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Psychodrama and the terminal patient : concepts and application

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AN ABSTRACT OF THE THESIS OF Marilyn Jacobs Bohan for the Master of Science in Education presented May 6, 1981.

Title: Psychodrama and the Terminal Patient: Concepts and Application

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

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This study examines the concepts of psychodrama and dying, death and bereavement that effectively meet individual needs for working through grief. It is the premise of this thesis that the working through grief to foster acceptance, self-worth and dignity, in the final stage of life, is facilitated by psychodramatic methods of "acting through" the problems of the situation.

Research studies of psychodrama in relation to the terminal patient are limited. The method of psychodrama has been used mainly in treatment of the mentally ill; however, in recent years the therapy has been extended into the area of terminal illness and injury. There has been an increased awareness, attention and activity regarding the final phase of life. Because of the diversity within

the dying network, there are many considerations that interconnect with the terminal patient. It is in this network that the willing patient can act through problems with psychodramatic techniques. This result can come about when the counselor-dramatist knows the concepts that bring about a peak performance to help internalize and finalize the problems. This paper provides an understanding of dramatic action and a method which the counselor may use to help the patient cope with the process of dying while living. Through this awareness, the professional may aid "the movement of spirit" within the terminal patient, using the attending therapeutic action of psychodrama.

The concepts of psychodramatic methods investigated for the therapeutic "acting out" of psychological and physical suffering in the grief of death, dying and bereavement are the art of the moment, spontaneity, creativity, tele, catharsis and insight. This literary search includes psychodramatic techniques of role play rehearsals, role reversal, mirror, doubling, self presentation, soliloquy, future projection, aside, and hypnodrama as appropriate methods for use by and for the professional helper, patient protagonist, and social network confronting a terminal situation.

Results of the study of psychodrama in treatment of the terminally ill reveal six areas for scenario intervention: (1) Adjustment Living, (2) Amending Life, (3) Future Projection and Fantasy, (4) Overcoming Fears, (5) Letting Go and Saying Good-By, and (6) Dying and Death Scene.

PSYCHODRAMA AND THE TERMINAL PATIENT:
CONCEPTS AND APPLICATION

by

MARILYN JACOBS BOHAN

A thesis submitted in partial fulfillment of the
requirements for the degree of

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CHAPTER I

INTRODUCTION

Dying is inevitable. However, the preparation for this phase of life is often overlooked or left unattended by the patient and professional care-givers. Appropriate methods of working through and confronting this experience for each person presents a problem for all concerned. How can the ambiguity and ambivalence that an individual experiences as death approaches be met? It is with this question in mind that this thesis is being written.

The patient with a terminal condition is often caught in closure with gripping fears, regrets, and anguish. Unanswerable questions give rise to inner doubts and suspicions. Some tormenting questions are; "How long do I have?" "Why me?" "Will my family, spouse, and friends turn away from me?" "How can I accept body changes and still have hope?" "What will be the financial burden?" "How can I help my loved ones to cope?" "What physical and emotional changes will take place during treatment and drug use?" "Where and how will I spend my remaining days?" The unpredictability of most questions raised during the process of dying does not allow the patient to realize quality time.

How then can professionals help bring the patient to closure with dignity and with a preservation of self-concepts? Attachments are made, regardless of age, and it is in this anticipated separation that grief becomes apparent. How can we prepare to meet the most

forboding, challenging and final experience, the letting go of attachments made during a lifetime? The working through of the grieving process can be brought into final awareness by the use of psychodramatic techniques. Many needs can be met through the acting out, in rehearsal, of fears of the unknown, exploring fantasy expansion of the self for desires, regrets and missed moments, adjustments in living, and catharsis for saying good-bye and letting go. For the action oriented patient this thesis will review concepts and application of psychodrama favorable to the dying process.

This thesis consists of four chapters. Chapter I is the introduction and terminology, followed by a review of the dramatic action from the Greek theatre that evolves into the present day psychodramatic therapeutic theatre. The chapter concludes with a review of the concepts of psychodrama beneficial to the terminal patient. Chapter II describes the structure of psychodrama and outlines techniques and goals valuable to patient catharsis. The components and framework of an enactment that interact to bring a problem to a meaningful conclusion are discussed. Chapter III plays to the therapeutic theatre of the terminally ill by discussing concepts of dying, death and bereavement that are conducive to action therapy as applied to the care-giver, patient and family in the home or institution. In conclusion, Chapter IV reviews implications for counselors and ends with "acting through" problems of terminal illness with psychodramatic techniques.

TERMINOLOGY

"Acting through" means working through a problem by action methods, to bring a problem to an insightful conclusion.

Action is the inter-relationship of the players while acting out a problem brought to a therapy session by a protagonist.

The audience is the group of spectators who share in a closing scene - generally significant others who relate to the patient.

An auxiliary ego acts as a player portraying a part of the protagonist.

Catharsis is an emotional purge.

Creativity is the novel rearrangement of perceptions and motive patterns that are brought to reality.

Closure comes at the end of a psychodrama at which time feelings are shared, incorporating players (actors-patients) and audience.

A double acts as an alter ego that assists by playing part of the self.

An enactment is an event in the here and now, played out to understand the past for re-education for the future.

Hypnodrama combines hypnosis and psychodrama for a therapeutic technique.

Insight is perceptual awakening that closes or forms a new gestalt in restructuring one's perceptual field.

The protagonist is a patient-actor presenting the problem for psychodramatic action.

Professional atom refers to the care-givers who treat the patient.

Social atom is the individual's social unit, such as a family, in which there is a supportive relationship.

Spontaneity means to act with the inspiration of the moment rather than from habit - (to be optimally adaptive.)

Tele is an interaction between two or more players. A telic communication brings out mutual empathy and understanding.

A warm-up frees one from external - internal influences or previous patterns, in order to act out a problem spontaneously.

THE RISE OF DRAMATIC ACTION FROM GREEK THEATRE TO 20TH CENTURY THERAPEUTIC THEATRE

The early Greek theatre is the prototype for the Therapeutic Theatre of psychodrama. Acting out thoughts and desires for cathartic benefit is as old as theatre history. Early Greek theatre sought spectator catharsis, but the twentieth century therapeutic theatre turns to patient-actor catharsis through spontaneity. This section reviews Aristotle's theory of drama that lays groundwork for Moreno's concepts of (1) dramatic action to benefit actor-audience through catharsis; and (2) action of the moment that brings peak performances through insight. Then references to dramatic action in life and death continue from Greek to European dramatists, into the twentieth century psychology. In this century dramaturgy takes on the theory of action through role rehearsal, and Moreno develops psychodrama. Psychodrama is discussed in three parts. Discussion follows (1) history, concepts and techniques in the development of the Theatre of Spontaneity, turning to (2) the Therapeutic Theatre and (3) psychodrama from the theatre into daily living.

Early Greek Theatre:

The psychology of dramatic action begins with Aristotle's Poetics, in the 4th Century B.C. Aristotle vividly projects theory and techniques of playmaking taken from his direct association with the early Greek theatre (Ferguson, 1969). These principles are found in the basic premises of psychodrama as presented by J. L. Moreno in the 20th Century.

Dramatic Action: Catharsis Moves From Audience to Actor:

The dramatic action as set forth by Aristotle is not to be interpreted as physical action but a movement of the spirit imitative of "the representations of the countless forms which the life of the human spirit may take" (Ferguson, 1969, p.7). An action, or praxis, is the motivation that powers the deed to its successful or unsuccessful end. "The praxis that art seeks to reproduce is mainly a psychic energy working outwards" (Ferguson, 1969, p.8). The benefits of the psychic action is ascribed to the spectator rather than to the actor, and it is here that Moreno is inspired to reverse Aristotle's focus (Moreno, 1947). Benefits of drama, as related by Aristotle, are greater in the pleasure of seeing an imitation rather than through direct experience. The spectator gets satisfaction in relating to the actor's representation through a sense of familiarity as understanding takes place with "pity and fear effecting the proper purgation of these emotions" (Ferguson, 1969, p.9). Dr. Moreno places the actor, instead of the spectator, into the role of primary recipient of the satisfaction through catharsis.

Action of the Moment: Leading to Peak Performance Through Insight.

Aristotle notes that every action coming from man's character is in reaction to a given situation, as "perceived" at that moment. Moreno also plays to that "moment" throughout his work. The psychology of Aristotle's dramatic action and character finds birth in suffering of psyche called "pathos" or passion. It becomes the problem of life to work out all human actions through a known purpose to the end, while suffering the arrows of passion with insight (Moreno, 1940; Ferguson,

1969). This rhythm of action is called "Purpose, to Passion, to Perception" (Ferguson, 1969, p. 13). Aristotle places great emphasis on the climactic action of the plot; this is also the peak performance sought by Dr. Moreno. The action of the moment brings discovery by insight, or surprise, and leads emotions from grief to joy as the catharsis takes place. This dramatic action and action of the moment for catharsis and insight is the therapy of psychodrama for the dying patient.

Dramatic Action In Life and Death From Greek To European Dramatists Into Psychology.

Philosophers, dramatists, and psychologists have devoted lifetimes to developing equations relating life to the theatre. Epictetus (60 B.C.) says one is but an actor, acting whatever part the Maker has ordained. It may be short or it may be long (Wood, 1899). Carlyle developed the theme from external acting to internal acting in his words, "Man carries under his hat a private theatre, wherein a greater drama is acted than ever on the mimic stage, beginning and ending in eternity" (Wood, 1899, p. 262). Shakespeare, in As You Like It, placed man in his environment with his famous lines: "all the world's a stage, and all the men and women merely players. They have their exits and their entrances: And one man in his time plays many parts." The Twentieth Century social psychologists, of dramaturgical bent, can identify with the diverse acting roles of Shakespeare.

Dramaturgy Favors Dramatic Action Through Role Rehearsal.

Important to dramaturgical performance is the underlying study of meaningful behavior in accord with a theory of action and purpose rather than a theory of knowledge (Brissett and Edgley, 1975). Individual internal needs or external influence of the environment does not adequately explain human interaction to the dramaturgical follower. Human interaction, for satisfaction, is portrayed best through drama analysis in which each actor relates best "as if" one were playing roles. Meaningful behavior exists only when there is a consensus among human actors playing out their roles. It is in this unstable and undependable "meaning" that problems arise as the behavior is constantly being performed and rehearsed. To Brissett and Edgley (1975), "meaning is not a given; people create it." Options abound. Dramaturgists find understanding of current personal difficulty lying in the possible behavioral options of the individual and others. It is maintained by Brissett that conditional sequences and patterns of behavioral interaction take on descriptive understanding, not explanation, in which the actor is fundamentally a communicator. The dramaturgists' desire is to understand behavior more clearly (Gosnell, 1974). This goal is also sought in Moreno's psychodrama. However, dramaturgy brings to the mirror of life a past reflection to be reviewed (Moreno, 1946), and in psychodrama, the event is staged for the first time. Both methods of dramatic action, rehearsal of the new and reenactment of old experiences, benefit the willing patient. Not all patients desire to enter into action methods and their decision should be respected.

Psychodrama: Theatre of Spontaneity, History and Concepts:

Psychodrama developed in the early Twentieth Century coincidental to dramaturgy, bringing a new direction to Gestalt psychology. Moreno established a Theatre of Spontaneity in Germany in 1925. The key, leading into the psychodrama of life, was furnished by children. While viewing children at play, Moreno would be drawn into a fairyland of the act, into the air of mystery, and into the paradox of the "irreal" becoming real. Dr. Moreno found the key to spontaneity. The principles of play form a cure, therapy and catharsis. Play becomes the positive factor that transmits spontaneous creative expression for the child and adult patient from the beginning to the final phase of life. It is from this idea of play that psychotherapeutic theatre of psychodrama and sociodrama has been inspired. Play, through dramatic action, fosters the psychotherapeutic climate.

How did Moreno develop dramatic action into psychotherapeutic form? By reflecting on the early Greek theatre, Moreno found two principles to bring into his psychodrama: (1) spontaneity and (2) a stage that incorporated the audience, which was not found in present day theatrical form. He realized that a script and memorized scripting of the actors was in conflict with spontaneous creativity. To overcome scripting, the actor would have to become a spontaneous playwright. The script that the actor had to select from would engage every dimension of nature, the self, the cosmic, the spiritual, the cultural, the social, the psychological, the biological, and the sexual from which a new force of inspiration could form (Moreno, 1947). A limited viewing access to the stage by an audience was not in the flow

of total movement. This audition could only be met from a stadium, tiered, all in the round (Moreno, Z, 1976), as viewed in nature and the early Greek theatre. There would be no escape or curtain to which the actor could seek refuge as everything occurs before public eyes for "full exposition and exhibition" (Moreno, 1947).

Psychodrama: Therapeutic Theatre, History.

Dr. Moreno turned from the dramatic spontaneity theatre to the therapeutic theatre as he found the pressures of a materialistic age and public attitudes toward the spontaneous creative self were hard to change. Moreno (1947) felt that a cultural and creative revolution would have to occur to reconcile the forces. The theatrical audience could not trust their own spontaneity as they had been nourished on cultural conserves, Moreno's words for fixed traditions. Audiences would become suspicious that the spontaneity was rehearsed if the production was good, or that spontaneity does not work if the scenario was poorly played (Moreno, 1947). He also discovered that it was difficult to find actors who had a talent for spontaneity. Demands the audience made on a professional actor were not the same as those demanded of a patient by the audience. The patient taking the acting role brought greater spontaneity to the theatre. Imperfections from a patient were to be tolerated, welcomed and encouraged. Hence, the therapeutic theatre flourished. The theatre created a second world, unconnected from the first world from which the patient could cleanse the self in the non-real world. Within this theatre form, there arises an expansion of existence which continues from the Maker's creation... real flowing into the non-real.

Psychodrama: Extension From Theatre Into Everyday Life.

The rise of dramatic action into Moreno's therapeutic theatre gave foundation to many dimensions in psychotherapy during the mid Twentieth Century. A form of cultural and creative revolution did take place (Moreno, 1974b). Gestalt Therapy was on an upswing under the leadership of Fritz Perls. Perls took psychodramatic techniques out of the theatre and applied them to everyday living. The idea of the moment, here and now, humanism versus materialism, role reversal, empty chair, role-playing, doubling, and body language are but a few considerations.

