk informally amongst themselves, without leader intervention, until a matter of mutual concern emerges
- extracting realistic problems from the content of a makebelieve improvisation
- continuing interest from the most valuable aspects of a previous role-play session or a contributory episode.
- leader's introduction of a topic believed to be significant, based on prior knowledge of a patient's past behaviour.
- asking patients to state or role-play their fears or dislikes
- asking patients to illustrate in role-play their views of types of experience e.g. "Nothing annoys me more than" or "The best present I ever had".

The techniques used here to find suitable role-play topics are mainly practices involving discussion. Ideas for future role-play may arise out of the discussion of previous work and associated situations. They may stem from the casual conversations of patients. The techniques listed are those evident in a limited number of study sessions and it is recognised that there are many ways of stimulating discussion to indicate suitable role-play, that are not mentioned here.

C2. The need to discover diagnostic factors related to specific problems

Techniques in study sessions.

- enactment of past real situations in which patient plays 'self' as if the situation is occurring 'here and now' e.g. (1) TAPE F.121-177.

(The patient concerned in this conversation about transference to a group home was a chronic schizophrenic with indistinct speech, therefore dialogue is difficult to follow, but her main worry at the time, unbeknown to staff, was her belief that she was being offered the place because someone had died).

e.g. (2) TAPE F.177-251

(In this episode the leader had to decide if the facts could be more clearly shown if the patient played himself or if he took the role of the nurse in a role-reversal situation - an alternative technique.

It seemed that the patient's view of his illness and of the attitude of staff toward him would be more successfully revealed if he did play himself).

- enactment of situations with role-reversal so that the patient is playing a role complimentary to his own real role, while someone else enacts the said patient's role. e.g. TAPE F.252-322.

- enactment of predicted situations related to real circumstances in which the patient may play 'self' or a role-reversal, complimentary role.

e.g. TAPE F.323-406.

(Role-playing possible future situations may be concerned with the observer's assessment of a patient's attitudes and opinions but it also gives opportunity for the patient to explore and express these in relation to his future reality as he perceives it).

- the 'role of unspoken thoughts,' where the patient voices thoughts unuttered at the time of an important encounter. Alternatively the thoughts may be predicted by someone else, identifying with the patient's likely feelings, and subsequently authenticated or otherwise. Such a technique could be used to expand a real past situation or a future anticipated situation. e.g. TAPE G.001-172.

(Voicing potential thoughts may encourage closer identification of those present with the problem of another and lead to greater scrutiny of behaviour in discussion. This is a complicated technique which may be beyond the ability of some patients. Care is therefore needed in the choice of suitable participants).

- enactment of ad hoc hypothetical situations not necessarily associated with anyone's problem but anticipating likely situations with which patients may have to deal e.g. TAPE G.173-273.

(Role-play techniques which may be used to give patients practice in social skills may also usefully reveal abilities).

- semi-role, where the patient is asked to express an opinion or make a suggestion from within an imagined situation without necessarily being involved in role-play dialogue as TAPE B.422-498.

- patient's comment about 'self' stated in the role of a third person. e.g. TAPE G.274-599.

(This technique requires patients to take an objective look at themselves. They were asked to imagine any complaint about themselves which they might make to a member of staff.

This session was not one attended by the patient in the case study but as the technique seemed to effectively encourage patients to examine their own behaviour and may have resulted in their insight into their own problems, it seemed an important one to include here. The ward sister was present but preferred the group leader to play the role of 'sister' in the role-play dialogues to leave her free to observe and comment. Each

role episode was followed by discussion with the group of each problem. Not all of the discussion is included here. Again this technique needs careful explanation to suitably able participants).

- narration of experience or formal address to group e.g. TAPE H.001-048.
- discussion of matters arising from role-play. e.g. TAPE H.049-107.

(The discussion selected as illustration here arose from the interview role-play TAPE B.086-101. It emphasised attitudes already expressed in previous discussion concerning patient's opinions of care services after discharge and about Maureen's attitude to social workers in particular. Neither patient could base further corroborative role-play on fact probably because they were reacting to hearsay rather than first hand experience).

- the encouragement of patient's expression of opinion and the making of judgements about facts and circumstances but in particular about their own behaviours and problems. There are many examples of this in taped discussion.

The techniques identified here as helpful practices to reveal abilities and problems are not presented as a comprehensive list of all possibilities. There is no mention here of minor strategies which may induce a patient to disclose some relevant diagnostic fact. The techniques which are described are in the main types of role-play form used by the leader (in some cases several times) in the course of the study sessions. As mentioned in the introduction the re-employment of a technique may be related to the leader's assessment of the effect of its prior use.

While the above techniques are suggested as practices which may reveal behaviour they may also be part of the leader's policy to help deal with problems, particularly when used to encourage the patients' consideration of inter-personal situations, their own attitudes, actions and possible difficulties.

C3. The needs in helping to deal with patients' specific problems

In contrast to the broad descriptions of need and role-play forms in the previous category C2, the following analysis looks in detail at the leader's selection and use of techniques in relation to the specific needs of patients, as assessed by the leader at the time of role-play sessions.

The analysis involves reference to some role-play events already mentioned in the case study of Chapter 5, and in connection with satisfying other criteria in this chapter. Such overlap is inevitable when a limited number of role-play sessions are used to illustrate different aspects of technique selection.

C3. THE NEEDS IN HELPING TO DEAL WITH PATIENTS' SPECIFIC PROBLEMS

This section has been confined to problems approached in the sessions Maureen attended. Those which were particularly relevant to her own specific problems are marked with an asterisk.

Patient need - i.e. criterion	Technique to help deal with problem
- a new patient appears shy and withdrawn in the unfamiliar environment of the unit	- experiences which require face to face communication e.g.-
*- a patient is reticent and shows little interest in his fellow patients	Non-role-play techniques such as games and discussion. Role-play encounters e.g.
*- a patient finds it hard to make friends and to talk with peers	(a) dialogue between doctor and patient, telling patient of proposed transfer from the main ward to the rehabilitation unit
- a patient appears to lack the confidence to open a conversation	(b) discussion between nurse and patient of the implications of transfer, and reassurance of patient by nurse
- a patient is very self critical and has a poor self image	(c) conversation between an established unit resident and the newly admitted patient
- patients need to know that they are not alone but have had experiences in common with other patients	- talking over matters arising from these common experiences
- a patient is apprehensive about change	
*- a patient avoids communication with the opposite sex	Role-play situations which require conversations with the type of person patient normally avoids. This may be helped by the building-in of particular requirements e.g. meal time conversations or buying and selling between patients of both sexes, asking a nurse for advice on a specific problem or sister for leave to go home.
- a patient avoids contacts with staff	
*- a patient needs to view future job prospects realistically	Non-role-play such as games involving non-verbal skills e.g. miming or an aspect of past job in a guessing game, required and displayed memory skill in games. Role-play e.g. (a) patient's instruction of group in simple job skills; (b) job interview situations; (c) dealing with relationships at work e.g. coping with annoying habits of work mates or appropriate approach to the boss. Non-role-play discussion of above content.
*- a patient lacks confidence and appears anxious when asked to respond verbally	
*- a patient needs to be forward looking and face up to the reality of discharge from hospital	- Role-play - all incidents which require decisions Particular situations such as - - Doctor and patient interview prior to discharge - Patient's enactment of any difficulty he foresees after discharge
- a patient appears to be reliant on hospital support and fails to recognise his excuses for dependence	Non-role-play - discussion and drawing attention to particular behaviours shown in role-play, encouraging acknowledgement of any problems
- a patient avoids even minor responsibilities	
- a patient shows little knowledge of how to plan adequate meals	- Role-play e.g. (a) helping a housebound friend plan and shop for adequate meals. (b) advising a friend who does not eat sensibly (c) discussing with a friend appropriate dishes for - a quick snack, a picnic, a vegetarian (d) patient demonstrating the preparation of simple dishes to the group
- a patient cannot cope with basic cookery skills	
*- a patient appears not to respect others	
*- a patient is intolerant of the ineptitude of others	
- patients seem 'out of touch' with social skills such as - making an introduction, terminating a conversation, making or accepting a compliment, asking a favour, thanking someone, listening to others, making an apology	- Role-play e.g. (a) the simulation of situations such as - the recalled, real experience of a recent social evening - the imagined experience of a visit to a new pub or the laundrette etc. - (b) the isolation and practice of specific social practices (appropriate behaviour being decided by group)
- a patient needs to practice an appropriate response	