Psychodrama is now practiced with many points of view, there are as many varieties of psychodrama as there are personalities and background of the therapists who direct the therapies. In addition to the classical psychodrama of Moreno (1946, 1959) there is psychodrama with a psychoanalytic frame of reference (Sacks, 1960), psychodramatic group therapy (Corsini, 1957), psychodrama with an Adlerian emphasis (Starr, 1977), Transactional Analysis, Primal Therapy, and Reality Therapy models (Yablonsky, 1976), and a social learning mode (Haskell, 1975). Moreno's philosophy and method, have also influenced the separately derived systems of Gestalt Therapy (Perls, 1969) and Psychomotor Therapy (Pesso, 1969). (Fine, 1978, p. 25).

These points of view also influence the approach to patient's living their final moments in the light of death.

CONCEPTS OF PSYCHODRAMA'S THERAPEUTIC THEATRE

The study of psychodrama is in essence the study of the philosophy of Jacob L. Moreno of Vienna, Austria (Haskell, 1975). Moreno takes the concepts of catharsis and insight from the Greek theatre as the desired elements of the method of psychodrama and adds to the process spontaneity, creativity and tele. Tele is Moreno's term for a mutual unseen and unheard communication. These five concepts

combine to form Moreno's personality theory for the therapeutic theatre (Greenberg, 1974). The object is to develop spontaneous creativity in an individual for an adequate response and creative acts. Spontaneity training is outlined for the removal of cultural conserves favoring inspiration of the moment. Telic communication is described in two parts as affecting (1) self-expansion and (2) psycho-social network. Reviewed at the end of the sequence is psychodramatic therapy of catharsis and insight.

Spontaneous Creativity: Development of an Adequate Response.

The spontaneously creative act sets the individual apart from the rest of the animal kingdom. Living in the world brings one into close approximation with other creating beings and forces one to choose to be either a "willing and active" or an "isolated and alienated" individual (Moreno, 1947). An important goal of psychodrama is to aid a client to enter into a group feeling secure and spontaneous. Spontaneity is defined as "the variable degree of adequate response to a situation with a variable degree of novelty" (Haskell, 1975, p. 25). The mark of the behavior is being self-starting with impulsiveness that is consistent with the situation. "To act in accord with the demands of the moment rather than from habit is the essence of spontaneity," writes Dr. Fine (1978, p. 30). Spontaneous behavior exhibits the inner being rather than showing a behavior forced from outer demands, social constraints or fear of future penalties. The spontaneous creator becomes a risk taker. However, the behavior must be an adequate response, determined by the understanding of roles to be played and their "permissible limitations" (Haskell, 1975). In the many psychodramas that the

patient plays, one learns to act, improvise, and exercise spontaneity and creativity (Moreno, 1947). The inexperienced individual generally cannot, in a terminal situation, call forth a spontaneous and adequate response. There are three responses to a situation: (1) Novelty of response, but out of context to the situation, (2) a response apropos to the situation but not original, (3) a novel and creative response in keeping with the situation (Haskell, 1975). Only an individual who is aware of inner strengths and weaknesses finds security in a role of spontaneity and creativity. Creativity is sparked by spontaneity, but one's being spontaneous is not necessarily creative. To create, one brings into existence novelty from pre-existing material in connection with the ability to improvise or invent new roles and vary plans of action that meet individual or group needs. The challenge then is to act out the perceptions and motive patterns to develop creativity and produce reality. This augments an orderly brain transfer, which takes place when changing creativity to reality. To rehearse new responses and relationships through psychodrama by using feelings and emotions aid in the readiness for the act (Yablonsky, 1976). Spontaneity frees one to live creatively until death.

CREATIVITY AND THE SELF

How can a terminal patient develop creative acts? There is no separation between the rational and intuitive mind for the continuously creating individual; according to Moreno (1947). Reality and fantasy should not be in conflict; patients need to use both. It should be recognized that the highest achievements of man most often come from the compatible function of intellectual and intuitive thoughts.

Creating individuals continue to fill and empty the storage tank of the unconscious mind. It is in bringing together real and nonreal that an extension onto life is formed. Also, through the use of psychodrama the creative personality can be developed in fantasy enactments that foster creative acts.

In order to help one identify or label the creative act Moreno's (1947) five components follow:

1. Spontaneity
2. An unexpected happening - a feeling of surprise
3. Changing reality to unreality - living the fantasy of "As If"
4. Acting - rather than being acted upon
Creating - being creator rather than being creature
5. Mimetic effects - finding the comic side of life

Herein the terminal patient can find expression of a creative personality through creative acts when an interaction of spontaneity takes over.

SPONTANEITY AND THE SELF

In therapeutic theatre the pursuit of spontaneity training, in order to find the real person, removes the reproductive process of learning which has evolved roles that are conserves (Moreno, 1947). Over the centuries the emphasis has been placed on one striving for the completion and perfection of ideas in the form of a lasting work. (Diagram 1) These finished works have taken on a God-like value in the form of cultural conserves. Cultural conserves are lasting works that influence and maintain a social unit. Lost to the creating individual is the moment of inspiration, of incompleteness and imperfection of

DIAGRAM I

ART OF THE CONSERVE

Corrective Therapy →

ART OF THE MOMENT

Completion and Perfection

Incompletion and Imperfection

of
IDEAS

of
IDEAS

THEORY OF VALUE
Conserving Types

← Balances →

CATEGORY OF THE MOMENT
Spontaneous Types-Creative

God-Idea-Sacred Quality

Idea

Process
Brought to
an End

"Works"
Perfected

Acts-Products
Finished

Improvisation
of the
Moment

Intensity
of the
Moment

Imagination
of the
Moment

Inspiration
of the
Moment

Intuition
of the
Moment

Fosters Tradition
Covers Threatening Situations
Secures Cultural Continuity

← Balances →

Fosters Surprises
Covers Individual Social Emergencies
Secures Daily Living

My Interpretation of:
Moreno, J. L. Mental Catharsis and Psychodrama. New York: Beacon Hill, 1940, 213.

ideas. Moreno proposes a corrective therapy to live the moment valuing the incomplete and imperfect ideas brought out from one's spontaneous-creative nature. After removal of one's conserving nature, the first emphasis, according to Moreno, is on the productive, spontaneous-creative process that is the real person. It is in this discovery that terminal patients find inner worth as they continue to create. In the spontaneity state, the patient acts from within, flexible, with liberation of the internal process, and in a social, external relationship with another creating person. There are two parts to the spontaneity state caused by the dual nature of the self (Meyer, 1974). The state is disturbed by the spontaneous patient (1) portraying the self and, (2) the inner observer watching the self (Moreno, 1940). Herein a moment in life and a moment within the creator converge and emerge. It becomes a blending of the moment. This spontaneity is boundless and is at the direct command and use of the individual. The potential is limited only by the hesitancy of the person to discover and develop the resource. It becomes the work of the counselor to help develop spontaneity in the terminal patient. It is this spontaneous creativity that is "a constant rearrangement, re-ordering, turning around of the representations of the perceptual world: so that a novel and new pattern of expectancy is seen" (Smith, 1970). This inner creativity must be nurtured, as "the self is the melting pot of experiences coming from many directions" (Moreno, 1946, p. 8), and released from the locus of the self which is spontaneity. Dr. Fine (1978, p. 8) states; "Effective behavior is spontaneous (optimally adaptive). Pathological behavior is conserved (frozen, fixated)."

TELE: AND SELF EXPANSION

In the personality theory of Moreno, the sending and receiving of communications is transmitted via psychodramatic tele. Included in this section is an explanation of telic communication that expands the self through a drawing from others known as retrojection. Then the discussion ends in the development of tele as it expands into the psycho-social network of others to form a group process.

Moreno (1939, p. 1) describes tele as a "feeling process projected into space and time in which one, two, or more persons may participate." It is a communication that occurs between two or more persons (Enneis, 1974). A telic communication is one of mutual empathy and appreciation (Greenberg, 1974). According to Moreno (1939), the structure of the self comes from a collection of single and multiple roles that reach out of the inner person and "beyond" into the inter-personal area and into the universal self. Expanding the self on the interpersonal level is directed through the tele process. In communicating, and individual's ideas and feelings are cast upon another through projection, whereas, in tele retrojection there is bringing in or a "drawing and receiving" of another's ideas that confirms one's identity or adds to the self expansion (Moreno, 1947). In the development of tele, a terminal patient may connect with others and draw from them in self-expansion. The great persons of our time retroject and identify with the experiences of others to determine needs for the times and people, according to Moreno.

This assimilation expands the self, because if retrojection does not take place, the self diminishes. (See diagram II) This mutuality of exchange or inspiration of shared expansion may be what sparks the peak response in a tele communication. It is an interchange that makes living bearable when shared in appreciation and respect for the dying self.

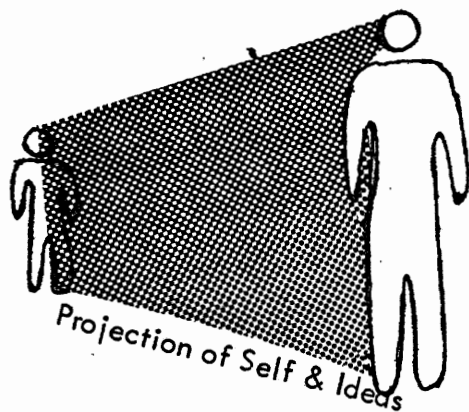
The Moreno (1947, p. 9) problem becomes, "Will the self, as it learns to expand, gain in mastery or control of the section of the universe which it invades, or will it be pushed back and forth as in the past by events beyond its control?" Simply stated, will the terminal patient gain control over life while dying?

Tele With Psycho-Social Network:

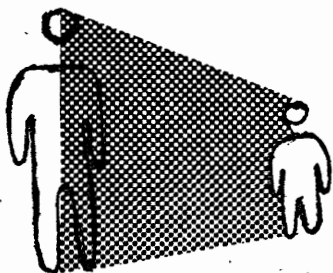
It is important for the terminal patient to be in communication with others who foster reciprocal regard. Moreno's dynamic communication has transposed the Freudian transference based on suggestion and magnetism into an "attraction-repulsion" concept of tele. The communications between the self, and the self and others, expand from self-love into a "psycho-social network" of others (Moreno, 1939). Network structure of inter-personal linkage is an outgrowth from the tele of an individual's psychological range with another's social atom. The orbital span of one's social atom (Moreno, 1974a; Enneis, 1974) contains all attracted or repelled persons entering the constantly changing cycle. Moreno suggests (1939) that it is in this social atom tele communication that reality is returned to the individual in using a sociometric approach in the therapeutic theatre. The "I" becomes "we" to form a group process where a problem of the

DIAGRAM II

TELE-GIVES DIRECTION TO SELF EXPANSION

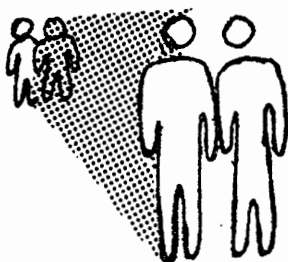


A Tele Retrojection Communication:
 Draws From Others
 Confirms Identity
 Strengthens Self Expansion
 Assimilates Experiences



Without TELE Communication

Self Shrinks
 Nothing Coming In For Expansion



IN TELE -

There is The Mutual Expansion in
 SENDING AND RECEIVING or
 Sharing The Awareness of a
 Telic Communication

My Interpretation of:

Moreno, J. L. Theatre of Spontaneity. New York: Beacon Hill Pub., 1947, 9.

group is acted out. Through patterning the distance of relationships in the study of the social atom, a new frame of reference is established from which to work through the psychodynamic disturbances (Haskell, 1975) of the terminal patient and/or group.

In the therapeutic theatre an anonymous, average man becomes something approaching a work of art--not only for others but for himself. A tiny, insignificant existence is here elevated to a level of dignity and respect. Its private problems are projected on a high plane of action before a special public--a small world, perhaps, but the world of the therapeutic theatre. The world in which we all live is imperfect, unjust and amoral, but in the therapeutic theatre a little person can rise above our everyday world. Here his ego becomes an esthetic prototype--he becomes representative of mankind. On the psychodramatic stage he is put into a state of inspiration--he is the dramatist of himself. (Moreno, 1940, p. 90).

It is as a self dramatist, a Creator, that the terminal patient shares in group psychotherapeutic work through the tele communication: "To live fully, one must have reality based, reciprocal relationships" (Fine, 1978, p. 5). Now the individual "becomes" empathic, "as if" walking in another's shoes or as Moreno wrote:

A meeting of two: eye to eye, face to face.
 And when you are near I will tear your eyes out
 and place them instead of mine,
 and you will tear my eyes out
 and will place them instead of yours,
 then I will look at you with your eyes
 and you will look at me with mine. (Anderson, 1974, p. 206)

The terminal patient's feelings become a shared telic communication.

CATHARSIS: END PRODUCT OF PERSONALITY THEORY

The ideal objective of psychodramatic therapy is to engage in a total production of life by supplying more reality than living permits,

which in turn, gives the patient control and mastery of the self and others through practice (Greenberg, 1974). Even though analysis occurs, it is secondary to the outpouring of emotions, which flow in an enactment, and is known as catharsis (Blatner, 1973). Moreno (1947) uses the analogy of respiration to catharsis. It is as though one inhales the "psyche" and exhales it in the process of spontaneity. As stresses and conflicts are "inhaled," they are "exhaled" by spontaneity, allowing the deepest personality to be freed. The condition becomes visible, and the patient purges forth the symptoms without help.

During a terminal illness an individual must encounter transitions that require spontaneity proportional to the magnitude of change. A disequilibrium results in the individual and social atom counterparts whenever the demand for spontaneity cannot be met, which in turn demands a proportional need for catharsis - a degree of purification. With the varied and numerous transitions in today's society, it is a wonder that an individual can achieve and maintain any degree of homeostasis. However, mental catharsis is one of the most powerful ways to achieve and maintain body and mind equilibrium. Catharsis can release grief and fears without the need to change any external conditions (Moreno, 1947).

Catharsis is possible through actions, gestures and speech within the patient and between others in a life situation and is a method to explore fantasies, real roles and relationships. Moreno feels that it is in the staging of the drama that the peak catharsis treatment occurs, not in the pre-interview or post-analysis. It is

after a catharsis that equilibrium occurs and spontaneity allows the patient the swift action necessary to meet life situations.

A secondary effect of the drama catharsis is that of spectator involvement. Group catharsis can take place through the element of surprise at the acting and talking things out, with insight from the protagonist's performance. The spectator trades his passive seat for active mental sharing of the problem in which one becomes "a part of and a silent partner" (Moreno, 1940) on stage. This tele communication opened a new avenue for Moreno in treating the spectators at the same time as the patient. It is generally recognized that Moreno was a primary innovator of group therapy (Fine, 1978). By incorporating the group, dramatic action of catharsis goes full circle. Catharsis evolved from Aristotle's spectator purge to Moreno's patient purge that returned to group spectator psychotherapeutics. Catharsis is sought in individual and group work in the therapeutic theatre.

INSIGHT

Along with catharsis, another end product is insight into Moreno's concept of personality structure, according to Greenberg (1974). Insight may occur during or after the act of catharsis. The insight of a shared enactment of a terminal situation brings inner peace. During the sharing time of closure when the audience and patient interact, a perceptual awakening, an "AHA", arises:

The sensory stimulations of the psychodrama, together with the emotional catharsis brought on by spontaneity and tele can and do, according to Moreno, cause a restructuring of the protagonist's perceptual field (whether he is on the stage or in the audience) and bring insight or understanding

to his problem by means of configurational learning.
(Greenberg, 1974, p. 19).

Whenever two separate ideas or areas of perception merge into a unified workable solution a "restructuring" or "configurational learning" takes place, according to Greenberg (1974). This is the insight of a psychodramatic enactment. Whether it is for individual or group therapy purposes, the results are much the same:

It is the purpose in group psychodrama to create a climate in which there can be a maximum of catharsis, of relearning and insight gained, to stimulate therapeutic potentials within the group, and to make each patient something of a therapist in his relationship to other patients. (Enneis, 1974, p. 117)

Self-help, while helping others, is a group approach in psychodrama enactments, wherein sharing insight brings a purpose and hope through a helping commitment among terminally ill patients.

In Summary:

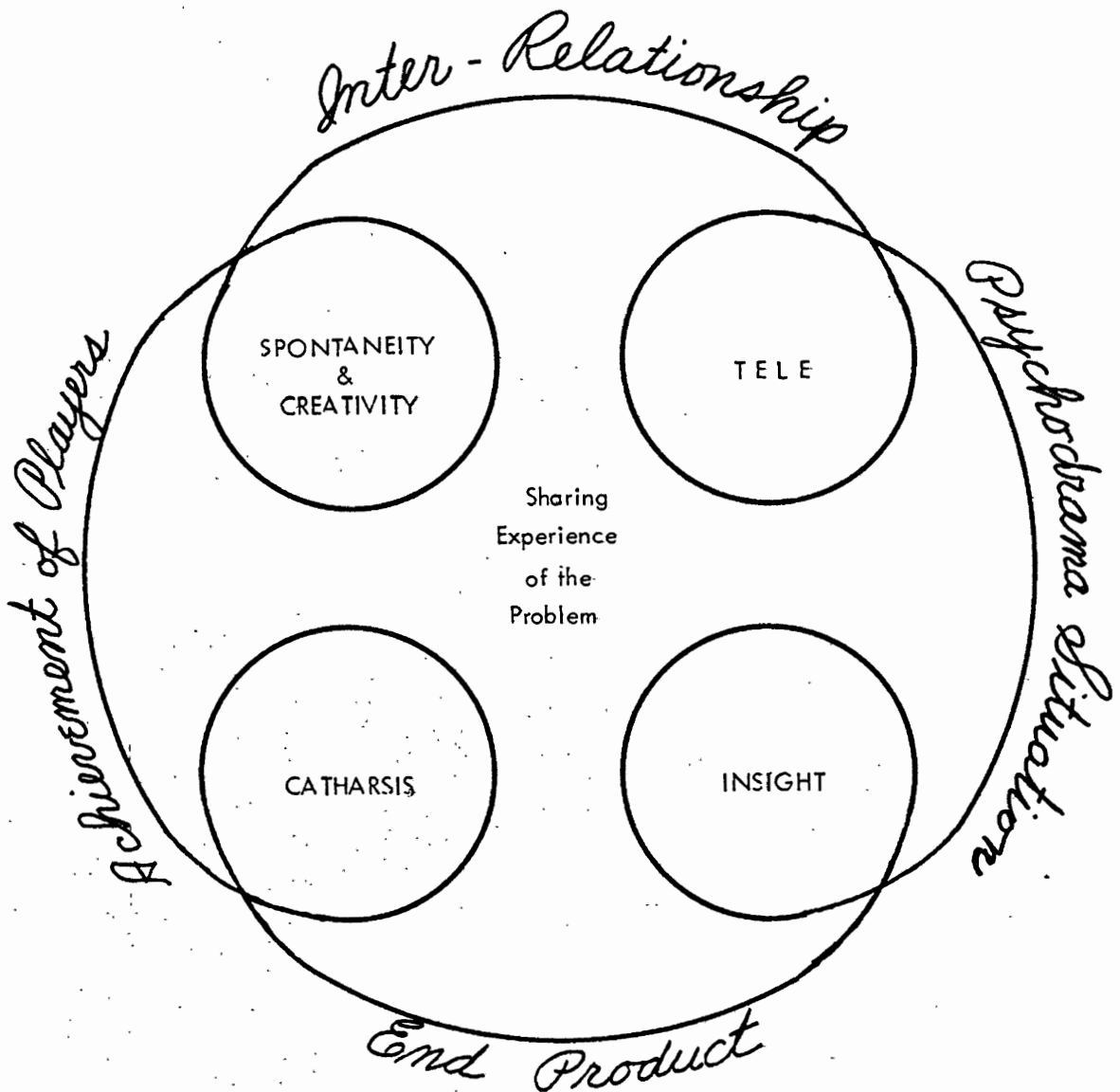
This chapter lays the foundation of psychodrama from the concepts taken from the Greek theatre through the concepts of Jacob Moreno's therapeutic theatre. The personality theory that psychodrama develops brings together the spontaneity and creativity necessary to live the moment in total involvement until death, through communicating by the "drawing" process of tele for self-expansion and catharsis with insight for internal and external therapy.

The two diagrams, III and IV, outline the external and internal therapeutic process of the psychodrama situation in which the key components are spontaneity and creativity, tele, catharsis, and insight. Diagram III shows the external therapeutic network:

In sharing the experience of the problem, the achievement of the actor-patient is the inter-relationship of spontaneity and tele in a psychodramatic situation, with the end products of catharsis and insight. Conversely, for the internal therapeutic network (Diagram IV), the component elements of the method of psychodrama become tele, catharsis and insight, and the end product of the process of psychodrama "becomes" a spontaneity and creativity that develops self-expansion. The diagrams conclude Chapter I.

Chapter II sets forth, for the dramatist, the mechanics of structuring an enactment. Favorable techniques, goals and enactment preparation used in a psychodramatic setting lay the groundwork for the necessary support system to act through a problem. The supporting components, which are director, patient, and auxiliary egos use the techniques to meet the situation. The movement of a production progresses from a tele warm-up, into a cathartic action, and ends with an insightful closure.

DIAGRAM III
EXTERNAL THERAPEUTIC PROCESS



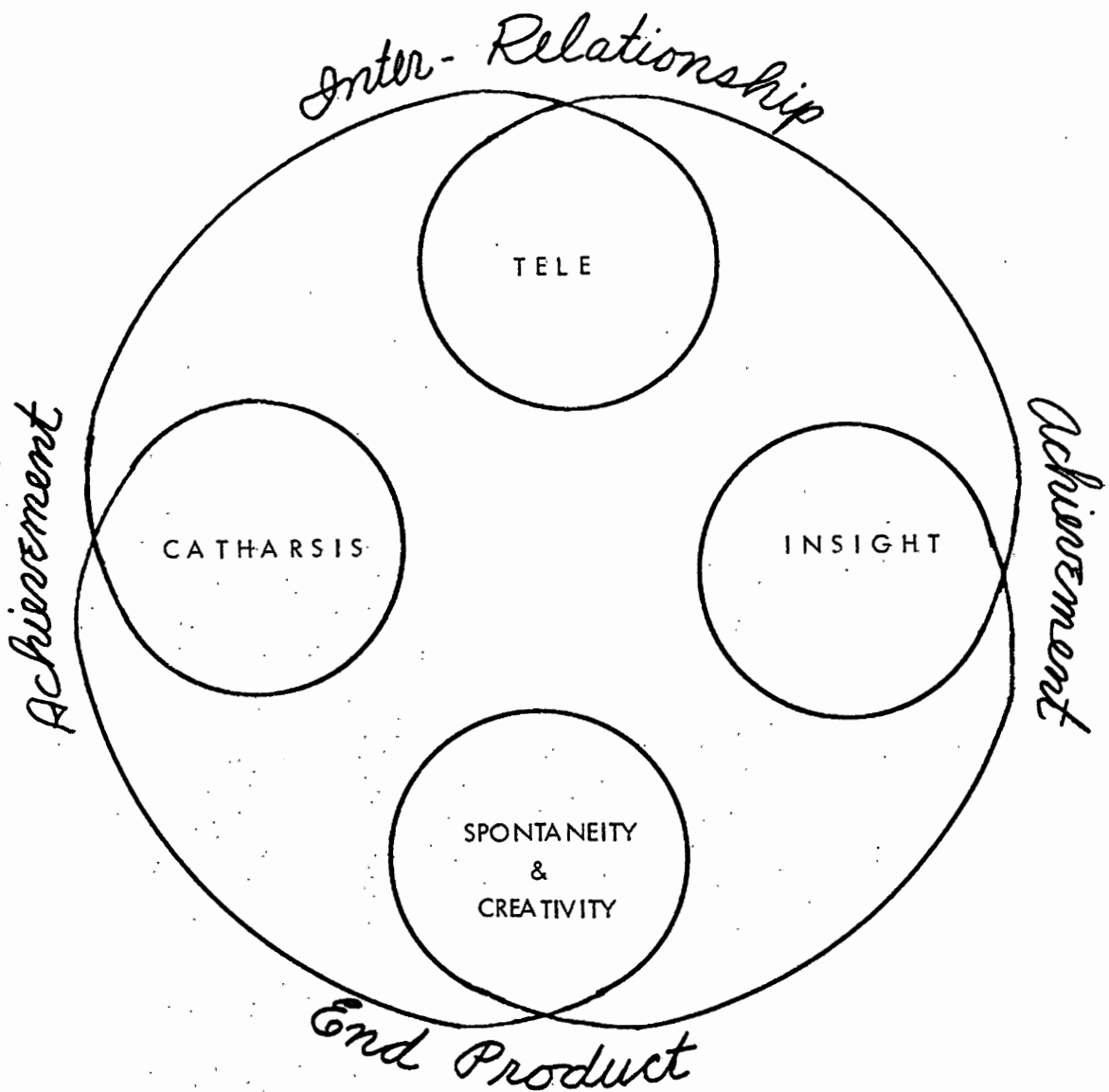
MORENO'S PSYCHODRAMA PERSONALITY THEORY:

In sharing the experience of the problem the achievement of the players through the inter-relationships of spontaneity and tele, in a psychodramatic situation, bring forth the end products of catharsis and insight.

My Interpretation of:

Greenberg, I. A. Psychodrama, Theory and Therapy. 1974, p. 18.

DIAGRAM IV
INTERNAL THERAPEUTIC PROCESS



CONVERSELY - WITHIN THE PLAYERS there occurs a reordering of the component elements of the method of psychodrama and the end product of the process of psychodrama "becomes" spontaneity and creativity. The diagram shows the shift: In sharing the experience of the problem on inter-relationship of a tele communication and an achievement of catharsis and insight occurs, while the end product of a psychodrama situation "becomes" the spontaneity and creativity that develops self-expansion.

CHAPTER II

STRUCTURE OF PSYCHODRAMA

This "how to" section identifies techniques, goals, enactment preparation, language, and components and framework necessary to produce psychodrama in therapeutic theatre.

TECHNIQUES OF PSYCHODRAMA

The review of techniques begins with the psychodramatist's attention to a patient's interior and exterior needs in order for the problem to emerge. Auxiliary ego, antagonist and a double are players mentioned that act to clarify protagonist's feelings. This is followed by a brief definition of techniques helpful in therapeutic theatre. Mentioned are role playing, role reversal, self-presentation, soliloquy, future projection, aside, mirror and hypnodrama. Hypnodrama as a technique is discussed as to history, application and use and ends in combination with psychodrama.

Because the creative mind is limitless and psychodrama taps into this creativity, the techniques are boundless. As the drama is presented, the creative mind of the psychodramatist projects techniques to the terminal protagonist patient. This heavy burden, as in all psychotherapy forms, especially in terminal illness, needs vigilant attention through honor, courage, caring, commitment and a love of humankind. The enactment and sharing of the problem is no different in terms of confidentiality than it is in any other form of therapy.

This method of presentation, in situ or in theatre, with or without audience, may appear as open, loose, or nonchalant attendance to a problem, but it is quite the reverse: It is an intense meeting. In this flexible and adaptable mode of therapy, there must be freedom of space, from the interior and the exterior, for the problem to emerge.

Additional players may be used to give space to the patient's feelings and to make clear the innuendoes, implications, ideas and conflicts in the problem portrayal. Other players added to the stage to support the protagonist are termed "auxiliary egos" or simply "auxiliaries." The social atom of the patient provides main characters, such as spouse, family, employer, and friends. When one of these role characters is portrayed as a main player opposite the patient protagonist, the player is known as the antagonist (Blatner, 1973). An alter ego of the protagonist is presented as the "double." This double, helping ego, plays to the expression by stating inner feelings in a basic and clear manner. This portrayal of the inner self, of the protagonist's deepest emotions, with the help of a doubling technique becomes "the heart of psychodrama" (Blatner, 1973). Generally, the double acts to promote support that will encourage risk-taking for the patient to explore their problems. It is in this action that the double sparks an exchange that expedites the psychological encounter of the patient to the problem. Helpful techniques are role playing to act out a rehearsal; role reversal in which places are exchanged to view the situation more objectively (Bratter, 1974; Moreno, 1974; Yablonsky, 1974b; Yablonsky and Enneis, 1968);

self-presentation in acting out self needs and wants; soliloquy, expression of thought out loud (Moreno, Z., 1974); future projection (Yablonsky, 1974a) for preparing to enter another time and place; aside, responding to situation verbally and then turning head to speak true feelings and thoughts; mirror, using an alter ego to duplicate behavior (Haskell, 1975); and hypnodrama, using hypnosis in therapy (Moreno and Enneis, 1950).