Patient need - i.e. criterion

Technique to help deal with problem

- a patient is easily distracted and restless (paces the room or rocks on chair), when not actively participating in the group's activities
- a patient has difficulty expressing himself coherently
- a patient does not speak clearly
- a patient tries to involve leader in personal, irrelevant chatter throughout session
- a patient seems afraid to approach other residents directly about problems arising from communal living e.g. avoidance of duties
- patients need to be able to approach others displaying a variety of temperaments or moods, e.g. a depressed patient, a vociferous, hyperactive patient
- a patient cannot sustain a conversation beyond a brief comment or answer to a question
- *- a patient shows little interest in other people
- *- patients need opportunities to take initiative and to make decisions
- a patient seems to seek attention by repeatedly complaining of tiredness and lack of energy - possibly he would benefit from a forum to express and exhaust his feelings
- a patient frequently does not respond to the instruction of staff who are unsure if this is due to genuine lack of comprehension or to pretence to avoid complying
- a patient is difficult to motivate
- a patient seems reluctant to talk about his parents and family
- a patient seems afraid of change such as going out alone (in particular using buses), or approaching people alone
- a patient becomes agitated when contemplating a real experience (? may benefit from effectively coping with a similar simulated situation)
- Non-role-play - encouraging relevant contribution by converting ideas into relevant role-play situations.
- Role-play patients asked to take easy roles in easily identifiable situations e.g. (a) as in above social settings; (b) as might occur in the unit (emphasising need for communication between patients not with leader); (c) group role, telling others how to get on well in the unit by each patient beginning a sentence "When you go to South View you will be alright if you just remember"
- Role-play e.g. (a) Demonstration (modelling) by another patient of directly tackling a fellow patient with a complaint; (b) leader role-playing a way in which a patient may dodge complaint and criticism, while the hesitant patient insists on consideration of the problem; (c) leader role-playing a patient with characteristic behaviour tendencies i.e. depressive, over-excited, while patients try various ways of dealing with such behaviour.
- Non-role-play - discussion of first hand experiences of encounters similar to the above and the effectiveness of methods of handling (i.e. alternative solutions to problems)
- Non-role-play - listening games, leader's practice of asking open-ended questions which require more than yes and no, expanding the patient's conversation, leader's own interest in patients' experiences.
- Role-play e.g. (a) All role-play activities requiring verbal communication.
- (b) Simultaneous paired dialogue, where several patients speak together to their partners, varying the requirements of the conversations, e.g.
 - gradually lengthening the minimum time from $\frac{1}{2}$ min.-2 min.
 - specifying the topic content
 - specifying the type of response from partner such as unresponsive, encouraging, impatient, etc.
- (c) Use of narration by a patient to accompany some role-play action e.g. as if by a radio reporter in describing a rescue scene or a sporting event.
- Non-role-play - Narration of experience.
- Role-play - patients encouraged to develop role situations from a simple starting point e.g. mother greeting a tired son in from work
 - offering someone a cup of tea
 - answering a knock at the door (the knock demands a response) to admit various visitors, e.g. father, an old friend, a doctor, a social worker
 - the use of group roles in which everyone contributes in turn so that a patient may be motivated by the examples and expectations of others
- Role-play - simulation of the feared circumstances and rehearsal of an effective appropriate way of handling the situation. This may allow the patient to cope both with the task itself and the associated emotions so that the practice experience can be a reference point for the real experience e.g.
 - practice in asking for the correct bus
 - practice in asking someone to buy a raffle ticket
 - practice in asking for goods to be changed in shop

Patient need - i.e. criterion

Technique to help deal with problem

- | | |
|--|---|
| <ul style="list-style-type: none"> - patients show poor recall of recent experience - patients tend to lean on authority figures (including the role-play leader) - patients lack spontaneity - await direction *- a patient seems scornful of the efforts of other patients in role-play sessions
 *- a patient seems uncompromising in requiring others to adjust to her wants - a patient needs to talk about the reasons for her failed marriage *- a patient needs to consider alternative solutions to problems *- a patient states very adamant, inflexible opinions
 - a patient can become over-excited in both role-play and real situations - a patient is reticent and not easily roused to defend his own situation - patients seem 'out of touch' with work disciplines and expectations - a patient complains about not being able to get up in the morning
 - a patient tries to dominate conversations - a patient lacks confidence *- a patient rejects the prospect of support from social workers - patients are slow in leading to the requirements of a situation e.g. slow in answering questions, slow in performing practical skills, slow in assessing what needs to be done *- patients need to be able to talk to many contacts outside hospital
 *- patients need to think for themselves, to consider cause and effect and make judgements - a patient is careless and untidy with property - a patient is unreliable *- a patient appears to be gaining in self-confidence which may be further reinforced by the experience of directing others | <ul style="list-style-type: none"> - Non-role-play - recall of previous week's activities. - Role-play - at a patient's suggestion, developing an idea from previous session, into a whole group improvisation of a dream (in a dream anything is possible). Improvisation provided many opportunities for decisions on story-line and roles within it - full rein to imagination. (Sceptical patient in minor advisory role). Non-role-play - discussion of dreams and extension of ideas from above to plausible situations and real problems. (Illustrating mainly for benefit of the one sceptical member that even fantasy ideas of another patient may in a role-play session be a valuable incentive to useful discussion).
 Non-role-play - recall of real interpersonal relationships (in this instance arising from previous week's role-play). Role-play - many short encounters involving adjustment or compromise to maintain close relationships e.g. between friends, in a family, of marriage e.g. - illustrating problems of conflicting social activities <ul style="list-style-type: none"> - resolving problems of a working wife and mother - illustrating the need for wise family budgeting Non-role-play discussion of alternative attitudes and outcomes.
 Role-play (a) short episodes about the breaking of a law or a rule e.g. ignoring no parking signs, demonstrating different reactions to law enforcer <ul style="list-style-type: none"> - hyperactive patient in placid role - reticent patient in emotive role (b) encounters between worker and boss to illustrate work rules and expectations e.g. good time-keeping, no-smoking areas etc. In the above context the patient deploring his own inability to get up in the morning was asked to play the role of a boss reprimanding his worker for lateness. In this kind of role-reversal a patient is faced with criticising his own maladaptive behaviour and sometimes suggesting solutions. Non-role-play - discussion of way of helping the above patient overcome this problem.
 Role-play - jobs drawn out of hat in pairs enacting feasible encounters between people with such job, e.g. policeman, shopkeeper, librarian, hairdresser, repair man, etc. and particular inclusion of social worker.
 Non-role-play - limelight on social worker's role in society. In job combination dominant patients could be asked to take less assertive roles and vice versa. Circumstances of encounter determined which job expertise is paramount e.g. policeman questioning shopkeeper about pilfering is dominant. Policeman asking advice of TV repairman may be subservient.
 Non-role-play - leader reading a list of statements of regret, each beginning "If only I hadn't" Patients were asked to pick the 'odd one out' where the majority referred to physical accidents caused by thoughtlessness but one referred to action which led to a broken marriage. Discussion of the above occurrences and the chances of their avoidance. Role-play - patients chose their own two sub-groups to devise, in the leader's absence and show on return, scenes to illustrate "If only I had met him as I said I would this would never have happened". Non-role-play - patients relating the above implications to real personal experiences and drawing conclusions. |
|--|---|

Patient need - i.c. criterion

Technique to help deal with problem

- a patient needs to prepare for imminent discharge to her sister's home
- *- patients need to consider the support services which they may need in the community
- *- patients need ideas on where to go to make new friends after discharge
- *- patients need encouragement to talk between themselves after role-play sessions
- a patient says she is worried by the presence of a nurse when being interviewed by a doctor
- a patient needs to further explain her problem, qualifying circumstances and expressing feelings more clearly
- 7. relationships in the unit may be improved if patients and staff consider each other's viewpoints
- a patient has a poor self-image
- a patient is apprehensive about moving to a vocational retraining unit
- a patient needs to be more assertive
- a patient needs to practice coping with outside situations
- *- a patient needs to learn to live with physical handicaps, (a) accept unavoidable limitations without embarrassment; (b) make the most of those abilities he does have
- *- patients tend to be self-centred and rarely consider the problems of others
- Role-play - (a) Patient discussing with a friend the matters about which she will have to come to some arrangement with her sister, e.g. housekeeping contribution, sharing chores, sleeping arrangements. (b) Patient asking her sister for information about support services in the neighbourhood, e.g. G.P., social security (c) Group role - asking whole group to join in to advise. (d) (i) Patient tells his friend of loneliness living by himself after discharge from hospital. (ii) Friend meets another companion in the club and together they discuss how to advise the one living alone on suitable activities which may help him meet new people. (The above discussion really forms a shared role to pool ideas). (e) Patients are asked to play self-roles (i.e. responding as they would themselves with no role impositions) in natural advisory conversations, to encourage them to continue communicating in this way, to help each other outside role-play sessions.
- Non-role-play discussion of the anxiety.
- Role-play (a) A conversation between patients in which one expresses her dislike of the practice of a nurse always being present in a doctor's interview, and the friend tries to reassure her. (b) Re-enactment of the above situation but with the patient encouraged to state her reasons for anxiety more fully. (c) Leader adopts the role of a fictitious patient with a history and symptoms decided by the patients. Patients in roles of doctor and nurse interview this imagined patient e.g. (1) The interviewing of patient by the doctor with nurse present. (2) Conversation between doctor and nurse when the patient leaves the room.
- Non-role-play - discussion of staff's responsibilities to patients and their job roles and duties.
- Role-play (a) The patient due to move to a retraining unit role-plays his meeting with an established resident in which he describes his new job and his companion promises to 'show him the ropes' in the unit. (b) As an 'expert' craftsman the patient describes his precision tools and their use to fellow residents.
- Role-play - of likely outside situations, e.g. (a) Callers at the door - coping with traders, rent man, neighbours, religious fanatics, etc. (b) Choosing and interviewing for a suitable job. (c) Domestic problems in group living accommodation. (d) Renewing acquaintance with friend or relative. (e) Managing finances - wise buying etc.
- Role-play (a) past real incidents which reveal and allow a patient, in role, to express attitudes to them and their own feelings about the circumstances associated with the handicap, e.g. developing an improvisation about a child running away from a special residential school. (b) Patient with handicap playing a complimentary role (such as the mother) through which she can explain the behaviour of the child, whose problems and feelings were akin to her own. (c) Simulating the conditions of a member's handicap e.g. deafness - playing lip reading games, cross-dialogical experiences to show confusion of partial hearing. (d) Leader simulating some kind of unexplained collapse with which the group (which includes an epileptic) has to deal. (N.B. It is important to make it quite clear to the group that a feigned collapse is part of a role-play ploy and is not real).
- Non-role-play - patients encouraged to discuss attitudes to their handicap with the group members.

Patient need - i.e. criterion

Technique to help deal with problem

- a patient cannot come to terms with hostility or suspicion of the general public to 'mental' patients

Role-play e.g. (a) Encounters in which patients can show their experiences of hostility toward themselves or other 'mental' patients.