Combining Psychodrama and Hypnosis: Hypnodrama.

Another valuable technique, gaining in therapy popularity is hypnosis. Although hypnosis has not always been a favored method, it has been used since ancient time. The Austrian physician, Friedrich Anton Mesmer, introduced his theory of "animal magnetism" in 1775, but no creditable discipline was developed. The technique of hypnosis became more a show piece for exhibiting foolish theatrical antics, and thereby fell into disrepute. In the light and shadow of hypnotic appeal, the method is affirmed as a mysterious state of consciousness that provides amazing glimpses into the powers and paradoxes of the psyche. Hypnotism is a state of highly concentrated attention. Researchers find that persons easily hypnotized have good mental health, usually enjoy acting and imaginative activities, are creative and generally have had a warm, accepting and trusting childhood (Hilgard, 1965). However, no single personality structure has been formulated to identify the easy-to-hypnotize person. The hypnotized do not sleep, and a better word to use would be "influence" to describe the state (Brenham, 1960). This influential power of imagination and suggestion can be misused.

In the hand of the professional, this two-edged sword can excise and exorcise psyche demons; in others, it becomes a stabbing psyche plunder. Professionals are beginning to use hypnosis to effect a better mind-body relationship.

Medical uses of hypnosis are recorded as an analgesic and anesthetic (Blythe, 1971), a diagnostic tool (Gross, 1980), a control of pain (Wain, 1980), a removal of symptoms (Gill, 1947), phobias (Smith, 1937), and a dream therapy technique (Hilgard, 1965). Reports of medical conditions treated and cured range from asthma and cancer (Blythe, 1971), to warts (Wain, 1980), and from the functional to organic disease. Removal of pain in terminal cancer has been effected through hypnosis (Wain, 1980). Patients can be taught self-hypnosis to control pain (Blythe, 1971; Simonton, Simonton and Creighton, 1978) as an adjunct to orthodox medical treatment.

A professional therapeutic combination of psychodrama and hypnosis forms the basis of hypnodrama (Supple, 1974). The psychodramatic action is used in all its aspects. The hypnotist is the psychodramatic director helped by auxiliary egos; there is a warm-up to bring about the hypnotic state on stage to influence the verbal suggestibility within the patient. The patient protagonist becomes a psychodramatic actor, venting the internalized mental world. Hypnodrama gains in value as a psychological warm-up to psychodramatic productions and can replace shock and chemical therapies (Moreno and Enneis, 1950). Dr. Moreno was the first to advance experimentation and techniques of hypnodrama. This medium brings about the freedom to act, which is of primary concern in hypnodrama. Barriers are removed through hypnosis.

Greater insight is gained by the patient as expression is found through acting from the non-verbal portion of psyche. Improvement of patient role function, better social interaction, and enhancement of self-concepts are products of hypnodrama (Moreno and Enneis, 1950). A cardinal principle of all psychodrama (and so it is in hypnodrama) is to close on a high note. It is important for the patient to be in a pleasant situation which can be handled satisfactorily before being awakened. Re-entry is very important. If this precaution is not taken, depression or anxiety may result. After the patient is aware, the hypnodramatist should interview and analyze the session psychodramatically with the patient to effect satisfactory closure.

Technique Goals:

Technique goals important to the terminally ill are pointed to helping in (1) alternative choices; (2) relationships; (3) self-expansion and self-acceptance; (4) facing the unknown; (5) rehearsal of expectations; (6) social equilibrium; (7) self-therapy to overcome problems; (8) conflict; (9) communication; and (10) comprehension.

The therapeutic goals that can be reached through these techniques are also varied. It is important to increase awareness of alternatives that allow the patient to be free to choose and act. With freedom to move to alternate solutions, and improvement of relationships can be enhanced. Through the use of greater spontaneity and the emergence of the creative moment (Haskell, 1975), greater self-expansion and self-acceptance (Osherson, 1974) can take place. Exploring experiences through fantasy projection allows for more positive experiences and independence in facing the unknown. Rehearsal of

forth coming events offsets worry and dreaded expectations. Acting out the letting-go process for the bereaved and the patient lightens the intensity of the final encounter, focusing on the tele relationship instead. It is also in the therapeutic realm to use psychodrama to maintain social equilibrium through continuous self-evaluation and self-therapy in becoming one's own psychodramatist (Moreno, 1940). It is up to the patient, through directed psychodrama, to use spontaneous-creativity to deal with life that can be enhanced by self-therapy. The professionals can provide only the tools. Through self-therapy, the patient frees the self from irrational inner conflicts and works through problems of conflict, communication and comprehension.

The implications for therapy are clear. To counter the negative categories of anxiety, fear and defense, Moreno proposes a positive category: spontaneity. Frustration, projection and sublimation are negative categories and presuppose a positive category, creativity. (Haskell, 1975, p.28)

As Dr. Fine (1978, p.6) succinctly states, "the primary goal of therapy is to reclaim one's innate ability to meet each moment in a fresh optimally adaptive way, in short -- to be spontaneous."

Enactment Preparation:

Preparation reviewed is divided into (1) relating ideas; (2) choosing actors; (3) assigning roles; and (4) warm up for the enactment. A brief mention is made of setting, drawings, props and masks. The preparation phase ends in discussion of lighting that helps produce tele.

Preparation can be divided into four stages (Moreno, 1947). At first the (1) director relates the ideas of the scene to be played to

the producer in front of the audience, (2) after which the actors are chosen and (3) assigned roles and a leading motive. The patient-actor then (4) warms up for the enactment in order to change from the private self into a role character, either by means of mask, costume, physical make-up or behavior and gesture, as appropriate to the problem.

Backdrops consist of impromptu settings of varying sizes, colors and shapes. Impromptu drawings are also used by a painter that illustrates, from the stage, coming scenes and developing sequences. Some props are covered with white lacquer which can be drawn upon and erased. If used, masks, as well as improvised costumes, are cut and painted in front of the audience.

Each scene may be separated by a pause or blackout. The drama is then presented after this total blackout. The drama begins as the director speaks and a weak light spans the scene, growing in intensity as the preparatory play reaches its peak. A sixth sense guides the anticipation of feelings, ideas and actions that invisibly connects to heighten the sensitivity for producing a telepathic inner response.

Psychodramatic Language: Nonverbal.

"The importance of nonverbal communication, body tone and movement, posture, position, territoriality, lighting, sound, music, colors, textures, body contact, laughter, and humor as elements in human relationships" (Blatner, 1973, p. 13) is recognized in psychodrama. Also because part of the "psyche" is not given to language, bodily contact such as touch, caress, embrace, and handshake become an important part of psychodrama. "In addition to what we say with our verbal language, we are constantly communicating our real feelings

in our silent language - the language of behavior" (Hall, 1959, p. 10). It becomes necessary then to study, understand, and use body language and tactile communication for proper psychodramatic enactment. The spontaneity state is reached by appropriate levels of speech, which brings together body behavior and the mental state.

Verbal:

Verbal language used in psychodrama is often that of slang and unfinished forms of speech or the speech of children that has been a hidden and repressed language (Moreno, 1947). It is also language of the imagination and not of the conscious, having less inhibiting primitive thoughts, emotions and conflicts.

COMPONENTS AND FRAMEWORK OF PSYCHODRAMA

Psychodrama can be divided into five necessary components. There is need for (1) a psychodramatist director, (2) a patient protagonist, (3) therapeutic aides as auxiliary egos, (4) a group support system, and (5) methods and techniques to meet the problematic situation (Blatner, 1968). Methods and techniques have been discussed. This section will deal with the human component that interacts with the framework. This network utilizes a three part psychodramatic production framework. There are the (1) warm-up, (2) the action, and the (3) closure through audience participation (Yablonsky, 1974; Blatner, 1968). It is within this framework that the necessary parts come together as a sharing unit that will bring a problem to an insightful or meaningful peak performance.

The Psychodramatist Director:

Mentioned in this section are the director's abilities, tele, warm-up and attending techniques for working through a problem. In order to achieve therapy in an enactment, the director must be quick, inventive, insightful, and challenging. The movement of the episode is aided by the mood, character, advancing or pacing patterns that the director takes.

One of the functions of the director is to establish a many level relationship through telic communications with the protagonist and group. Techniques are also necessary for overcoming negative tele, and resistance can best be handled through playfulness or guided fantasy.

The director needs a personal warm-up and can begin by using physical movement or by talking to others to develop the spontaneity necessary to become the group model of self-disclosure, humor and tolerance. Varying warm-ups through person, musical or poetry presentations (Haskell, 1975) encourage self-disclosure and theme development that build group cohesion. When this warm-up has peaked and the director or group selects a patient to act out one's own or group problem, the problem will be identified, discussed and patterned for enactment. It is imperative for the scenes to be played in the "here and now," and this is given marked attention by the director. As the action progresses with the moment of inspiration, other people are brought in as significant figures of the drama. It is through role reversal, soliloquy, the double and asides that greater self-exploration can be directed (Moreno, 1974).

The Protagonist:

The various patient attitudes to a role are related as (1) the non-performer; (2) the intellectualizer; (3) the reluctant; (4) the refuser; (5) the non-problematic; (6) the highly problematic; (7) the dominator; and (8) the disruptor. The protagonist director movement that brings about catharsis of integration is discussed.

The protagonists, or patients, are the individuals who are the subject of the enactment (Blatner, 1973) or bring a problem in order to gain insight. Patients vary in their approach to the psychodramatic role. An outline of types of protagonist patients, as suggested by Seabourne (1968), includes (1) the non-performing patient who story relates material without emotion, by using the past of "I did" "They did." This approach can be met by enforcing a here and now enactment, by having the scenes played by others and directed by the protagonist, by allowing non-involvement, except to watch others playing out the problem, or by not having verbal participation, only action, by the protagonist while others verbalize.

(2) The intellectualizer uses words instead of emotion to confound the action. All of the methods used in number one can be of value. It may be desirable to utilize a double who reaches the emotions through slang. An increase in action and emotional outbursts helps to bring the wordy protagonist into a nearer balance with the emotions. An increase in group involvement will also circumvent the verbally active patient by cutting into sharing of the time and by decreasing protagonist input.

(3) A reluctant patient needs satisfactory on-stage involvement. Placing the patient into an auxiliary role, such as being a double, may help one to project. Fantasy and wish fulfillment projections can stimulate the creativity of this type of patient. All attempts should be made to increase on-stage time and to keep emotional material paced with distancing until the patient becomes a willing participant.

(4) Refusal to participate - or one who gives up on production - can be met by use of a double. Putting the problem into action by using the patient to check for validity may be of help, especially if the action uses extreme distortions, forcing the patient to correct the scene. Gentle persuasion by the director in touching or extending a hand and starting the scene from the audience section may move the patient onto the stage. When the protagonist leaves a scene prematurely, the action can be moved to the floor, another person can take over, or shifting to a double may be wise. Again, to promote distancing from the emotional content to allow the patient to be supported by the group without feeling that one is disappointing others is a vital concern.

(5) A non-problematic patient who either maintains there is no problem or cannot face a problem may do well with fantasy material, restructuring situations, performing a living family picture, or making up a story.

(6) On the other side is the protagonist who goes from one problem to the other to confuse the issue and backs off from feelings. If the patient is talking because of being upset, a few minutes of hand holding or comforting statements may be in order. If this becomes a

persistent situation, then confrontation, after trying all other methods, may be the last resort.

(7) Patients who dominate the group by talking, emotional outbursts, fears, advice-giving, or who act as attention seekers need to be quieted so that all have a chance to participate. A change of focus, hostile group reaction, and confrontation may bring this patient into submission. Two methods of confrontation that can be used are that of "behind the back" and "the mirror." Both must be used with caution and with regard to the ego strength and needs of the patient, the group reaction, and the timing in the therapy plan. The technique of "behind the back" can be powerful when a patient asks for group opinion, is in need of knowing behavior effects, when group reaction is unfavorable, or when one does not listen. This type of confrontation may best be used with the support of a double or an auxiliary that will strengthen the ego verbally or nonverbally. Group comments and feelings should not be lengthy or vindictive. Overwhelming the patient with negative comments should be tempered with positive additions, and all confrontations should allow time for reactions and support of the patient. "The mirror" technique is used with the same precautions and is more often used with the patient who is "unaware and resistive" to acknowledging one's behavior pattern effects on others. This is a good method to use on the group as a whole if it is divided on a problem. This is a simple maneuver in which some one reflects another in verbal and nonverbal behavior.

(8) The disrupting patient must be handled as a special problem in line with the situation. In problems of the suicidal (Trautman,

1974), psychotic, hysterical, homicidal or the sexually deviant, goals of approach must be sought by the director in order to ensure supportive group direction. Acting out the problem along with the consequences may bring greater realization of the finality of the act. Especially when dealing with death issues, adequate time must be given for supportive closure. There must not be an abandonment of the patient due to the strong feelings exhibited, but all members must show caring and a concerned willingness to help. Auxiliary and group support can be more helpful than withdrawing by isolation from members.

The dynamics of psychodrama take on a form of battle between director and patient. A realistic transference begins but is projected into a battle of wits as the threatened patient gives to the demanding director the freedom of speech and exposure, to the dynamic inner drama through words and actions. Within this battle, the patient and director are warmed up, assessing one another like prize fighters, facing the stress and challenge, drawing from spontaneity and creativity to exorize the self into a whole being that can enter life to its fullest measure for the moment. In the drama presentation, the director retreats for auxiliary egos to take over and to divide the tele, transference and empathy of the protagonist. Transference is subjugated to the operating "tele" that gives shape and balance to all interpersonal relations. All the adventures of the mind are exposed to restore spontaneity, productivity and power to the patient. The illusions and magic spells lose their power as the patient learns to reorganize, put forces together, integrate them and attain self-power and relief, and, so a "catharsis of integration" (Moreno, 1939) occurs. In working

through a personal drama, a wider range of reality is gained, a "surplus" reality is the prize (Moreno, 1947).

Auxiliary Egos: The Double.

It is important that the group tele communication is transmitted to the patient to help in developing an open attitude to the artful persuasions of the auxiliary egos. The double becomes a sounding board for the protagonist to see and hear in reaction to oneself. Doubling the protagonist can be compared with the Rogerian response (Blatner, 1973) through psychodrama as it turns out to be a type of paraphrasing in action. The double paraphrases the protagonist, which allows the patient either to amend or to sanction the doubling response. The double becomes the other self (Moreno, 1974), an alter ego that carries on the inner dialogue, paraphrasing statements that are representative of the patient's feelings (Seabourne, 1968a). The statements should be corrected by the protagonist patient.

There are many methods of using the double (Moreno, Z., 1974). Blatner (1968a; 1973) lists doubling for: living response to body language, miming the conversation, disagreeing with feelings, questioning the statements, defending and giving support to feelings through humor, and in provoking power. The double can be "divided" and played by one or more actors to play the dual nature of man. Multiple doubles, more than one, play the wholistic patient whereas if a divided double is used, only parts of the psyche are addressed (Blatner, 1973). It is up to the discretion of the director for the double to have a double, as well as a double for the audience. A double in soliloquy or "talking

to oneself out loud" (Blatner, 1973) can be used. Other types of helping ego roles are those of a make-believe character, or the adding of persons that are in the social atom. In these situations the auxiliary ego elaborates upon the role assigned, using like responses, in the here and now. There may be times when another person is selected just to be on stage in support of the patient. It may also be more advantageous for the protagonist to play all parts of the enactment, and this would be called an "autodrama" or "monodrama".

Group Support: The Audience.

A drama from the audience takes over the production. The stage is moved to the audience, where the former listening group realign the tele complex and begin to relate feelings and insights of the production in a group catharsis (Moreno, 1974). Now the love given the audience is given back to the protagonist through this sharing time. Herein the psyche is remolded by another group. This feedback becomes a time of self-disclosure for the group in a sharing supportive measure. It is important to deal with "re-entry" and separation after the close contact and emotional exchange has taken place. A closing ceremony, after taking care of resentments and appreciations" is often set up to help in the letting go of the group ties (Blatner, 1973). This also acts as a beginning process in establishing a "letting go" enactment that aids the terminal patient as a rehearsal for final good-byes.

Warm Up:

The framework in which the human components interact progresses from the warm-up, to the action, to the closure. A warm-up moves the performance

into the non-real world and places the group in a receptive mood and atmosphere for entering into an enactment. Warm-ups serve to free one from past patterns and associations so as to move freely into the "state" of another with flexibility and a high degree of spontaneity (Moreno, 1974). Mood lighting, "yellow for sorrow, blue for introspection, red for violence" (Kobler, 1974) help the tone and warm-up of the group. The arrangement to warm-up a group can be entertained in different ways, three that Blatner (1973) and Enneis (1974) discuss are, "(1) the cluster warm-up, (2) the chain of association warm-up, and (3) the directed warm-up". In the cluster warm-up, the group begins to discuss a variety of topics in small clusters. As the group mingles, a merger of interest becomes apparent. The group decides on the topic of highest rank from the cluster gatherings and also identify the protagonist needing to express and develop the topic to its peak. In the chain of association warm-up, the group topic evolves from total participation that adds to the conviviality and spirit. The protagonist emerges through group consensus looking at interest in the problem and personality needs. For a teaching warm-up, the directed type is of importance. A patient or director of the group wants to present definite information or problems to the group. Action can then proceed on stage which will be intensified by the warm-up tele extension from the group. This group tele becomes an important part of the psychodrama in therapy as it promotes catharsis and insight to benefit the protagonist as well.

The Action:

It is in the second part of the psychodrama, the action, that the director is highly active. The action part is often referred to as the enactment. It is in this frame that the spontaneity of the protagonist pours forth catharsis toward a peak performance.

Closure:

After the action, the third and final portion of psychodrama is a working through period, a time for sensing mastery of the problem receiving group support, and dealing with "re-entry" (Blatner, 1973). This becomes a sharing time of insight.

In Summary:

This chapter has identified techniques and goals that can be effectively used by the terminal patient meeting the moment in an optimally adaptive way. In a theatre setting, or in situ, the patient's language of psychodrama promotes the freedom of expression and spontaneity. The director, patient, with auxiliary egos and audience, when used, tele communicate to share the insight of the problem from the time of the warm-up through the action, to the closure, for the catharsis of integration.

The following chapter sets forth the challenges of dying, death and bereavement in the home or in a hospital or a hospice, that confront the care-giver, the terminal adult and the social atom, and the terminal child. The chapter ends with a discussion on the responses to death.

CHAPTER III

THERAPEUTIC THEATRE IN TERMINAL ILLNESS

It is in the unchaining of reality that the terminally ill can seek refuge and solace. In the escapism of the theatre the "acting through" problems of living pave the way for a more acceptable death. In many aspects of dying and death the action-oriented patient can find cathartic benefit, self-worth, and dignity preservation through spontaneous creativity. However, this does not come about by itself. A director, counselor, dramatist needs to bring together the knowledge of psychodrama and dying, death and bereavement factors to facilitate a therapeutic theatre that addresses the diverse circumstances of individual patients. Each dramatist must find one's own workable methods through understanding facts about the nature of death, dying and bereavement in being aware of stress factors in care facilities, in care-givers and in the grieving aspects that will be amenable to psychodrama for the patient in all stages of life. Hence, this chapter evolves the concepts of dying, death and bereavement in relation to home, hospice or hospital confinement, professional atom, terminal adult patient and family, and terminal child. Responses to death are listed.

CONCEPTS OF DYING, DEATH AND BEREAVEMENT

This discussion centers around death as a creative and destructive force, causing fear of physical and psychological suffering. Fear and anxiety with need for acceptance are briefly discussed. An explanation of resolution of fears through psychodrama and hypnodrama is followed by a discussion on bereavement and grief, needs, stages, psychosomatic illness during grief and ends with the grief syndrome in relation to hyperventilation.

Death As A Creative And Destructive Force:

Contemplation of death can be as keen as a double edge blade. Over the centuries man has tried to cut out death by keeping alive through creative works in cultural conserves. In some however, morbid thoughts cut through to wound the psyche in forms of neurosis (Meyer, 1975) and psychosis (Becker, 1973). Paradoxically, death causes both creative and destructive forces. The apprehension over death and the yearning for immortality motivates a creative behavior. Conversely, the dread that may accompany the apprehension of death can be a cause of mental illness. Our society concentrates on the negative aspects of dying, which only helps to promote the destructive forces. There is a masking of death and an evasion of death subjects in favor of clinging to a cult of the youth, the young look and the young attitude. We have never encouraged in our culture, such as the Chinese, a veneration of old age and the wise mature. There is little grace in the eyes of our society in growing old. Individual fears become too intense and unresolved to deal with the inevitable end results of life, that of

death. What is so fearful about death? The list of reasons can be long, yet death distress arises from the fear of "psychological and physical suffering" (Schulz, 1978, p. 19). These two interrelate to compound the misery and often become the self-appointed affronter.

Fear of Physical Suffering:

We are a nation accustomed to comfort and the medical relief of ailments. Millions are spent each year on health. When the fear of a prolonged illness, such as a cancer, a debilitating or degenerative disease, taking over the body, death thoughts can become terrifying. The mental and physical pain suffered during the deteriorating process is a concern of many people. Loss of a part, loss of function, loss of control in a part or in all of the body underscore many fears. Physical suffering is generally controlled by medical measures and drug dependency is often a side effect in a prolonged condition. The psychological aid of auto hypnosis is gaining in credence and in application (Simonton, Simonton and Creighton, 1978). The use of hypnosis, hypnodrama and guided fantasy for pain control is also being tried.

Fear of Psychological Suffering:

This leads into another fear, that of humiliation. No one knows what they will do in time of intense pain and suffering. The fear of becoming a coward, of being abandoned or reacting in violence is self-threatening. Just as serious a threat to a person is the concern for others who may be dependent on them. Worry over economic strain, loss of income and the loss of a parent figure are among death stresses,

and can arise over the thought of the death of others, or a loss, as a worry over caring for them or in seeing them suffer. For some, there is also the religious atonement, that gives rise to a fear of punishment. In the same manner a belief in existential anxiety brings together a concern over living an actualizing life and the threat of non-being develops into an acute, anxious awareness of death (Schulz, 1978).

Fear and Anxiety Defined:

It is fear and anxiety that need to be dealt with in facing death. Fear can be identified as the reaction to specific places, events or objects, and anxiety as an emotional state that lacks specific cause. Herein one can see the duality in which one can fear the objects associated with death, eg. pain, bed confinement, or prosthesis, as well as the unknown and unspecified areas of death: The when, where, how and why of death.

Need for Acceptance:

Resolving fears and anxieties is necessary for death acceptancies and understanding. Resolving fear is the core of the grief process. At its most basic level, a fear stemming from very early childhood separation experiences is that we will not survive. (Heikkinen, 1981, p. 327)

It becomes the task of the ill and bereaved, in dealing with fear of survival, to realize that change does not necessarily diminish the self-concept but can add dimensions of adaptability and inner independence. Whenever one is faced with loss of "control" of life and a love, it becomes apparent that the suffering comes from the lost illusions of control, and the agony one causes oneself is from trying

to protect those illusions (Davenport, 1981). Life's illusions can be resolved, acted out, in therapeutic theatre to regain control and acceptance.

Resolving Fears Through Psychodrama-Hypnodrama:

How to resolve the fears of death becomes an individual decision.

"Psychodrama, the oldest of the therapies utilizing theatrical techniques, and the only one to possess an articulated theoretical framework" (Goodman, Prospero, 1976, p. 20) should be an option available for the terminally ill patient. The value of mental catharsis at this time should be encouraged with active release. An avenue open for counselor use is that of hypnodrama with the acting out process of fear-producing thought. The relaxation response obtained through hypnosis can be carried into self-controlling and self-correcting measures for overcoming fear and anxiety distress.

Bereavement: Grief.

Grief, another cause of mental distress, occurring in the patient and family during and after dying is in need of management. This following section is concerned with the grief of bereavement and discusses working through normal grief and need of supportive measures. Stages of grief are listed as are psychosomatic illness that may occur during grief. Grief as a syndrome and hyperventilation are viewed with management techniques.

Grief Needs:

Personal testimonies written for the self-help approach to grief, attest to the working through of normal grief with the support of

another. A friend, counselor, or relative is needed to supply encouragement, compassion, understanding and acceptance. Bereaved authors, Schiff (1977), Caine (1974), and Jones (1979), stress the need of others to understand their grief feelings. Helping the bereaved consists mainly of letting one talk in a climate of trust and to have someone around to do tasks which enable the bereaved greater freedom to grieve (Pincus, 1975).

Stages of Grief Need "Acting Through":

Stages of normal grief are discussed by many authors (Bowlby, 1975; Averill, 1975; Pollack, 1975; Matz, 1979; Kubler-Ross, 1969). Elizabeth Kubler-Ross is the most adamant advocate of the stages of grief in dying and bereavement. She describes stage one as shock numbness, and denial, that advances to anger in stage two, is replaced by bargaining in stage three, and followed by depression in stage four. It is during these stages that the patient should be encouraged to "work through" or "act through" grief to find the final fifth stage of acceptance, and here the methods and techniques of psychodrama are of value. Kubler-Ross in her workshops uses psychodramatic techniques to maintain realism in re-enacting life situations to reach deep feelings. Dr. Kubler-Ross encourages medical personnel and family to work with the patient to find the acceptance stage for a "dignified" death. Even if one does not believe in the stages of death, or cannot clearly define where the patient is in relation to the symptoms, it is still imperative for a support system to be open to discussion, awareness and encourage catharsis of moods, fears, and anxieties that may besiege the patient from day to day.

It is also of help for personnel and family to take note of the possible reactions of those who have been told the prognosis so they may encourage discussion of feelings, without erasing hope. There is also a period when the patient's inner withdrawal or self-contemplation can be misinterpreted as depression. In retrospect all stages and symptoms can be acted out for psychodramatic catharsis. Recurrences of grief are not generally of concern and should not be viewed as pathological unless the bereaved is unable to cope with life situations.

Psychosomatic Illness During Grief:

During the grieving stages the patient should be observed for psychosomatic illnesses.

There is substantial evidence to conclude that the period of bereavement presents a host of serious problems. The untoward consequences of a loss include, among others, death of survivors (Krause, 1959; Parkes, et al., 1969; Rees, 1979; Young, 1963; Cox, 1964); psychosomatic reactions such as ulcerative colitis (Lindemann, 1945) and rheumatoid arthritis (Cobb, 1939); increasing rates of mental illness (Parkes, 1964; Stein, 1969); poor physical health (Parkes, 1970; Maddison, 1968); and general emotional unrest (Clayton et al., 1971; Marris, 1958; Parkes, 1970).

(Gerber, Wiener, Battin & Arkin, 1975, p. 311)

Pathological grief studies reveal that there is a higher mortality rate seen during the first year of grieving for relatives, and a relation of grief to somatic symptoms that may increase physical illness.

Evidence strongly suggests that the psychic state emanating from separation and object-loss may contribute to a number of diverse somatic reactions, ranging from those which involve actual cellular changes (for example, cancer) to those which comprise such subjective sensations as pain (for example, burning mouth). While consistent with generalizations con-

cerning the intimate reaction between psyche and soma, the relationship between object-loss and symptom formation carries implications for prevention and management which have hardly been touched upon in our present approaches to physical illness. While it has sometimes appeared that the great lack is that of appropriate theoretical models to explain "how" psyche and soma influence each other, the much greater practical need is for approaches to prevention and management which take the relationship for granted. (Carr, Schoenberg, 1975, p. 213)

Prevention and management should direct the efforts of the grief counselor, dramatist. In acute distress, emergency psychodrama may benefit the patient (Ackerman, Ackerman, 1974). The dramatist should remember to include "acting through" disease symptoms and treatment as well as the psycho-social aspects of dying with psychodramatic techniques for those patients willing to enter into spontaneous creativity.

Grief As A Syndrome:

Early research of grief as a definite syndrome with a predictable pattern was formulated by Erich Lindemann (1975), and his study is referred to in many texts, (Matz, 1979; Volkan, 1974; Clayton, Demarais & Winokur, 1975; Averill, 1975). Lindemann's descriptive and empirical study on grief details symptoms of uncomplicated grief in the acute stage, common to all, and sets up the syndrome as follows:

Sensations of somatic distress occurring in waves lasting from 20 minutes to an hour at a time, feeling of tightness in the throat, choking with a shortness of breath, need for sighing, an intense subjective distress described as tension or mental pain.