(b) Showing projected situations in which patients can imagine their responses to people who question about illness.

(c) Role-playing incidents which may bring an awareness of the implications of their actions e.g. should they lie about their period in hospital when in a job interview?

*- a patient needs to be able to adopt and deal with unexpected occurrences

Role-play (a) Patients taking a variety of phone calls e.g. taking messages, interrupted calls, etc.

*- a patient says she can speak with greater confidence on the telephone

(b) enacting situations requiring the use of a telephone e.g. calling a taxi, informing the unit if delayed or stranded, etc.

- a patient cannot cope with skills such as telephoning, shopping, budgeting, etc.

Role-play e.g. developing situations in which patients advise each other about diet, cooking, where to shop economically, etc.

Non-role-play e.g. games describing cookery skills.

*- a patient seems quick to judge others by hearsay

Non-role-play - Discussion, derived from recall of a previous role-play episode, of hasty judgement made without full possession of the facts.

(Although other criteria were related to Maureen's problems as indicated, the behaviours concentrated upon in this session were all particularly relevant. More detail of the sequence of events is given in Chapter 5, Session 29. A brief summary of the techniques employed is given opposite.) TAPE H108-240.

Role-play (a) leader asking a patient (chosen at random) to do her a favour but patient instructed to say "no".

(Knowing a good reason for refusal but not stating it at the time). Favours asked (1) request for shopping to be done; (2) asking neighbour to mind baby for short time. After each of these requests and refusals the group were asked to suggest possible reasons and discuss which would justify the refusal to help.

(b) (During the course of session the patient most concerned had deliberately changed her seat). Leader illustrated, in the role of an offended fellow patient, a possible misinterpretation of her action saying "That Maureen does not like me. She has gone to sit on the other side of the table".

Non-role-play - patients, appreciating the reason for the move, defended her explaining that the patient next to her was smoking and Maureen was wearing contact lenses for the first time. They went on to relate the incident to their personal experiences.

Role-play - one of the other patients demonstrating a way of avoiding giving offence to the smoker by politely explaining her reasons as she moves away.

*- a patient makes adamant statements and is often inflexible

Non-role-play - patient asked to consider exceptions to her statement that her brother would never bring in his dog if she had a house of her own.

*- a patient is abrupt in her manner and sometimes inadvertently offends

Role-play - (a) Patient asks favour of leader (in role of a fellow patient) - to lend her her clothes line. Leader says no to request in polite manner and later explains her reason.

(b) Repeat of the above request but with leader refusing in abrupt, annoyed way, without explanation.

Non-role-play - Discussion of possible reasons for both attitudes to the request to borrow. (Maureen said of the latter illustration - "You sounded like me then" and "I don't borrow and I don't lend!").

- Long discussion of the 'borrowing habit' on hospital wards, with minor role-play illustrations.

*- patients appear to doubt that social workers can help them personally

Discussion of hearsay reputations being accepted ahead of personal experience.

The above influence of 'tales' related by others affecting attitudes to rehabilitation activities, such as role-play itself, and support service personnel, such as social workers, was discussed at length. (Social worker was present).

Patient need - i.e. criterion

Technique to help deal with problem

- *- a patient needs to know and talk about herself, as perceived by others - the image she presents. (Maureen was very near to discharge from the unit. This was to be her last role-play session. She had asked that the activities should be devoted to giving her some idea of how people saw her and what they thought about her behaviour. Details in Chapter 5, Session 30. Here those events are summarised in terms of her needs at that time and the techniques used to try to meet them in a particular session).
 - *- patient needs to be put at ease at onset of session
 - *- patient shows little interest in grooming or appearance and adheres to what may be considered immature, unsophisticated fashions
 - *- patient tends to make aggressive, dogmatic statements
 - *- patient is inflexible
 - *- patient often voices suspicions of the motives of others
 - *- patient tends to be intolerant and critical of inefficient behaviour of others
 - *- patient may take greater interest in her own grooming if she hears others talk of their own preferences and pride in appearance
 - *- patient needs to be able to comment on the behaviour which may be likened to her own
 - *- patient needs to hear the opinions of others about the behaviours displayed in role-play which they most associated with her
 - *- patient needs to be able to explain and ?justify her actions
 - *- patient needs to feel there is a balanced view and appreciation of the favourable and unfavourable traits in her nature
 - *- patient wants to hear the opinions of others before she herself disputes or concurs with the leader's portrayal of her behaviour
 - *- patient needs to be reassured that her good qualities are appreciated
 - *- patient needs security at conclusion of session
 - *- patient needs to be able to 'unwind' and express her feelings about the way the session was conducted and her associated emotions
- A role-play session devoted almost entirely to Maureen's needs and the request in her words - "To see myself as others see me". TAPE H241-595.
- Non-role-play - Lighthearted statement from leader that she and the staff members present were likely to be doing most of the work and were therefore the ones at a disadvantage. Explanation to the group of Maureen's request to examine her own behaviour and the reassurance that she will have opportunity to comment on any aspect of behaviour considered.
- Role-play - Leader, in role of said patient, illustrates three different sets of reactions to suggestions that she update her image by changing her choice of dress or hair style. Attitudes shown in reactions were:-
- (1) Indecisive, choice influenced by others, non-aggressive
 - (2) Eager to try new style, easily persuaded by others
 - (3) Suspicious of motives behind clothes marketing techniques, not swayed by others, aggressive, argumentative
- Non-role-play - Discussion of fashions, tastes and appropriateness of dress.
- Discussion of which attitudes and reactions enacted in role episodes most typified Maureen's behaviour. (This raised a hitherto unmentioned behaviour, named by Maureen herself, that of manipulating people, by going along with what they said but ultimately pleasing herself). Patient given the opportunity to offer reasons for her behaviour.
- Role-play - In the context of an office situation via dialogue between the leader, in the role of said patient, and a work colleague, the leader responds as she thinks Maureen might, i.e. pros - co-operation, helpfulness, efficiency, honesty, forthrightness, common sense.
- Cons - hearsay judgement of newcomer, criticism of inefficiency, forceful statement of what she will and will not do.
- Non-role-play - At her own request other patients asked to comment first on above portrayal and role-play episode, before Maureen adds her remarks.
- Leader thanking Maureen, praising her courage in requesting and going through the scrutiny involved in the session. Similarly encouraging the appreciation of the other members of the group.
- Patient asked if she was satisfied with the activities and if she thought similar focus would be a valuable experience for other patients

The writer acknowledges here that establishing patients' problems, as outlined in category C3, is dependent on someone's interpretation of need, and that needs as perceived by patient, staff member or role-play leader may not necessarily concur. The leader has to operate from his understanding of these combining factors in assessing criteria priorities as a role-play session is planned and developed.

The criteria not asterisked in C3 indicate that many techniques were not chosen with Maureen in mind, but some other patient, and the analysis illustrates yet again the overlap of purpose behind many decisions on the selection of techniques when role-play is used as a group therapy.

With regard to topic there is one notable omission in the type of problem and suitable activities indicated in this particular series of sessions. There was little emphasis on family relationships and associated problems. This is because they did not feature prominently in the background to illness or recovery of this particular group of patients. Had other patients and sessions been included in this section of the study, establishing relevant influence and coping with close personal relationships may have been a more apparent role-play focus.

The amount of discussion which is encouraged in association with role-play may vary according to the leader's estimation of its value and in particular his view on the chances of it increasing patient insight. Other values of discussion are mentioned, the most important ones perhaps being the development of 'talk' which may, open up suitable areas for further role-play work, provide additional diagnostic evidence for observers concerned with care and treatment, or improve communication between patients, staff and the role-play leader. Discussion following role-play often led to attempts by patients to deal with their own problems. The realisation that many had similar difficulties was calculated to reduce possible feelings of isolation.

Mention is made of needs which are not concerned with a patient's ability to cope with a specific set of circumstances, but with attributes which may well infiltrate nearly all of a patient's responses such as spontaneity, assertiveness, self-confidence and the ability and willingness to converse with other people. Many of the techniques chosen to help develop the above skills were only expected to have effect after long-term experience. The very act of accepting a role, joining in group activities and being willing to converse with group members requires some degree of initiative and repeated involvement may help promote competence.

The total experience of attending role-play sessions may help fulfil a patient's need to be heard. As the consultant psychiatrist observed, it may be significant that patients have the opportunity at this rehabilitation stage, of speaking and being listened to by someone from outside the hospital system. Valid though the provision of this facility for patients may be, it is conceivable that discussion groups, if chaired by a member of the outside community, could also provide opportunities for them to express their problems and views. Whether, when compared with discussion alone, the patients' participation in role-play group activities is a better preparation for discharge from a psychiatric hospital, is open to question.

The analysis of aims, needs, motivations and practices in this one role-play project may provoke further questioning into the use and value of role-play as therapy to aid recovery from psychiatric illness and hospitalisation.

CHAPTER VII

SUMMARY AND CONCLUSIONS

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Summary and conclusions

As stated in the introduction, the aim in the thesis has been to trace the source of influence which may underlie a leader's choice of action made in the immediacy of directing role-play sessions that are designed to help patients to prepare for discharge from a psychiatric hospital. Because of the dynamic nature of role-play and allied group activities, the leader operates via a series of decisions taken at the time of his contacts with the patients. In summarising and drawing conclusions from the findings of the thesis I wish to begin from the 'in situ' point of contact between the leader and patient, reviewing potential criteria which may prompt a leader's action, and techniques which form the basis of that action. The approach to this consideration of possible origins of influence will involve referring to the content of earlier chapters in reverse order, from Chapter 6 to Chapter 1.

Chapter 6 examined the application of techniques to satisfy criteria. What actually took place in selected role-play sessions was analysed and taped excerpts were used in two ways. In some instances the recordings were used to illustrate specific points about criteria, techniques available, and the reasons for the leader's choices in the circumstances of particular role-play sessions. In other instances longer extracts of sessions were used in order that the interaction and continuity could be discussed and broken down to examine motives within that interaction which again would suggest why certain criteria or techniques were given preference. What was particularly evident from the analysis was the complexity of the ongoing, face-to-face situations which constitute a role-play session. The leader has to decide his priorities from among the many needs and wants evident to him at each juncture in the session. Some of these decisions he may have made in the

planning stage of possible activities, while others may only come to his awareness 'in situ', if new facts are revealed or he sees new possibilities. Similarly, his choice of technique may be premeditated or almost spontaneous to meet his perceptions of needs emerging while a role-play session is in progress.

In the study the term technique was applied to any measure used by the role-play leader to achieve a desired effect. Some techniques were based on the leader's control of the content of the group's activities; the subject matter with which they dealt. Some techniques were the means of manipulating the structure of the session as a whole, or of the various activities in a session. The leader's responses to the group members were also included as techniques.

Techniques concerned with content were very much to do with the pertinence of a topic to the stage of the patient's rehabilitation and his ability to handle and benefit from the experience of situations arising. Relevance to the patients' real experience past, present or future was an important factor in the choice of topic. The study of sessions showed that there was often some continuity of content throughout a session, or even carrying over from one meeting to the next. This usually arose in one of two ways. Either because group members showed their interest in a continued or related topic, in which case the leader's technique was that of allowing patients to develop their interests, keeping content relevant. Alternatively, continuity could be due to the leader's deliberate extension of an idea to explore other channels, in other ways, many of which would not have occurred to the patients. The patients' suggestions of suitable activities for role-play sessions usually consisted of ideas on subject matter. Unless very experienced they rarely foresaw 'role-play ways' of developing ideas. The actual manipulation of role-play situations and the selection of techniques involved was usually the province of the leader.

Techniques concerned with structure were those aimed at achieving effect via the organisation of what was done in sessions. It was the form of events that created the desired situations and requirements of participants, not the topics being considered. The study encompassed techniques of structure pertaining to the total role-play group experience throughout the whole of a session, not just those within the 'drama game' elements of a session. It therefore took account of role-play techniques and non-role-play techniques. Role-play techniques used were discussed in association with influencing criteria, to illustrate the leader's handling of imaginary situations, the taking of roles and role-interaction, to meet chosen objectives. The description of the role-play techniques used included definitions of several named role-play forms such as 'role-reversal', 'role of the expert' or 'role of unspoken thoughts'. Because such techniques can be recognised as patterns of role-play procedure, they can be readily recalled and repeated should their outcome be particularly worthwhile, or the leader wish to explore their use further. Although the thesis did not set out to evaluate the outcome of applying various techniques, it was nonetheless evident in the review of criteria and associated techniques, that the leader's observation of effect may influence the subsequent use of a technique. If a technique is counterproductive, the leader is unlikely to use it in that form to meet that need again. If a technique yields good results the leader will be encouraged to try it again even if with another patient or patients, or in some modified form appropriate to criteria.

The most frequently used non-role-play techniques were games and discussion. The analysis of sessions showed that the proportion of discussion to time spent in role-play varied greatly from one session to another. The leader's objectives in encouraging patients to talk also varied. He may have wished patients to talk their way into a suitable, relevant topic for role-play, or to discuss role-play content and its

implications, possibly extending this to problem solving and the making of value judgements. Problem sharing and the realisation that other people have similar difficulties and experiences may be considered an important part of therapy. The recall of experience made evident in role-play group discussion may provide diagnostic information not proffered in more formal interviews or general conversation with staff. The integration of role-play and discussion, as in the sessions studied, did at times change the course of thought and conversation, as role-play in action, led to unforeseeable situations which may well not have arisen in discussion alone. The leader may aim to develop conversation in group discussion and within the role-play situations themselves in the hope of improving communication skills and social integration which may extend to relationships in living situations outside role-play sessions.

Conversation frequently involves associated body language cues and qualifications. The most common indicators are likely to be hand gestures, facial expressions and body postures. Such signals of a leader's attitudes, wishes or intentions have been included in the study as leader response techniques which may be used to effect in or out of role-play. Tone of voice or the leader's manner of speaking to a patient were also included as response techniques, which like the aforementioned non-verbal indicators, may be conscious or unconscious means of directing action in role-play sessions. It seems doubtful if these expressive means should be classed as techniques if they are no more than the natural accompaniment to the leader's communication with the group.

However, the use of such techniques was shown to be quite deliberate at times, as when the leader held a pause to give a patient time to think and act, or was intentionally gentle or aggressive to encourage a patient's response. Care may be needed to ensure that patients do not confuse the leader's role or semi-role responses with his natural responses which indicate his real attitudes. This may be particularly important if the

role responses are unfavourable. Evidence of a leader's real attitudes may be an important means of building patient confidence but may also be designed to encourage similar attitudes in other group members. Whatever degree of awareness the leader has of his use of response techniques, their practice and effect in the study suggests that he should be mindful of their potential. The leader's response to patient's contributions to group activities may have a beneficial or detrimental effect on patients' future efforts and on relationships within the group.

The study showed that the employment of a technique may be multi-purposed. A leader's general aim, such as promoting confidence or spontaneity, may be relevant to the needs of all group members, or of one individual only. Equally, quite a specific objective, such as improving the ability to deal appropriately with a telephone call, can be pursued to benefit the whole group or one person in that group. The prospect of using a technique to simultaneously satisfy more than one need may be a factor in its selection. If a leader can envisage several techniques which may help toward an objective, should one of those techniques also have potential for other worthwhile effects, on the same or another patient, it may be for the additional benefits that it is chosen. However, the study also suggested that this may not always be the case, for if one technique seemed superior in its suitability for one prime purpose, any secondary benefits which might accrue through the use of a slightly less pertinent technique may be forfeited in achieving that one purpose. It is evident in the analysis of criteria and associated techniques that in establishing and aiming toward his priorities the leader on some occasions may compromise to cater for combined individual or combined group needs, while on others he may work almost exclusively toward one specific goal. Whichever course he chooses he will inevitably have to sacrifice some needs in pursuit of others.

Before the leader can embark on any work to deal with individual problems or the patients' needs in preparing for life out of hospital, he may have to

familiarise the group members with the practices he intends to use and their purpose. This may mean that he needs to select techniques which demonstrate how he hopes his methods may work to help patients. He may also need to take measures to ensure that the procedures he proposes and the total atmosphere of the sessions are acceptable enough to encourage the patients to continue to come and join in the sessions. This may mean the selection of initial activities which will not impose too much stress on patients. In the study lighthearted activities, such as games or informal chat, were often used at the beginning of sessions and sometimes toward the end, with more serious work done in the middle. What seemed important in the introduction of role-play to patients was that advantages were seen to outweigh any anxiety in the demands of participating. Only when patients were sufficiently secure were the demands of concentration, degree of difficulty in role requirement, or emotional involvement, gradually increased. Again it was important for patients to appreciate the potential benefits of being in a role-play group if they were to give to it the required time and effort.

A willingness to be involved in the activities of a role-play group may depend as much on the patient's attitude to sharing his experiences with other group members as on his acceptance of the nature of the activities themselves. The pressure imposed by taking a role, participating in a game, or expressing an opinion cannot be separated from the attendant anxieties of doing so in front of a number of other people. A patient's relationships within a group may be very varied. In a role-play session a patient may be in the presence of fellow patients who he knows well and counts as friends and others who are practically strangers. Participation is likely to bring contact with both sexes. If there are staff present he may feel that his actions reveal his behaviour to authority figures, responsible for his treatment. He may also be concerned about the attitude of the group leader who sets the requirements. The leader may therefore need to employ supportive techniques to maintain a patient's self-confidence or prevent his embarrassment.

In the role-play sessions this was done in part through the leader's own responses to patients and by his efforts to control the reactions of others in the group if there was any danger of these damaging morale or inhibiting participation. How much a patient is prepared to give and reveal to a group is also likely to be related to his knowledge of how such information is used. In the sessions the leader took deliberate steps to ensure that group members knew who had access to what transpired in sessions, whether via verbal or written reports or from tape recordings of events. The leader's respect for patients and their disclosures had to be evident not only to reflect the leader's own attitude but also to foster a similar respect from other group members. The prevention of too much anxiety or embarrassment was also a criterion in the choice of topics which needed to be made with consideration for patient ability and experience. Topics which may have been too painful or humiliating if approached openly were at times dealt with indirectly via a role-play or game analogy. Preserving dignity within the group was regarded as an important objective, particularly since the members not only met once a week for role-play, but also had to live together.

The need for patients to be secure or insecure where appropriate, emerged as significant criteria and again the techniques used to achieve either state were concerned with content, structure or leader's response. The analysis of techniques showed many ways of regulating the degree of exposure that a patient could be expected to tolerate. The relevance of the topic chosen would be likely to affect the prospect of a patient being the focus of attention. The length of time for which a patient was expected to sustain a role-play performance and the difficulty of the requirement in interpreting a role-play situation or adopting a role could be related to the leader's estimation of the patient's capability and real or role-play experience. The amount of support given by other participants in a role encounter was variable. This could affect the degree of dominance expected of him in role, how much he was expected to initiate or sustain dialogue or

action and how much his ideas and opinions could be challenged. The acceptance or rejection of ideas, in or out of role, and the manner of expressing any contrary views could all be adjusted to meet the security/insecurity needs of patients. Praise for effort, though always an important reinforcement, seemed of particular consequence in the reassurance of apprehensive patients. Approval, or the lack of it, in words or gestures could be regulated to indicate to the patient how appropriate and satisfactory the leader considered his contributions to be. Not getting this feedback from the leader could be one way of creating an insecure situation if such a test of his ability to cope was thought fitting. The tolerance of insecurity was suggested in the study as a necessary stage in the rehabilitation process where the aim is to prepare the patient for the move from hospital and its support functions.