He continues to point out the striking features as

(1) The marked tendency to sighing respiration; this respiratory disturbance was the most conspicuous when the patient was made to discuss his grief, (2) The complaint about lack of strength and exhaustion is universal and

is described as follows: "It is almost impossible to climb up a stairway." Everything I lift seems so heavy." "The slightest effort makes me feel exhausted." "I can't walk to the corner without feeling exhausted." (3)
 Digestive symptoms are described as follows: "The food tastes like sand." "I have no appetite at all." "I stuff the food down because I have to eat." "Everything seems slowed up in my stomach." (Clayton, Demarais, & Winokur, 1975, p. 50).

With this combination of symptoms there is a need for prevention and management of the physiological and psychological involvement. The symptoms of grief and hyperventilation share commonalities that may through management moderate grief.

Hyperventilation: Management During Grief:

Clues to hyperventilation are:

Weakness, malaise, sense of impending doom, excitement, and apprehension, lightheadedness, feelings of unreality ("floating") and "dizziness", tinnitus, blurred vision, syncope, seizures (rarely opisthotonus), tightness in chest, inability to breath deeply, frequent sighing and yawning, palpitation, precordial pain, tightness in throat, dry mouth, epigastric distress, tingling and numbness in extremities and face, muscle cramps, "stiffness" of joints, twitching tremors of extremities, cold moist feet and hands (Lowry, 1967, p. 92).

Lindemann's respiratory distress symptoms, noted in his grief syndrome, are contained in the hyperventilating "clues" pointed out by Dr. Lowry. This finding suggests the need of monitoring respirations for hyperventilation in grief work, when there has been bouts of crying and anxiety. The more one overbreathes the greater the inner stress and continued overbreathing. The hyperventilator is usually unaware of the respiratory response though, there may be deep sighing noticeable to others. The reaction can be prevented by teaching slow, diaphragmatic (abdominal) breathing. In acute states of hyperventila-

tion, breathing into a paper bag and rebreathing and air brings relief. Another management technique is to encourage slow nasal breathing with the mouth closed during inspiration. Particular attention to respiration brings a relaxation response that helps the induction in hypnodrama and ease of presentation of problems in psychodrama for the terminal and bereaved clients. The patients, in order to minimize grief, from the time of pronouncement to death, needs support to deal with transitions.

HOME, HOSPICE OR HOSPITAL CARE CENTERS

Home and Hospice: Overview:

Major distressing concerns of patients facing death are where will the final time be spent? How long can one stay at home? Who will take care of me? No one wants to be a burden. Many of the ill have come to believe that hospitalization relieves the family of their burden by being out of the home, thereby avoiding family care responsibility. Gaining impetus in America is the hospice movement that provides palliative and supportive care for terminally ill patients and their families. The hospice emphasis is on home care supplemented by institutional care as needed by the development of the patient's condition. In hospice, the patient and family constitute the unit of care and the patient retains decision-making power as long as possible. A hospice team, which comes into the home, ensures continuity of care. There is, within the network of the hospice philosophy, a counseling component directed toward the patient, family, hospice staff, professional and lay community members. Counseling

becomes an important, on-going aspect of hospice. Decision making problems, separation grief, and letting go of home, work and family can be attended in psychodramatic enactments. The need for action therapy may become more appropriate as institutionalization rises.

Hospital Care Center: Concerns.

There has been an increased need for institutional care in our society in the past decade, and it is estimated to be over 66 percent in 1981. Degenerative diseases have become the greatest contributing factors of death. Since heart disease, cancer and cerebral hemorrhage are at the top of the list institutional care may be used more often. This places emphasis on the medical staff as care-givers for the physical and psychological last needs of the patient. There is also increased need for emotional support for the last days of the patient which can be provided by the staff. Many patients without family support may turn to the professional team which becomes more important in the patient's effort to hope. Strong attachments and transferences take place which should be recognized by the counselor. Personality changes often take place due to hospitalization, when the patient is taken out of the home and away from routine and put into a uniform way of life that separates one from the real world. More and more it becomes apparent that the degenerative diseases have a longer terminal period during the process of dying. The longer the final stage, the heavier the financial, emotional, and physical burden for all involved family members and care-givers. A terminal prognosis is usually a signal that there is evident progressive deterioration, to

be followed by a hopeless outcome. All measures having failed point to a hopeless outcome-that of death.

The final stage ushers in a different type of treatment as the recovery support systems are either maintained or withdrawn. There is a growing concern over who shall be the determinate voice for allowing terminal patients to die or to be selected for access to support systems. This issue has not been resolved. The two schools of conflicting thought are headed by Dr. Christian Bernard and Dr. Edmund Pellegrino (Schulz, 1978). Dr. Bernard believes that controlling and terminating life is a medical decision and not a personal one, whereas, Dr. Pellegrino advocates the need for patient and family consultation so that the life values of the doctor are not forced onto others (Schulz, 1978). Gaining increased use is the Living Will document in which the patient directs the medical authority to refrain from the use of extraordinary measures to sustain life when there is no hope for survival. The need for a Living Will is thought necessary by those who view the ramifications of maintaining life through medical technology in all organs except the brain. Life support formerly designed for the critically ill have been extended to the terminally ill and justification for this practice is being questioned. Should the life of a terminal patient be prolonged by technology or taken by euthanasia methods?

Euthanasia:

Euthanasia, popularly known as mercy killing, may be better understood by discussing its two parts, passive and active termination. (Schulz,

1978) There has been an increase in approval for the use of passive euthanasia by public and professional people when considered in context with the individual's circumstances. Passive euthanasia refers to the practice of refraining from medical measures to prolong life. This is done by either withholding or withdrawing medical treatment which in turn generally shortens the terminal phase. Passive euthanasia can be illustrated in a case of a patient with terminal lung cancer and who is suffering pain and slowly drowning in chest fluid. At the same time the patient is being maintained on drugs for congestive heart failure to support life. In passive euthanasia the withdrawing of the drug that maintains the heart beat will in all probability hasten death. This action may be looked on by many with favor when it is recognized that the patient has two irreversible conditions.

Active euthanasia has been practiced in the control of cats and dogs who are in pain or are homeless. This form of euthanasia is a deliberate act of destruction and is often confused with the medical practice of passive euthanasia. But the issue is not always clear cut, because many people do not realize a difference and do not see a moral or ethical difference.

Legal, Moral and Ethical Implications:

There are many legal, moral and ethical implications that confound the issue. There appears to be no legal consensus on the designation of authority to terminate life. Even though mercy killings are not recognized as lawful, juries tend to weigh motives and acquit the accused. There is no consensus in the religious, moral factions either. The

Protestant Church sways from the very liberal to very conservative measures. Pope Pius XII dictates that the Catholic Church members are not morally held to using "extraordinary measures" to keep the terminally ill alive. The Jewish faith is the only clear cut position that maintains the sacred quality of life that should be preserved at all cost (Schulz, 1978).

As understanding of the consequences of death becomes more general and when people become aware that they can take part in or decide their fate, they become more apt to challenge established ways. As technology grows that prolongs life, so will the issues. The expression of disfavor through court action by patient and family over medical decisions made without their knowledge or approval has become a legalistic quagmire. The legal, moral and ethical issues are varied, abundant and without definitive answers. Members of the professional unit, including counselors, are often in jeopardy over conflict about patient concerns that relate to the termination of life. Even here, psychodrama may be of use in decision making of such import by acting through the problem to gain insight, to review alternatives, and to point out the consequences of the act.

THE PROFESSIONAL ATOM

Professional Attitudes: Patient's Right to Know.

The role of the care-giver must be supportive and sustaining. Schulz, (1978) indicates that doctors and nurses avoid the terminal patient (Livingston and Zimet, 1965; Kubler-Ross, 1969; Glaser and Strauss, 1965; Kastenbaum and Aisenberg, 1972). Medical school lays the ground

work for death attitudes, and a "detached concern" (Lief and Fox, 1963) philosophy is generally taught (Schulz, 1978). Training is geared to saving life and not the termination of life. The resultant death of a patient may be viewed as a personal failure, pointing to the professional's limited knowledge and expertise. The physician's training and personality will determine the compassion with which the situation is handled, how the patient will be told, or if they will be informed of the prognosis. Literature reviews confirm the opinion that patients have a right to know and should be told. Schulz (1978) lists Kubler-Ross, 1969; Glaser and Strauss, 1965; Noyes, 1971; Wahl, 1969; and Oken, 1975 in support of the patient's right to know. It is the manner of the physician's presentation that will relay to the patient either hope or fear. A brusque, impersonal and clinical attitude will not provide the inner hope and understanding needed for calm acceptance. An empathic discussion of the condition with gradual prognostic revelation that does not cancel out all hope brings greater peace.

Dilemma of a "Hopeless" Sentence

It is surprising that polls show anywhere from two-thirds to 95 percent of physicians do not inform patients of terminal cancer because of the hopeless sentence it invokes. This presents a dilemma for the nursing staff in close contact with the terminal patient. If the patient has not been counseled, the nurse must tactfully circumvent probing questions and yet be true to professional ethics and patient's rights. In jeopardy, the nurse must tread lightly. Even if the patient has been given a prognosis, the question of how to keep hopes alive

realistically becomes a problem. This inadequacy of response on the part of nursing staff has been documented and Kastenbaum and Aisenberg (1972) list five general attitudes. They note that most often, the nurse skirted the issue through humor, fatalism, denial, or by changing the subject. Very few would engage the patient into the fifth appropriate response, discussion to allay fears. This psychological avoidance on the part of medical staff only adds to the isolation, abandonment and accumulative fears in the patient.

Often when patients are not informed of their terminal state, they will nonetheless pick up cues from those around them (Kubler-Ross, 1969). Also reported is that a high percentage of patients suffer anxiety and depression which may disappear in the final stage. Some professionals believe there are stages in the process of dying, while there are others who believe it is to be a stageless process. Whatever the view held, there needs to be continued education for the professional atom in death preparation.

Need for Death Education Through Psychodrama:

Psychodramatic education is growing within the professional atom to help prepare those in medicine to meet more effectively the psychosocial aspects of the dying patient. Communicating effectively with terminally ill patients has been reported as enhanced through dramatic action training (Howard, 1975) of the professional staff. Dr. Howard effectively uses three of Moreno's techniques: Role playing, doubling and role reversal, in upgrading nursing interpersonal skills with the terminally ill patient. Psychodramatic techniques to reduce anxiety,

distress and attitude is also of benefit to the nursing student (Hall, 1979). It is suggested by data collected that contrived role play training is the most effective model for improving listening skills, and self-confidence of the helper (Ferree, 1976) as a behavior rehearsal to cope with long term hospitalized patients (Withersty, 1976) and as an educational aid in dying, death and bereavement (Barton and Crowder, 1975).

THE TERMINAL PATIENT AND SOCIAL ATOM

Art of the Moment: Producing Self-Expansion:

As a patient views one's past, the insignificance of what has been done or has been left undone often brings depression and despair to the terminally ill. Moreno's (1947) concept of the cultural conserve and the art of the moment addresses this dilemma. Very few people bring a lasting conserve into reality. Yet everyone does have creative conserving thoughts that expand and enhance the individual life even though not culturally lasting or recognized by others. It is in the moment that the individual builds and enjoys when creating from the inner responses that are spontaneous. It is in an inter-connectedness with others that this creativity expands. "Drawing" from one another in mini-dramas foster monodramas creating spontaneous, moment to moment art forms never to be performed again and build a microcosm within each individual. In assimilating a world of experience for growth and expansion through retrojection, or drawing from one another, each gives to the other moments of inspiration. From this interaction, people experience creative catharsis and individuality. A person be-

comes the sum total of experiences, and those shared through a drawing commitment with others aid self-expansion of one's mini-mind theatre, as problems, fears and hope are enacted through psychodrama by the terminal patient. What are the concepts of psychodrama that make dying, death and bereavement more tolerable? That we each have a spontaneous part to play and a part to create each moment of life becomes the underlying theme. It is playing to that moment of life that we outwit death. This is the challenge for the dying, as well as the healthy: To give to each moment the most spontaneous-creativity possible. It is that spark of creativity that continues to draw on inner and outer resources to gain in self-expansion, the "elan vital", that preserves worth and dignity of the terminal patient. The terminal patient may be of two types: those afflicted with a terminal illness caused by a disease and those affected by terminal injury due to an accident.

Needs: Alleviation of Pain (1)

A variety of needs are to be met for the individual patient with terminal illness or terminal injury. However, the three major needs are: (1) the alleviation of pain, (2) the maintenance of dignity and self-worth, and (3) the continuance of love and affection. The alleviation of pain (1) has been discussed in the section concerned with physical and psychological suffering and will not be reviewed.

Psychological Need For Dignity and Self-Worth: (2)

After the pain is controlled, attention can be given to meeting the needs of maintaining dignity. This can only come when the patient is in control of the decisions that affect the dying process. Involving the

patient in decisions helps to overcome the helpless and hopeless feelings that accompany the terminal prognosis.

In my own work with the aged (Schulz, 1976), I have found that loss of control--from decreased mobility and financial status, loss of the work and child rearing roles, loss of freedom after insitutionalization--was psychologically as well as physically devastating. In a field experiment, some insitutionalized aged individuals were given the opportunity to increase their control over an aspect of their environment; this significantly improved their psychological and physical status when compared to other aged individuals who were randomly assigned to conditions and did not have the opportunity to exert control. The terminal patient's plight is especially difficult in that physical limitations have drastically reduced his or her effectiveness in manipulating his or her environment. Perhaps even more important, the terminal patient must live with the realization that soon his or her impact will be reduced to zero.

How can we give the terminal patient the feeling that she or he is still an effective force in her or his environment? Probably the easiest way to accomplish this is to make the terminal patient a participant in his or her treatment program rather than the object of a program contrived by the medical staff. The patient's participation, however, makes sense only if he or she is knowledgable about her or his condition and the alternatives available... The patient may also benefit from having control over the intensity and quality of his or her social contact with individuals. The patient should be encouraged to stipulate what kinds of interaction she or he wants, with whom, and when. (Schulz, 1978, p. 79).

Institutional care often robs the patient of control of the environment. There is a need to rehearse living patterns that return control to the patient. Unfortunately, routines established to accommodate staff work hours take precedence over patient comfort and expectations. However, the hospice philosophy does address this issue and attempts to offset the rigidity of an impersonal care system by allowing patient control over scheduling one's own daily needs. No matter what insitution, there remains a need for psychodramatic rehearsals for all adjustment living transitions so as to ease distress and establish self-confidence

and feeling of worth while maintaining dignity.

Psychological Need For Love and Affection; (3)

An important extension to the feelings of self-worth and dignity is a love of self that can be shared with others. It is also significant that acceptance of oneself must precede acceptance of the love given by others. Illnesses or accidents place the patient in an inferior position with abject feelings, and with this view of self, one feels that others see them in the same manner. The patient needs, at this time, more open expression of love through action. "Action speaks louder than words" and is appropriate to this situation. The healing touch becomes an imparter of the sense of worth, caring and love. Physical contact through hand holding, embracing, stroking the hair, rubbing the back and feet bring comfort and secure feelings of warmth and affection. Smiling, eye to eye contact, listening and perceiving the patient's verbal and nonverbal communications brings a unique one-to-one sharing.

Patient-Family Concerns:

Patients are often "cued" into the emotions of others and because they are highly sensitive to their own distress, they project onto others their concern. Major concerns for the patient, and or the relatives are:

1. Severe and/or unrelieved pain.
2. Mental distress, depression, and isolation.
3. The belief that life is no longer meaningful.
4. Desire for a dignified death while still in control.
5. Desire to control when and how one dies.
6. A desire to avoid becoming an emotional or financial burden on family.

7. Finances.
(Schulz, 1978, p. 89).

It should be noted that the first five conditions are directed to the needs of the patient and with careful consideration, can be met by the professional and social atom in cooperation with the patient. All seven are good psychodramatic targets. Another imperative variable is to nurture the will to live. In the grief of dying, the element of hope adds to maintaining life, whereas, the hopeless state adds to the deterioration and hastening of death.

THE TERMINAL CHILD

Optimum Adaptability:

What is it that the dying child needs? There are no pat answers to the processing of a death sentence at any stage in life. It is in dealing with the reality of a cancer or leukemia, cystic fibrosis, congenital heart disease, nephrosis and other potentially fatal diseases in the young that brings one to a deeper awareness of the necessity of living. The focus becomes one of supporting the part of the dying child that is still alive. Measures should be taken that address the change on how to "regroup" as life goes on (Wright, 1980). A supportive goal is to help the patient love and understand oneself, so as to live fully in the time left, being optimum in adaptability and creativity as long as possible.

Realization of Death: Age Groups

It is important in working with children in therapeutic theatre to understand their death realization. Fear of abandonment and separation

is foremost in the thoughts and feelings of the under five age group, because the concept of death has not been established. Death remains reversible in the understanding of the under five child, and by seven or eight, the suspicion of the permanency of death starts to take hold. However, by the age of ten, most children do comprehend the consequences of death and begin to realize it does not just happen in the aged (Wilder, 1980).

Remain Hopeful and In Control:

A point of departure from adult disengaged acceptance is that of adolescent children that generally do not disengage or give up hope. "The typical adolescent feelings of immortality and a lack of planning for the future may facilitate the denial of the illness and thereby keep the adolescent very much engaged in the process of living" (Nannis, Susman, Strobe, 1978, p. 6). Children retain attitudes of their age group. They live with the same concerns as their peers. School activities, appearances, fads, attractions, career choices and peer pressures continue to be anticipated by the afflicted adolescent. It is especially important for the counselor to remember that this age group should retain as much active control over one's life as possible. In this behavioral rebel stage the adolescent needs a sense of action and independence. This is especially essential, considering that emotional and physical dependence will increase as the condition progresses.

Psychodrama: Natural Technique for Children

Action is a way of life for the child. Acting, make believe and fan-

tasy are a large part of the child's life and herein psychodramatic techniques are a natural aid. It is useless to try to help the child make sense of a life in which they have had little part or experience. For a child without a past, the major hope is to make a future. The search is for a model to help live with the threat of death. This model can be found in therapeutic theatre. The prime hope, the moment to moment involvement becomes an "as if" the child were to go on living. This "as if" attitude lends to psychodramatic action, passim, for self-expansion through projected fantasy.

Fantasy techniques have been applied in a variety of situations to help young clients work through emotional problems and blocks (Kelly, 1972). Investigators in this field have demonstrated that fantasy methods can facilitate the desensitization process in eliminating childhood phobias (Lazarus, 1971), can reduce test anxiety (Deffenbacher & Kemper, 1974), and can control acting-out behavior (Anderson, 1975). The use of fantasy has also helped the children to relax in various school situations (Davis, 1969; Koeppen, 1974.) Therapists and counselors who have used fantasy as a therapeutic tool agree that its potential to help the healing process is great. (Anderson, 1980, p. 39)

The Bereaved Child:

For the grieving, child behavior is most often affected. Individual or group work with terminal children and/or grieving children aim at catharsis, directed play therapy, and use of punching bags or "Whompers" (Wright, 1980) that act as hitting devices to act out aggressions, anger and hostilities. Kubler-Ross (1978) also advocates the use of a rubber hose for a hitting device, to release pent up emotions. Many children believe themselves to be responsible for the death of a loved one (Wilder, 1980) and this needs cathartic attention. Grieving children often exhibit anger, depression and withdrawal which should be

taken into consideration in the family and school setting, whenever there has been a grieving situation, touching the life of a child, one should watch for changes in behavior and feelings.

"Usual body language and behavior may be ways of expressing pent-up grief" (Wilder, 1980). To encourage freedom of expression regarding loss, being on hand to talk out problems and to help in finding answers to questions is a supportive counselor role. A child needs reassurances that someone cares. Through caring encouragement the child may talk out feelings and thoughts of loss, loneliness, abandonment, guilt and/or rejection. It is important to use simple language and terms that do not evade the subject or attempt to negate the finality of death.

A child needs preparation when visiting the dying or going to a funeral, if they want to go. Literature indicates at no time should they be forced into going. A simple discussion as to what to expect lessens the anxiety and helps in the acceptance of death. Role playing scenes help in understanding the act besides being a good catharting agent.

Some children grieve immediately while others may begin after a year or more. There are children who carry the pain and grief over a death loss the remainder of their life (Wright, 1980). Supporting the grieving child can be a long process; however, it is lessened by dramatic action, as is noted in the following scenario of Billy.

Billy

The following scenario is of a delayed grief reaction in a five year old that was worked out in psychodramatic role reversal. Billy is a five year old child who started having nightmares two years after the death of his seven year old brother. At the age of three Billy would help play and care for his ailing leukemic brother. Ricky, the dying child, would often tell Billy he hated him but loved the younger brother, Chuckie, who was then six months old. Ricky would say, "I hate you Bill, you're not my brother, Chuckie is!" This would bring a torrent of "I hate you" interchanges. The solo parent mother would try to ease the tension with explanations of brotherly love and illness. The older brother died after four months, and Billy did not appear to be affected. Two years later, Billy became overtly aggressive about meeting death. Billy would stand in front of on-coming traffic and say, "that's how you become dead!" At unexpected times he would become sullen and withdraw, because his dead brother hated him. When the child awoke with disturbing nightmares of "hate" the mother sought professional help. It was during the second session, after a trusting bond had been established, that a psychodramatic technique of role reversal was enacted in a modified psychodramatic setting.

Counselor - Billy, what makes you so sad?

Billy - I hate my brother.

Counselor - What did Chuckie do to make you hate him?

Billy - It's not Chuckie I hate, It's Ricky.

Counselor - Tell me about Ricky.

Billy - He's dead.

Counselor - What made him die?

Billy - He got sick and died. He had things in his head.

Counselor - What are things in his head?

Billy - I don't know. Mom took him to the hospital and the doctor put things in his head.

Counselor - Is that why you hate Ricky; because he had things in his head?

Billy - No. (sullen)

Counselor - What did Ricky do to make you hate him?

Billy - He said he hated me first... and that I wasn't his brother... only Chuckie was his brother.

Counselor - What did you do to make Ricky say that?

Billy - Nothing, I loved him. I wanted to play with him.

Counselor - And Ricky was too sick to play?

Billy - Most times he was sick.

Counselor - Could you play with him outside?

Billy - No. (emphatically) He was sick.

Counselor - But you could go outside and play and walk around and help.

Billy - Yes.

Counselor - How about play acting, like on TV and you be Rickie and I'll be Billy.

Billy - Yeah. (enthused)

Counselor - You'll have to lie on the couch and cover up.

Billy - That's fun.

(Counselor put on Billy's hat.)

Counselor as Billy - What shall we play?

(Billy on couch, covered, as Rickie) - Let's play puzzles. (Aside)
We'd play puzzles most often.

Counselor as Billy - But I don't want to play puzzles. I want to go outside and play.

Ricky - I can't go outside when I'm sick.

Counselor as Billy - But I can, I'm Billy, and I'm not sick. (boastfully)

Billy as Ricky - We can play something else.

Counselor as Billy - I'm hungry.

Billy as Ricky - Me too.

Counselor as Billy - I want candy but you can't have any 'cause you're sick (tormentingly).

Billy as Ricky - Yeh, I'll throw up.

Counselor as Billy - I'm going outside to play. You play with the puzzle. TV doesn't work.

Billy as Ricky - Don't go.

Counselor as Billy - I'm Billy (reinforcing identity) and I want to play outside. Good-bye. (Goes out and waits about five minutes - then comes back to couch.)

Billy as Ricky - I don't want to play this anymore.

Counselor as Billy - But you're Ricky.

Billy as Ricky - But it's no fun to be alone.

Counselor - How did you feel when Billy was outside running and playing?

Billy as Ricky - I wanted to do it too and couldn't.

Counselor - Okay let's go back to being ourselves - you be Billy again.

Counselor - What was Ricky wanting to do when he was sick?

Billy - Go outside and play.

Counselor - Like Billy. (emphasizing-like)

Billy - (recognition reflex) Yeah! Like me!

Counselor - Baby Chuckie couldn't walk or go out to play. Who was Chuckie like?

Billy - (thinking) Chuckie wasn't sick.

Counselor - No, but he had to stay in the crib, and couldn't walk like you.

Billy - Yeah, he was like Ricky.

Counselor - What made Ricky like Chuckie?

Billy - They couldn't walk.

Counselor - What would Ricky say then, when he couldn't be like you and run and play?

Billy - He'd cry and yell and say he hated me.

Counselor - What did you hate when you were Ricky.

Billy - Not going outside.

Counselor - Did you hate me?

Billy - No, but you went and left me.

Counselor - We have to leave people we love at times don't we?

Billy - Yes, Ricky left.

Counselor - You helped him and your mother. What did you like best to play with Ricky?

Billy - Puzzles.

Counselor - Okay let's put this puzzle together now...

(Closure would follow a typical counseling session.)

THE BEREAVED RESPONSES TO DEATH

Throughout the dying process the bereaved child and adult need to be monitored for grieving responses. The bereaved state encounters five responses to death: (1) depression; (2) heightened concern; (3) guilt; (4) rehearsal of the death; and (5) adjustment that is significant to acting through for resolution. The individual crisis of dying and death is also a group crisis. Death marks an ending for the patient but a transitional beginning for the survivors. The finality of separation comes as a devastating psychological and physical action that is difficult to outwardly assess. The impact, however, will be determined by the amount of death preparation accepted by the bereaved. An unexpected sudden death, as in accidents, generally brings a deeper grief response, whereas with expected death, as in prolonged illness, the grief stage has less shock value. Robert Fulton (1970) lists five responses in expected death situations. The first response is depression over the news. This, according to Fulton, does not prepare one for a better adjustment after death. He reports the reverse, that the degree of depression met prior to death returns after a death. A second response is that of a "heightened concern for the ill person". This seems to dissipate guilt in the expected death survivor but those

who must deal with unexpected sudden death dwell on the third response, a "should have" guilt trip.

The most vital step to prepare for the expected death is the fourth response, "rehearsal of the death". Preparation for a stressful event is known to lessen the severity of impact on the body and mind. Through rehearsal, one learns to cope and bring forth an adequate response rather than stressors harmful to physical and psychological well-being. An intensity of feelings is worked through to diminish the emotions of stress but not love feelings. Preparation and rehearsal are key words to a healthy response. It is a letting go process that becomes more realistic through practice. Psychodramatic therapy of role playing rehearsals is of value. This fourth response of rehearsal leads into the fifth response of "an attempt to adjust to the consequences of the death." Mentally ordering the process and procedures of death and actively working through or acting through the motions, as in psychodrama, puts the bereaved in control. The feeling that one can do something and has put the life of the deceased in order with one's own life allows the bereaved the freedom to internalize the "good" points of the relationship. In internalizing the "good" points, the helpless feeling is minimized, the frustration of not knowing what to do is lessened, and a coping mechanism is established. This point in time becomes a sorting out phase. There is more of an understanding of the reason for death and the fear and fright of death have less impact. In a sudden death, whether by accident, murder or suicide, the not understanding "why" it occurred is a serious impediment to the acceptance and the working through of

grief feelings. A fear of a repeat performance of the accident often "possesses" the bereaved. It is this fear that most often precludes a healthy return to living and favors dramatic action attention.

In Summary:

Chapter III provides a basis for the action oriented counselor and patient in recognizing concepts of dying, death and bereavement. The creative force of death is established as a tool to overcome the destructive tendencies of physical and psychological suffering. Fear and anxiety encountered in the terminal situation needs resolution through acceptance which may be addressed through psychodrama and hypnodrama. A discussion of the mental distress of grief, its needs, stages and psychosomatic implications point to prevention and management through dramatic action. Grief as a syndrome is compared to hyperventilating symptoms with action methods to lessen mental distress.

The discussion expands to care center concerns exposing areas of distress and ends with legal, moral and ethical implications. Professional attitudes and patient's right to know poses the dilemma of a hopeless sentence and is discussed. It is suggested that to effectively meet the challenge of dying there is need for death education through psychodrama.

In discussing the patient and social unit an emphasis is placed on living in the moment for creative self-expansion, while attending to the three basic needs of, (1) alleviation of pain (2) need for dignity and self-worth (3) need for love and affection.