Role-play in rehabilitation may involve providing additional opportunities for staff to assess patients. If their observations are made in group interaction that is not being purposefully directed to that end, but is just the spontaneous outcome of people meeting together, facilitating assessment cannot be said to have been a factor influencing the choice of techniques. Once the leader sets out to create circumstances that might reveal factors relevant to diagnosis, the staff requirement of diagnostic evidence becomes a criterion for technique selection. The study showed that in almost all instances where techniques were employed to help with diagnosis they were simultaneously intended to help patients deal with circumstances considered relevant to their rehabilitation. Patient need was always put before staff need.

The assessment of a patient's need is dependent on someone's perception and judgement. Not all observers will necessarily perceive the same needs from their observation of the same episode. What they conclude from what they see is likely to be related to the aspect of behaviour they are particularly interested in at the time. It may therefore be far better for

personnel concerned with patient management or treatment, to be present in role-play sessions and see for themselves, rather than rely on the retrospective reporting of the leader who may not appreciate the significance of events which could be very meaningful to staff. Tape recordings may be a good second best to actual staff presence but the decision to include staff or use a tape recorder would need to be taken in the light of any possibility of either practice having adverse effects on patients' contributions.

The selection of techniques was seen to be related to short-term or long-term aims. Some techniques were employed in the hope of fairly prompt benefit to patients, as when the one-off experience of handling particular circumstances in simulated situations was thought to be good preparation for the successful handling of similar circumstances in real situations. Other techniques, or even elements in the same techniques, were intended as contributory experiences to improve functioning over a period of usage.

The individual case study in Chapter 5 showed that needs often emerged during a patient's time in a role-play group. If work done is to be as helpful as possible, should new behaviours, facts or wishes indicate other needs, the leader may have to deviate from his original prediction of role-play requirements. The temporary suspension of the use of the tape recorder, to prevent the inhibition and hostility of the patient, indicated that a leader may have to choose between his own research needs and the patient's therapy needs. There was also evidence in the study sessions to suggest that valuable ways of using role-play or non-role-play techniques, may grow from the discovery of the interests and abilities of patients, rather than from always looking for problems. The employment of techniques which allow a patient to demonstrate and experience his strengths may be a more effective rehabilitation practice than dwelling on his weaknesses.

In the individual study, it was shown that the patient chose to be the centre of role-play attention; to be put at risk; to tolerate the anxiety of self and group criticism. In complying with her wishes the leader still

felt it was necessary to support the patient with praise and focus on commendable behaviours. When working with patients likely to be very familiar with failure, it seems particularly important for the leader to compensate any threat to morale with practices to restore it.

Attention was drawn to the possible significance of the relationship between the group members and the group leader. The main conclusion was that although a leader may need to guard against the adverse effects of becoming over involved with any one patient in a group, the leader's willingness to listen to individuals plus actions which show trustworthiness and reliability, may improve, not only the patients' attitudes to the leader, but also to the practices used. In group therapy, it is inevitable that certain topics will be more relevant at certain times to certain members. Not everyone present can be actively involved all of the time. No activity can be pursued to help one or a few, if it will have a markedly harmful effect on even one other member. Achieving a balance of attention given to each member, and accounting for individual and group welfare are criteria which will affect a leader's actions if interest is to be maintained in a cohesive group venture. Striking this balance of interest and involvement may not be easy if a role-play group includes patients of widely differing ability and experience. A group may therefore function more successfully if the members have a similar intellectual capacity, similar hospital background and similar rehabilitation prospects.

The consultant's report contained in Chapter 4 referred to two main types of patient likely to be selected for a role-play group; (a) longer-stay patients, and (b) short to medium-stay patients. One of the principal differences between these two types of patient which the consultant anticipated would be relevant to the selection of role-play techniques, was their likely level of intelligence. Her experience had suggested that longer-stay patients tended to fall into a lower range of intelligence, and were slower learners than most short to medium-stay patients. If the group's activities

were to be acceptable and effective the leader needed to be sure that the techniques were appropriately chosen to allow the patients success and satisfaction.

The consultant's report indicated that patients of a similar type, i.e. longer-stay or short to medium-stay, would probably have more than their length of hospitalisation and level of intelligence in common. Although the details of their experience varied, there were often similarities in their original illness symptoms. They had known similar hospital environments, procedures and treatments. Patients often shared similar problems and displayed similar behaviours likely to affect their adjustment to living outside hospital.

The differences in the criteria influencing role-play group activities, with different types of patient were examined by comparing and contrasting the role-play requirements of patients in two separate groups that met regularly at different stages in the project. The implications for technique selection were discussed and are briefly reviewed here.

The requirements of longer-stay patients fell into four categories:

1. The need to improve self-care skills - where role-play group activities were a useful means of drawing attention to ineffective behaviours and their implications, and of practising the necessary skills to improve self-management. Although the techniques used to meet the above requirements were previously aimed at improving functioning, a secondary criterion in their selection was the need to encourage positive attitudes to discharge.
2. The need to promote the increased awareness and possible modification of anti-social behaviours - where techniques were employed to explore the effects of anti-social behaviours and the need or ways of eradicating them.
3. Overcoming problems associated with withdrawal or lack of motivation - where role-play and allied group activities were used to promote interaction, communication and involvement likely to require decision and

action. In this category objectives were often long-term, the aim being to achieve them through the repeated experience of similar techniques. Games were often introduced to prompt response, spontaneity and a predisposition to action. In association with spontaneity, appropriateness of action was also encouraged, thus involving the use of discussion to assess performance and effects.

In the early groups of longer-stay patients there were some with additional physical problems such as epilepsy or impaired sight or hearing. Similar handicaps did present additional problems for patients in the shorter-stay groups but because of the overlap of occurrence, they are included here in category 4.

4. The need to encourage realistic attitudes to physical disabilities - techniques were orientated toward encouraging realistic attitudes in both the people who had the problems and those who contacted them. Whether the issues were approached seriously or through shared humour, discussion, where appropriate, enabled all of the group to talk of physical disabilities without embarrassment.

Because long-stay patients tended to be out of touch with situations outside hospital and unable to recall very much outside experience which was relevant to their current or future situations, much of the role-play done with them was based on hypothetical situations which the leader thought appropriate to their rehabilitation needs. Many of the problems of the longer-stay patients seemed to stem from their exclusion from social interaction in which they could experience their own responses and the reciprocal reactions of other people. The use of role-play to compensate for lack of real experience by providing meaningful contexts in which to try out or practise behaviour, seemed an important function of the group. An important criterion in the direction of role-play was the need to allow participants time as well as providing favourable circumstances. Many were slow in thinking, slow in response, and slow in speech or action. Their decisions required

time and if they were to assert themselves many of them needed stimulation, encouragement and opportunity. Speeding up the responses of slow or lethargic patients or steadying down the reactions of hyperactive patients was an integral part of the spontaneity-appropriateness requirement associated with the behaviour of longer-stay patients.

When working with shorter to medium-stay patients there did not seem to be any need to concentrate on self-care skills. The majority of the shorter stay patients seemed confident that they could handle their own domestic needs and finances. They were less confident about the appropriate handling of various types of interpersonal encounter and the area of functioning in which it was suggested by both staff and patients that additional role-play experiences could help, was social interaction. The problems of many of the shorter-stay patients were not related to a withdrawal from social contacts but to difficulties in various relationships, close or casual, formal or informal. A criterion in the selection of suitable role-play situations was that in addition to promoting the handling of likely circumstances they should also allow the patient practice in the handling of their own emotions in relation to those circumstances. Shorter to medium-stay patients could contribute many ideas to role-play sessions. They were able to feed-in first hand experiences and make specific suggestions of role-play activities likely to improve their readiness to cope out of hospital. The experience they repeatedly asked for was practice at job interviews. In relation to this and less formal meetings with members of the public, they were very concerned about the advisability of being honest about their illness, hospitalisation and treatment. In reaching any personal decision about whether or when frankness about their history was appropriate or necessary, they did, in role-play group meetings, come some way toward reconciling themselves to past mental illness, even if only in their willingness to discuss it. The acknowledgement that they had had psychiatric problems, the sharing of anxieties about treatments and the exchange of ideas about

how to approach life out of hospital, seemed to be a beneficial part of their preparation for discharge.

The shorter stay patients could attempt to analyse their own, and each other's, problems in a way that would have been unsuitable or impossible with longer-stay patients. They did not want to give group session time to games etc. but wished to get straight down to role-play and discussion of real or feasible situations. Discussion became increasingly important, not only because shorter-stay patients were more capable of manipulating ideas and reasoning their way through problems, but because the communication entailed, experienced in a secure group setting, where they could express opinions, listened to by someone from outside the hospital establishment appeared to be a valuable rehabilitation aid. The criterion in deciding when to employ a role-play technique and when to employ discussion; a non-role-play technique, was to pursue the line of development which seemed most appropriate to need, at that particular time. Because shorter-stay patients seemed more perceptive, it was possible, in some instances, for them to take over some of the responsibility for the direction of events. Encouraging patient leadership was in keeping with the criterion of promoting independence and self-determination but as patients tended to be more familiar with their problems than with role-play techniques or variations in their use, patient leadership frequently led to discussion and little role-play. The criteria for the intervention of the official leader were (a) it was necessary to support the patient/director; or (b) it was beneficial to the group in that it might change the course of events to open up new aspects or approaches to the problem.

In Chapter 3 the writer emphasised the opinion that role-play group aims and activities should be complementary to those of unit staff. Doctors or nursing staff can help the role-play leader to decide priority needs, provide him with details of patient's previous behaviour in the unit or future requirements in likely future accommodation. Their day-to-day contacts with

patients can break down the generalisations about patient behaviour to specific observations upon which appropriate role-play may be based. In the thesis it is suggested that not only should co-operation between hospital staff and the role-play leader exist but also that patients should be aware of its existence. A criterion in the introduction of role-play to patients was that it should be presented as part of their total rehabilitation programme. They were also reminded that although the leader could be discreet in deciding who should have access to information revealed by patients in group meetings, there was no place for 'secrets' from staff, who were after all responsible for treatment and welfare. Helping patients adjust to living in the rehabilitation unit was shown to be a useful role-play function. This included techniques to promote communication, socialisation and a pleasure from mixing with other people. It also presented opportunity for patients to raise problems arising from community life and relationships with other patients and staff. Unit staff saw the main functions of the unit as (a) the assessment of patients, and (b) the preparation of patients for discharge by improving levels of functioning, progressive de-institutionalisation and independence, and establishing a work routine with positive attitudes to leaving hospital. Such functions provided the role-play leader with many valid aims and criteria for technique selection. The nursing staff anticipated that in pursuing such aims the role-play leader would encounter domestic, work, social, personal or psychiatric problems. In helping patients to overcome their difficulties the leader needed to decide whether to focus on problem-solving; reviewing the pros and cons in particular problematic situations and encouraging decisions on the handling of specific circumstances, or whether to try to elicit maladaptive behaviours which may cause problems and concentrate on change in that behaviour being generalised to a variety of situations.

The causes of maladaptive behaviours were not considered irrelevant to the choice of role-play to help modify them. It was suggested in Chapter 2

that part of the role-play leader's 'frame of reference' in determining suitable topics and techniques to help psychiatric patients, should be a background of information about the causes and effects of psychiatric illnesses. From conversations with the Consultant in Rehabilitation, her written reports and other literary sources, the opinion formed and expressed was that after a prolonged period of hospitalisation, symptoms of original illness and the effects of institutionalisation are likely to be so enmeshed that for the purpose of deciding appropriate role-play group activity, in rehabilitation, it is futile to try to separate them. When a role-play leader meets a patient in a role-play session the interaction with him starts from the residual symptom end of the illness - recovery process. But although the effects may be indistinguishable a consideration of possible contributory causal factors in each condition can indicate the kinds of experience which patients may have missed, or mishandled, suggesting needs as criteria for role-play technique selection. These are summarised on pages 61, 68, 69, 79 and 80 of the thesis. It would be superfluous to generalise even further here, for an important conclusion with regard to technique selection is that it is so often based on detailed requirements, as appropriate for the patients present, not on nebulous generality. The leader's investigation into possible causes of mental illness should suggest ways of using role-play to try to counteract their effects. This does not mean that he will necessarily think that patient awareness of causes is essential to the eradication of symptoms. How the role-play leader approaches the lessening of problems will depend on his attitudes to the use of role-play as therapy and the whole psychotherapy process, including his convictions about learning and the promotion of sound mental health and adequate social functioning.

In Chapter 1, in the course of the comparison of different approaches to the use of role-play as a psychotherapeutic aid, it was suggested that as role-play is of itself only a 'technique'; a 'set of practices', how it is used will depend on the practitioner's bias toward a particular system of psychotherapy and learning theory. From each of the systems discussed in

the first chapter a list of criteria which could possibly affect the use of role-play or the direction of a role-play group, was drawn up. These are the details of influence which may be evident in a leader's use of his 'set of practices'. They can be narrowed to a choice of approach which may range from:-

- (1) Psychoanalytical - where personality is believed to be influenced predominantly by innate urges and one of the main objectives is bringing repressed causes of past conflicts and motivations to patient awareness and drawing his attention to the effects of these on his present and possible future behaviour.
- (2) Interpersonal-environmental - where personality is believed to be influenced primarily by interpersonal-relationships and social-interaction. The main objectives are revealing significant interpersonal events in the 'here and now' and investigating alternative behaviours which may improve the chances of success and satisfaction.
- (3) Rational-cognitive - where the importance of environmental effect on behaviour is again stressed. The main objectives are the rational analysis of past experience and effectiveness of behaviour and the exploration of alternative strategies to improve effectiveness with the emphasis on the problem rather than on the patient.
- (4) Behaviourist - where man's behaviour is believed to be moulded almost totally through environmental influence. The main objectives are the observing of the occurrence and effects of maladaptive behaviours and achieving a response to controlled stimuli which is considered by others, i.e. the therapist or concerned professionals; to be appropriate. This approach advocates the practice and modelling of adaptive behaviours.
- (5) Perceptual-phenomenological - where it is suggested that man is neither the pawn of his inner urges and needs, nor of external manipulation but has potential to choose what he is and does. The main objectives are to encourage the patient to identify his own problems, confide these to the therapist and contribute ideas on how to overcome them, the emphasis being on self-acceptance, self-determination and self-sufficiency.

(6) Existentialist - where the main objective is to encourage the patient to acknowledge his responsibility to and for himself and his actions.

Although the inclusion of the above summary of the main psychotherapy approaches discussed in the thesis is useful to illustrate contrasting philosophies and objectives which may give rise to criteria for role-play selection, what such a brief overview cannot include is the detail of minor principles or practices, associated with a psychotherapy. In developing role-play therapy, the group leader may incorporate some ideas presented in a recognised psychotherapy system, without accepting or using all of the theory or methods suggested.

In the investigation of the work of three role-play therapy exponents, in Chapter 1, it was seen that no one project exclusively adhered to any one system of psychotherapy. What they did show were trends toward certain approaches and the way that elements of contrasting psychotherapies could be employed in one role-play project to meet selected aims and individual needs. All three role-play projects were to some degree eclectic, but their comparison suggested that any bias toward one psychotherapy system or another was likely to be related to what the exponent believed the purpose of his therapy to be. It is this which each role-play leader must establish for himself and upon this decision he can begin to select the criteria which will in turn affect his selection of the techniques he employs.

The purpose of this particular role-play project was to aid rehabilitation. The overall aim in rehabilitation was to prepare patients for independent living in the community, by the gradual withdrawal of the support of the hospital system and personnel. This implied freeing patients from stereotyped or institutionalised behaviours and encouraging individual thinking, decision and action. The practices used had a definite bias toward a phenomenological approach to therapy. Patients were encouraged to recognise their own problems and abilities, and to tackle their difficulties and look to future goals without relying on other people to tell them what

to do. Acknowledging the patient's need of self-determination did not mean that contrasting ideas reflecting other approaches to therapy could not be incorporated into these fundamentally patient centred activities. Behaviouristic techniques, such as modelling, with reinforcement of the model and the patient observer, practice of adaptive behaviours and occasionally 'flooding', were employed. Such methods were rarely followed in true behaviouristic manner as the leader frequently chose to involve the patients in determining the needs and discussing the appropriateness of behaviour. Discussion was also important to the problem solving, rational-cognitive elements in the role-play. Much of the group's activity centred around the examination and development of interpersonal situations and the effects of patients' behaviour on their relationships with a variety of people. There was no pronounced psychoanalytical bias, aimed at the exposure of root causes, in the role-play work. Establishing causes of maladaptive behaviours was intended primarily to help in assessment and diagnosis. An aspect of Freudian theory which was thought relevant was the suggestion that coping with 'signal anxiety' in simulated situations may allay real anxiety in similar real situations. The basic assumption that the imaginary situations of role-play can be used to aid rehabilitation at all, relies on the Freudian learning premise, that responses in one set of circumstances, i.e. a role-play situation, can be recalled and transferred to another set of circumstances; the relevant real situation.

The above features of differing psychotherapies evident in the use of role-play in this project are just some examples to illustrate the 'pick and mix' approach chosen because it allowed the versatility that would enable the leader to operate via the response or role-play means which seemed most suitable and beneficial for an individual or the group - at that particular time. The appropriateness of the moment was the final criteria in technique selection.

In the introduction, the development of the thesis was likened to a journey whereby a role-play leader would attempt to identify influences

likely to affect role-play activities. The discussion of criteria and techniques, though theoretical, does typify the journeys of selection which culminate in the leader's decisions made in the 'here and now' of role-play sessions. The tape recordings were intended to illustrate the way in which techniques related to criteria, but in retrospect, the writer hopes that they also serve to relate theory to practice and show that, while taking account of priority needs or of planned strategies, the leader is finally required to decide and respond according to the 'nowness' of the evolving situations which constitute a role-play session.

It was because the approach to the use of role-play, in this project, was basically patient orientated and developed to help them prepare for discharge, that any research methods which may have compromised that purpose were not acceptable to the group leader. The investigation therefore focussed on the choice and application of the leader's 'set of practices' with only brief reference to assessment of outcome. For any guide to the success of the role-play group work done in this rehabilitation project the leader relied on her own observations and those of hospital staff familiar with patient behaviour, in and out of role-play sessions.

The modest findings of this thesis with regard to:

- (a) the identification of criteria governing techniques, and
- (b) the definition and categorisation of techniques employed, in a

rehabilitation programme of adult psychiatric patients are presented with the intention of opening up the use of role-play in therapy to greater scrutiny. In a different type of role-play project, the details of such analysis, may help to pave the way for further research into the effectiveness in the use of various approaches and techniques of role-play as a rehabilitation aid.

APPENDIX ASOUTH VIEW REHABILITATION UNITNURSES ROLE IN THE UNIT

The major role of the nurse is that of instructor in the various community, social, domestic and work situation.

Having initially portrayed the rôle of the instructor to the new patient, the nurse must then change to that of adviser as the help in the various tasks set the patient are withdrawn until the nurse assumes the role of an unobtrusive observer and only offers assistance or advice if the patient requests it or the nurse recognises the need for either one or the other. The above roles generally apply to domestic and work situations but when community and social aspects are involved then a very different role is assumed and instead of that of instructor it takes on the role of both adviser and one of silent example together with verbal encouragement to partake in various forms of communication, whether it be conversation, sporting activities, community participation as in dancing, dominoes, darts etc.

There are other roles which the nurse must perform for the smooth running of the Unit and these are mainly self explanatory and are as follows:-

- (1) Counsellor - i.e. to counsel patients with their personal problems.
- (2) To take part in all activities and assist whatever therapist is holding a session.
- (3) To act as a liaison officer between various disciplines and give assistance when necessary.

PATIENTS PROBLEMS WITH WHICH NURSES DEAL

The problems the nurse must deal with are too numerous to itemise as they cover every aspect of daily living from that of getting up in the morning and opening the curtains to marital problems. The following are just a few that may be encountered and can come under one of the five categories:-

- (1) Domestic problems - include - shopping, cooking, generalised housework, budgeting, hygiene, washing, ironing, nutritional needs, safety in the home.
- (2) Work problems - include - getting up for work and getting into a working routine.
Sustaining continuous employment.
Coping with fellow workers and their comments.
Applying for work.
Sickness during working hours.
Filling in various tax forms and D.H.S.S. forms.

- (3) Social problems - include - meeting people, using various public services, i.e. telephone, travelling on the bus and train, attending public functions, i.e. dances, bingo, public houses, football matches, coping with crowds, ordering a meal etc. in a cafe, using a post office.

A patient may have a real problem with the above if it is accompanied by a fear of people, crowds, open spaces etc.

- (4) Personal problems - include - marital, family, personal hygiene, writing, reading, speech, gait, appearance, dress.
- (5) Psychiatric problems - include - abnormal behavioural patterns, hallucinations, delusions of various types, anxiety, agitation, mania, depression, phobias of varying forms.

AIMS AND FUNCTION OF THE UNIT

- (1) Assessment of patients.
- (2) Improvement of patients level of functioning in all spheres.
- (3) Progressive de-institutionalisation.
- (4) Establish a work routine.
- (5) Prepare patients for a life in the community when discharged to either:-
- (a) Home
 - (b) Hostel
 - (c) Group Living Scheme
 - (d) Part III Accommodation

by use of a 24 hour rehabilitation programme.

NURSE - ROLE PLAY THERAPIST RELATION

The relationship between nurse and therapist is extremely flexible and may extend from full participation in the group to that of total exclusion, not only from the group but also from the room by the nurse. In any event, the role that is being played by the nurse can to a large extent play a big part in the session as to whether or not a patient portrays true facts when the nurse is present or false etc.

There is always full communication between the therapist and the nurse on all aspects of the patient and at all times the welfare of the patient is of the utmost importance. Their complete confidentiality is of paramount importance.

IT/CT: 3.3.80.

Ian Templeton,
Charge Nurse,
South View Rehabilitation Unit.

Copies to: Dr. M. D. M. Goodall
Barbara Howarth (Role Play Therapist)
Ian Templeton (Charge Nurse)

APPENDIX BSOUTH VIEW REHABILITATION UNITTHE FUNCTION OF THE UNIT, AS DESCRIBED BY THE CONSULTANT PSYCHIATRIST

South View Rehabilitation Unit opened 3 years ago for the rehabilitation of long stay patients at Winterton Hospital. Its use has now extended to include some short stay patients.

The longer stay group includes patients who have been hospitalised for anything from 5 to 40 years. These patients are usually Chronic Schizophrenics and they show residual symptoms of schizophrenia as well as the effects of many years of institutionalisation.

The behavioural consequences of both include apathy, inertia, lack of confidence, poor motivation, poverty of thought, emotional blunting, lack of interest in the environment, a fear of and resistance to change and in particular a fear of leaving hospital. There is lack of stimulation on chronic wards and lack of opportunity to develop new responses or try out new patterns of behaviour; and if a patient has been hospitalised since early life, there will be no firm foundation of life experience in the outside world on which to build. In addition many of these patients fall either in the dull normal or mildly subnormal range of intelligence and are slow learners.

Shorter and medium stay patients admitted to South View fall into a range of diagnostic categories which include Recurrent Depressives, Problem Drinkers, mildly Anti-Social, Vulnerable and Neurotic Personality Disorders as well as Psychosis. These patients often fall into younger age groups and tend to become "stuck" in hospital because their near relatives find it difficult to tolerate the eccentricities of behaviour; or because caring near relatives have died and patients are unable to cope alone.

The functions of the Unit and Multi-Disciplinary Team are:-

- (1) Assessment of Residual Psychiatric Symptoms
Behavioural problems
Deficits in social and self care skills
- (2) Improvement of a patients level of function in all areas -
social, domestic, occupational etc.
- (3) Discharge to the Community with appropriate support.

Initial assessment is carried out by all members of the Team before the patient is admitted. If the patient is felt to be suitable he will be admitted to the Unit. If there is some doubt about suitability the patient may be advised to attend as a Day Patient for a while.

The South View Nursing Staff observe and assess the patient over a period of 2-4 weeks to identify deficiencies and behavioural problems. Each problem area is then referred to the appropriate discipline for therapy, e.g. for problems of concentration in work situations the patient might be referred to I.T.U. Social skills deficits encompass a large number of situations in which the patient needs to practise his responses and gradually develop confidence in his own ability to make correct decisions and help and advice are needed here from a number of Multi-Disciplinary Therapists.

M. D. M. GOODALL,

Consultant Psychiatrist.

MDMG/CT: 13.3.80.

APPENDIX CTHE CONSULTANT'S DRAFT OF PATIENT HISTORY AND REHABILITATION
REQUIREMENTSMAUREEN

The above patient was originally admitted at the age of 19 in the mid 1960's. She showed symptoms of agitation and depression at that time, recovered after a short course of treatment, and was discharged. A second admission followed soon afterwards precipitated by an attempt at self injury.

She worked away from the area for some years after this, during which time there were two further admissions to psychiatric hospitals in the South, and at least one other attempt at self injury.

In her late 20's she was re-admitted locally and has now been continuously hospitalised for two years. She is single and has had no serious relationships with the opposite sex.

Her mother died several years previously, her father is alive and living locally and there are several siblings in the area with whom she has close contact.

Maureen has suffered from a defect of vision since birth and spent much of her life at a special school. Operative treatment in her early teens left her partially sighted. On leaving school, she worked in a variety of jobs as a Mothers Help, either locally or in the South.

She has little desire to live with her father or siblings again, and while she claims that this is because of their constant quarrels and arguments she does have insight into the fact that she is immature for her age and different from her peers and siblings for a number of reasons.

It may be that she is content only in situations where she is not presented with reminders of her differences i.e. when looking after young children or among a group of patients, many of whom, are more handicapped than she is. On the other hand she does not like to think of herself as a "patient" and has resisted suggestions that she live for a spell in a Group Living Scheme. The main problems to date are inability to make friends with her peer group, her ambivalence towards the opposite sex, her poor job skills, her partial sightedness and her immature personality and reactions to stress situations.

She has now been in the Rehabilitation Unit for nine months, her emotional reactions are becoming more controlled, she maintains reasonable relationships with patients and staff in the Unit, her domestic skills and capacity for organisation are among the highest in the Unit and she received a good report from a Work Rehabilitation Unit during a period of six weeks there last October.

Her present plans are to secure a house for herself close to her sisters.

Future rehabilitation should be directed towards improving her relationships with her peer group, encouraging her independence in the community by helping her to find a house and job, and sexual counselling when required. She will need long term support from Social Workers, Community Psychiatric Nurses and Consultant Psychiatrist.

BIBLIOGRAPHY

Books

- ARBUCKLE, D. S., Counseling and Psychotherapy: An Overview. McGraw-Hill, 1967.
- BALES, R. F., Interaction Process Analysis. Addison Wesley, Cam. Mass., 1951.
- BALES, R. F., Personality and Interpersonal Behaviour. N.Y. Holt, Rinehart and Winston, 1970.
- BANDURA, A., and WALTERS, R. H., Social Learning and Personality Development. Holt, Rinehart and Winston, 1964.
- BARTON, R. Institutional Neurosis. Wright and Sons Ltd., 2nd edition, 1966.
- BECCKLE, H. C., Psychiatry Theory and Practice for Student Nurses. Faber and Faber, 1946.
- BION, W. R., Experiences in Groups. N.Y. Basic Books, 1961.
- BRAMMER, L. M. and SHOSTRUM, E. L., Therapeutic Psychology. Prentice Hall Inc. 1960.
- BRITTON, J. Language and Learning. Penguin, 1970.
- BROEN, W. E., Personality and Psychopathology. Academic Press, 1968.
- COHEN, L., and MANION, L., Research Methods in Education. 'Role-Playing'. Croom Helm Ltd.,
- CORSINI, R. J., Methods of Group Psychotherapy. McGraw Hill, N.Y., 1957.
- CORSINI, R. J., Roleplaying in Psychotherapy. Aldine, 1966.
- DOUGHTY, A. and DOUGHTY, P., Language and Community. Arnold, 1974.
- ENGLISH, S. O., and PEARSON, G. H. J., Emotional Problems of Living. Allen and Unwin Ltd., 1947.

- EYSENCK, H. J., Experiments in Behaviour Therapy. Pergamon Press, 1964.
- FELDMAN, M. P., and BROADHURST, A. Theoretical and Experimental Bases of Behaviour Therapies. Wiley and Sons Inc., 1976.
- FISH, F. J. Schizophrenia. J. Wright & Son Ltd., 1962.
- FISHER, S., and GREENBERG, R. P., The Scientific Credibility of Freud's Theories and Therapy. Harvester Press, 1971.
- FLAVELL, J. H. The Development of Role-taking and Communication Skills in Children. Wiley and Sons Inc., 1968.
- FORD, D. H. and URBAN, H. B., Systems of Psychotherapy. Wiley and Sons Inc., 1963
- FREUD, S., Complete Psychological Works. Vol.1-14, (Ed. Strachey), Hogarth Press, 1962.
- FREUD, S., Introductory Lectures in Psycho-analysis. Urwin Bros., 1922.
- GIGLIOLI, P. P., Language and Social Context. Penguin, 1972.
- GOFFMAN, E., Asylums: Essays on the Social Situations of Mental Patients and Other Inmates. Penguin, 1968.
- GOFFMAN, E., The Presentation of Self in Everyday Life. Allen Lane Ltd., Penguin, 1969.
- GREENBERG, I., Psychodrama. Souvenir Press, 1975.
- GUNTREP, H., Personality Structure and Human Interaction. Univ. Press, 1961.
- HADFIELD, J. A., Introduction to Psychology. Allen and Unwin Ltd., 1967.
- HERSHER, L., Four Therapies. Butterworth, London, 1970.
- JOHNSON, J. A., Group Therapy: A Practical Approach. N.Y. McGraw-Hill, 1963.
- JOURARD, S. H., Personal Adjustment. Macmillan, 1958.
- KLEIN, J., The Study of Groups. Routledge, Keagan-Paul, 1956.

- KLEIN, J., Working with Groups. Hutchinson, 1961.
- MAHER, B.A., Principles of Psychopathology. N.Y., McGraw-Hill, 1966.
- MANN, R. D., GIBBARD, G. S., and HARTMANN, J. J., Interpersonal Style and Group Development. N.Y. Wiley and Sons Inc., 1967.
- MEDCOF, J., and ROTH, J. (Ed.), Approaches to Psychology. O.U.P., 1979.
- MILLER, G. A. (Ed.), Communication, Language and Meaning: Psychological Perspectives. N.Y. Basic Books, 1973.
- MILLER, G. A. (Ed.), The Psychology of Communication: Seven Essays. London, Penguin, 1968.
- MISCHEL, W., Personality and Assessment. Wiley & Sons Inc., 1968.
- MOLLOY, J. S., Teaching the Retarded Child to Talk. U.L. Press Ltd., 1965.
- MORENO, J. L., Mental Catharsis and the Psychodrama. Breacon House Ltd., N.Y., 1944.
- MORENO, J. L., Psychodrama, Vol.I. Breacon House Ltd., N.Y., 1964.
- PATTERSON, C. H., Theories of Counseling and Psychotherapy. Harper and Row, 1973.
- PIAGET, J., The Language and Thought of the Child. Kegan Paul, Trench, Trubner & Co., 1932.
- RANK, O., Beyond Psychology. Dover Pub. N.Y., Cover, 1958.
- ROGERS, C. R., Client Centered Therapy. Constable and Co. Ltd., 1951.
- ROGERS, C. R., On Becoming a Person. Constable and Co. Ltd., 1961.
- SCHEFF, T. J., Mental Illness and Social Processes. Harper and Row, N.Y., 1967.
- SLADE, P., Child Drama. U.L.P., 1954.
- SLADE, P., Drama Therapy as an Aid to Becoming a Person. The Guild of Pastoral Psychology Guild Lecture, 103, Sept. 1958.

- STAATS, A. W., Learning, Language and Cognition. Holt, Rinehart and Winston, 1968.
- TAYLOR, F. K., The Analysis of Therapeutic Groups. O.U.P. 1961.
- VETTER, H., Language Behaviour and Psychopathology. Rand McNally, N.P., 1969.
- VIGOTSKY, L. S., Thought and Language. M.I.T. Press, Cam. Mass., 1962.
- WACHTEL, P. L., Psycho-Analysis and Behaviour Therapy. Basic Books, 1977.
- WYATT, G. L., Language, Learning and Communication Disorders in Children. N.Y. Free Press, 1969.
- YABLONSKI, L., Psychodrama. Basic Books, 1976.
- ZIMBARDO, P. G., and EBBESEN, E., Influencing Attitudes and Changing Behaviour. Addison-Wesley, Cam. Mass., 1969.

Periodicals

- ADAMS, M., 'How should we measure outcome in Psychotherapy?' in Brit. Jour. of Psychiatry, 132, 1978.
- ANDERSON, A. R., 'Group Counseling' in Review of Educational Research, No.39, 1969.
- ANDREASEN, J. C. and PFOHL, B., 'Linguistic Analysis of Speech in Affective Disorders', in Arch. Gen. Psychiatry, Vol.33, 1976.
- BACHRACH, H. M., 'Empathy' in Arch. Gen. Psychiatry, Vol.33, 1976.
- BALES, R. F., 'A Set of Categories for the Analysis of Small Group Interaction' in Amer. Sociological Review, XV, No.2, April, 1950.
- BROMBERG, W., 'Acting and Acting Out' in Amer. Journal of Psychotherapy, No.12, 1958.
- CAMERON, D. E., 'The Process of Remembering' in Brit. Journal of Psychiatry, No.109, 1963.
- DOHERTY, E. G., 'Length of Hospital on a Short-term Therapeutic Community', Arch. Gen. Psychiatry, Vol.33, 1976.
- ESKSTEIN, R. and FRIEDMAN, S. W., 'The Function of Acting Out, Play Action and Play Acting in Psychotherapeutic Process' in Amer. Journal of Psychoanalysis, No.5, 1957.
- GOMEN, J. Y., 'The Use of Psychodrama combined with Videotape Playback on an Inpatient Floor', in Psychiatry, Vol.34, 1971.
- HANEY, C., BANKS, C. and ZIMBADO, P., 'Interpersonal Dynamics in a Simulated Prison' in Inter. Journal of Criminology and Penology, No.1, 1973.
- HARROW, G. S., 'The Effects of Psychodrama Group Therapy on the Role Behaviour of Schizophrenic Patients' in Group Psychotherapy, No.3, 1951.
- HERSEN, M., KADZIN, A. E., BELLACK, A. S. and TAYLOR, S. M., 'Effects of Live Modelling, Covert Modelling and Rehearsal on Assertiveness in Psychiatric Patients' in Behavioural Research and Therapy, Vol.17, No.4, 1979.
- JONES, E., DAVIS, K. and GERGEN, M., 'Role-playing variations and their Informational Value for Person Perception' in Jour. of Abnormal and Social Psychology, No.63, 1961.

- LAZARUS, A. A., 'Behaviour Rehearsal v. Non-directive Therapy v. Advice in Effecting Behaviour Change' in Behavioural Research and Therapy, No.4, 1966.
- MANN, J., 'Experimental Evaluations of Role-playing', in Psychology Bulletin, No.3, 1956.
- MANN, J., and MANN, C., 'The Effect of Role-playing Experience on Role-playing Ability' in Sociometry, No.22, 1959.
- MISCHELL, W., 'On the Future of Personality Measurement' in The Amer. Psychologist, April, 1977.
- MIXON, D., 'A Note on Role-playing' in Brit. Jour. of Social and Clinical Psychology, Vol.18, No.4, 1979.
- O'CONNOR, N., 'The Psychopathology of Cognitive Deficit', in Brit. Jour. of Psychiatry, 128, 1976.
- POLANSKI, N. A. and HARKINS, E. B., 'Psychodrama as an Element in Hospital Treatment' in Psychiatry, Vol.32, 1969.
- SELINGER, M. and DESMOND, R. E., 'Leaderless Groups' in The Counseling Psychologist, Feb.1977
- SHAKOW, D., 'The Adaptive Process in Schizophrenia', American Psychologist, Feb.1977.
- SPIEGEL, J. P., 'Psychotherapy as a System of Social Roles'. Jour. of Nervous and Mental Disease, 1954.
- SZABADI, E., BRADSHAW, C.M., and BESSON, J. A. O., 'Elongation of Pauses in Speech: A Simple, Objective Measure of Motor Retardation in Depression', in Brit. Jour. of Psychiatry, 129, 1976.
- TUCKER, G. J., and ROSENBERG, S. D., 'Computer Content Analysis of Schizophrenic Speech' in Amer. Jour. of Psychiatry, 132, June, 1975.
- VAN-MENTS, M., 'Role-playing: Playing a Part or a Mirror of Meaning', Sagest Journal, Vol.813, 1978.
- WILLIS, J., and GIBBS, D., 'Great Experiments in Behaviour Modification' in Amer. Jour. of Psychology, Feb.1977.
- WING, J. K., 'Institutionalism in Mental Hospital', in Brit. Jour. of Social and Clinical Psychology, VI, 1962.

Research and Unpublished Works

- BOLTON, G. M., 'Some Issues Involved in the Use of Role-play with Psychiatric Patients', Durham, 1979.
- CLARK, D. H., 'Psychiatric Half-way House', M.D. Thesis, Exeter, 1966-7.
- HILL, A., 'An Outline of Initial Role-playing Experiences of Adult Psychiatrics', Psychological Report, Parkside Hospital, 1977.
- LAWSON, J. S., 'Disorders of Attention and Language in Schizophrenia', Ph.D. Thesis, St. Andrews, 1964-5.
- MILL, D., 'A Study in the Use of Drama in Education as an Aid in the Language Development of Junior School Children', Dip. in Drama in Educ. Durham, 1972.
- STEWART, A. and WETTON, B., 'The Application of Flander's 10-Category System of Verbal Interaction Analysis to some Drama Lessons', Dip. in Drama Educ., Durham, 1972.
- TAYLOR, V. A., 'A Behavioural Analysis of Activity Group Therapy with Hard Core Chronic Schizophrenics', Ph.D. Thesis, Aberdeen, 1974-5.
- WIDDOWSON, H. G., 'An Applied Linguistic Approach to Discourse Analysis', Ph.D. Thesis, Exeter, 1976.