Optimum adaptability is discussed to help the terminal child to

enter from one's age group realization stage, to remain hopeful and in control, using natural action techniques of psychodrama. The terminal child section ends with discussion and scenario of the bereaved child. The chapter concludes with an outline of bereaved responses to death that may be amendable to action attention.

Chapter IV, the concluding unit, is addressed to the counselor and brings together psychodrama and the terminal patient using action intervention.

CHAPTER IV

PSYCHODRAMATIC IMPLICATIONS FOR COUNSELORS

This closing chapter is addressed to the counselor indicating psychodramatist qualifications, strength of psychodrama, spontaneity training, patients likely to benefit from psychodrama, attention to physical and psychological suffering, grief work, and acceptance. The thesis ends with psychodramatic enactments for terminal situations to direct the counselor to six areas for scenario intervention. Scenarios are: (1) adjustment living; (2) amending life; (3) future projection and fantasy; (4) overcoming fears; (5) letting to, saying good-bye; and (6) the dying and death scene.

Psychodramatist qualifications:

The counselor interested in using psychodrama for the treatment of the terminally ill or Therapeutic Theatre, needs additional training. To qualify as a psychodramatist one must earn 780 hours in psychodramatic study beyond an advanced degree (See attachment A). Due to the heavy requirements to become a psychodramatist, many find encouragement to study and learn the techniques without completing certification. It is interesting to note more and more hospitals are "employing 'psychodramatists' as an adjunct to more traditional methods of treatment" (Goodman and Prosperì, 1976, p. 10). However, there is also call for less qualified dramatists. Because of the limited number of certified psychodramatists some hospitals encourage individual or group enactments under the direction of professionals who rely heavily on a few

psychodramatic techniques. Another direction of training is Kubler-Ross's successful use of psychodrama in her "Life, Death and Transition Workshops."

Strength of Psychodrama:

Psychodrama is an exciting technique for the action directed counselor. The very basic concepts allow the counselor the freedom of the feelings to explore creatively, and the action to enter into that creative world. With the tools of psychodrama all three aspects of the person are attended in this mind-feeling-action orientation. It should become the challenge of the counselor to bring all three into equal strength. To bring together behavior change (action), and insight (cognitive) that treat the feelings (affect) becomes primary.

Spontaneity Training:

Patient spontaneity training is one aspect of psychodrama therapy that helps reach optimum adaptability. Psychodrama therapy underscores meeting each moment in a new and novel way. With the therapeutic techniques that counselor can prepare the patient to meet problems creatively and effectively with spontaneity. The test and development of spontaneity is through novelty (Fine, 1978). In a trusted theatre or therapy group, surprise situations can be handled easier. It is important to keep the range of activity within the limits, interest and copeability of the patient. It is important to remember that part of psychodrama is the warm-up and many patients need a warm-up to spontaneity in order to enter into therapy.

Patients Likely To Benefit From Psychodrama:

Because psychodrama is a holistic approach to psychotherapy and is recognized as beneficial to a "vast array of clients, it must be modified according to the goals, intelligence level, the attention span, ego strength and psychological sophistication of the client population" (Fine, 1978, p. 56). In modifying psychodrama for the terminal population the degree of engagement or disengagement from normal activity must be considered. How is the patient functionally limited in entering holistically into psychotherapy? This engagement or disengagement may divide psychodrama into a mental and/or physical state of treatment.

A disengaged state is that of a bedfast patient, or one immobile and in need of mental action. The use of counseling skills aimed at catharsis and insight is needed to help the patient to verbalize, acknowledge, and confront feelings, fears, desires and hopes, in order to face death comfortably. The tele communication which overcomes transference produces a counselor patient acceptance in the "as is" state and not as one was, or "should" be and is important in order to establish and maintain a supporting relationship.

An engaged state of psychodrama is accessible to the terminal patient who is able to participate in life to the end. The acting through muscular action for gesture, posture and movement catharsis is in line with mental catharsis.

Attending Physical and Psychological Suffering:

To aid physical and psychological suffering, especially the grief of a

terminal illness, the counselor dramatist brings spontaneity, creativity, tele, catharsis, and insight. The counselor can help prevent undue distress of grief by calling attention to the respirations in order to produce a relaxed state. A relaxed patient can enter into an enactment and hypnodrama with greater ease. By emphasizing the importance of establishing an "acting through" of problems many patients can develop self-therapy in the art of the moment. Psychodrama fosters the self-therapy necessary to overcome psychological suffering and to complete grief work.

Grief Work: Attending Unfinished Business.

The duration of grief will depend upon the amount of grief work done and the willingness of the client to accept the loss. Preoccupation with imagining the deceased image, feelings of guilt, inability to concentrate, inability to finish tasks, disorganization, and restlessness are a few of the symptoms noted in unfinished grief work. These can be "worked through" in psychodrama. Once there is acceptance, the process of inner healing begins, and grief feelings gradually recede. The initial stage of grief, with the shock and disbelief syndrome of cold, numb, dazed, empty and confused feelings, generally lasts a few days and gives way to periods of crying and weeping that last for several weeks. The intermediate stage begins when the reality that all is lost and life must go on takes over. This becomes the "if only" period along with the search for the meaning of death and the "why" period.

Accompanying the lost feeling is a searching period, "where" is the lost person, and the search begins when looking in familiar places,

such as the TV screen and crowds for the deceased. This is not unlike the search that animals undertake when they encounter a loss. Acting out the "search" often lays to rest the frantic feelings of loss. Finally, a recovery phase usually begins after the end of the first year after which the bereaved start a re-entry into social life and decide to get on with living. Self-confidence is stronger and one finds power of inner strength in having dealt with an emotional crisis (Schulz, 1978). The counselor should look for signs of pathological grief that take form in deeper intensity and duration with an ensuing psychosomatic disorder.

Successful Grief Work:

Successful grief work is achieved when all three points are met:

1. The bereaved must separate himself or herself from the deceased by breaking the bond that holds them together.
2. He must readjust to an environment from which the deceased is missing.
3. He must form new relationships. (Schulz, 1978, p. 156)

The most valuable counseling technique is that of active listening to help the bereaved to express their feelings while reviewing the relationship and reorganizing the old into a new "deceased" relationship with the dead person. However, it is often good to take the grieving person through the original grieving scenes so as to emotionally and intellectually, with psychodramatic action, put the self together again. It is of benefit to find the "linking object" (Wanderer & Corey, 1979) that holds the person to the memory. Sentimental objects such as photographs, rings, necklaces, letters and clothes should be replaced by a "bridging object" that symbolizes a new start or a

futuristic focus rather than a hold to the past. This is a good "ritual" acting out area for the client who is action oriented. Readjustment to the environment is helped by the social atom taking part in the rehearsal of new friendships.

Group psychotherapy and psychodrama are an underdeveloped group resource (Sacks, 1973) for the terminally ill and bereaved. However, there has been a rise in support groups on a non-professional basis for the bereaved, such as the Widow to Widow program (Toth and Toth, 1980), Parents Without Partners, Grief, Inc., and Compassionate Friends.

PSYCHODRAMA ENACTMENTS FOR THE TERMINAL SITUATIONS:

It should be remembered that setting the mood or tempo is extremely beneficial in therapeutic theatre. The warm-up of each session is important whether in an individual or a group session. To have the patient soliloquize a central concern for a few minutes just prior to the enactment helps to act out spontaneously. Also important is the sharing insight of the problem after the psychodramatic action.

Areas of acting out or acting through a problem area in dying, death and bereavement can be divided into six overall scenarios:

- (1) Adjustment Living;
- (2) Amending Life;
- (3) Future Projection and Fantasy;
- (4) Overcoming Fears;
- (5) Letting Go, Saying Good-Bye;
- (6) Dying and Death Scene.

Adjustment Living:

Psychodrama intervention, for adjustment whether an individual or group process, can be a vital tool for rehearsing an anticipated fear,

event or condition. The process is especially helpful for debilitating or degenerative disease such as cancers, vascular accidents and neurological involvement. For instance, a disease such as multiple sclerosis has many areas of adaptive living to rehearse. Due to loss of function in skeletal muscles the thought of having to be clothed, fed or bed-fast becomes an anticipatory fear to many. The loss of bladder and bowel control becomes embarrassing, and a rehearsal of what to say and how to act can reduce the feeling of fear in not being able to cope as the problem arises. Loss of sexual function is especially fearful for the sexually active male MS patient. Failure of penial erection should be understood by both partners and compatible measures such as massage can be discussed, with rehearsal in the privacy of their home theatre. Psychodrama can also better prepare the professionals in how to deal with the sexual advances of long-term hospitalized patients (Wethersty, 1976). The counselor should encourage open discussion as to how the patient can cope.

Loss of a body part due to illness or injury, such as a leg, arm, penis, eye, larynx, or breast can make use of psychodrama in anticipating a prosthesis, modifying life style and "regrouping" internal and external resources. For instance, the fear of a wheelchair existence can be frightening to the patient as well as family members. A rehearsal "ride" and learning the maneuvers can ease mental anguish, especially when using a fully equipped motorized model. Terminal patients can feel more independence in a wheelchair than if confined to sitting up in the room, and a preparatory knowledge will help in its acceptance.

Adjustment Living Scenario:

Role playing alternatives are of particular benefit in the counseling of the care givers who in turn can instruct the terminal patient. Role playing can be designed to initiate and facilitate any number of situations in loss of function or loss of part, to provide information, confront fears, and help in the adjustment of the patient. In this exercise a patient situation is typed on a card and the professional participants role play the problem (Barton and Crowder, 1975). The enactment is spontaneous. In the closure, after the play, other professionals relate how they may have handled the situation.

In role playing action - each player is given a role card::

Care Giver - (Situation): Your patient has a confirmed diagnosis of Ewing's sarcoma of the right fibula. The twenty year old man is on a college varsity team. In order to slow the spreading of the cancer an amputation of the leg is suggested.

Parent - As parent of the manyou are concerned and need to know every detail about the disease, its treatment and prognosis. You insist on answers from the professionals.

Patient - You are a twenty year old college man with aspirations directed to sports. After an injury during practice you noticed a swollen area on your right leg with moderate to severe pain for the past few weeks. You are not worried as you think it is due to the injury.

Amending Life:

"Amending life" scenarios point to those in need of acting out a situation of frustration, broken relationships, or hostility. The scenario may be enacted twice. The patient acts out the situation as it occurred and then reenacts the problem as one would like to have had it happen, an "as if" situation. In this enactment the patient corrects

a negative life response with a positive response as it "should have" happened to meet the patient's perception. The catharsis obtained and the justice in amending ways correct the psyche injury and relieves the burden of the problem.

Individual Amending Life Scenario Using Role Reversal

Rose, a 70 year old female sought medical attention due to back pain, right groin pain, and generalized weak feeling. Upon examination a large pelvic mass was found. Cervical biopsy showed a squamous cell carcinoma, stage IV, not amenable to surgery. Her daughter sought counseling help when the mother refused to return to the doctor after having been treated in a rough manner.

Rose - I'll never go back to that doctor again.

Counselor - What brings you to say that?

Rose - That doctor was rude to me and hurt me.

Counselor - What do you mean by rude?

Rose - He snarled, "You should have come in sooner. The cancer is beyond operating."

Counselor - How could he have prepared you for the news?

Rose - He didn't have to be so blunt and cross sounding. If his voice would have been softer and kind sounding, the words wouldn't have hurt so much. I knew I should've come in sooner but I'm alone and I don't care to live any longer.

Counselor - What would you have liked him to say?

Rose - He could've said "You've been uncomfortable for a long time by the looks of things, and now operating would only hurt you more and be of little help." I knew what he was going to say; it was just the way he said it while he was poking around on me.

Counselor - What did he do to hurt you?

Rose - The doctor took his fingers and with a lot of force jabbed them into my side. It took me three days in bed to get over the pain.

Counselor - Will you show me how he acted. I'll be you and use this pillow for the stomach mass so you don't have to worry about hurting me. Okay, show me. You're the doctor.

Rose as Doctor - repeats the dialogue while forceably poking the pillow. Relax your abdomen. I said relax (sternly).

Counselor as Rose - I can't relax because of a pain.

Rose as Doctor - There's not much more I can do for you. (abruptly). To nurse - She can go. (Doctor walks away.)

Counselor - Let's return to being ourselves. Tell me how did it feel to be the doctor?

Rose - I found myself getting angry at first, but as I struck out poking the pillow the anger left.

Counselor - (Discusses feelings, reactions and resolution, then ends):
Do you think you could return to the clinic if another doctor were in attendance?

Rose - I don't care to, but I know I must. Will you make the appointment?

Counselor - Yes. I'll do it right now. Try to get comfortable while I make the call. Etc.

Group Enactment: Amending Life.

Another way to treat the problem is through group psychodrama. This can be particularly effective if the patient's family becomes involved.

The following is an adaptation of the same situation, acting through the problem twice.

Warm-up:

The group enters and because all are known to each other there is no need for an introductory warm-up. There is need, however, to relax the people in order to feel the mood of the protagonist and find the tele sharing in the 'movement of the spirit'. In this psychodrama the mood is set by a poetry selection (See Appendix B). After the reading of the selection, "I'd Pick More Daisies", the protagonist patient, Rose, rises to narrate her problem to the group.

Action:

Rose - I'm angry with my doctor.

Director - Show us, don't tell us - (takes arm to bring patient onto stage). Where does the scene take place?

Rose - In his office, examining room.

Director - Describe the scene as to furniture, texture, colors, weather.

Rose - The examining room is cold, all white furniture, there is no window and only a recessed florescent light is on in the ceiling.

Director - Are you sitting or lying down.

Rose - I'm lying down on the cold examining table with only a skimpy sheet over me. The doctor is at the foot of the table.

Director - Let us have someone play your doctor. Your son knows the situation and will take over the doctor's part. (Son comes onto stage) What is it that the doctor is saying to you?

Rose - He's saying, "Relax your abdomen so I can feel your tumor".

Director - Okay, Paul repeat the lines - (director steps aside)

Doctor - Relax your abdomen so I can feel your tumor.

Rose - No, no, that's too full of life - say it with rudeness and scorn

Director - Rose, do a role reversal - tell us how it was said.

Rose - (takes place of doctor and repeats line with scorn.)

Doctor - (taking cue from protagonist) Relax your abdomen so I can feel your tumor.

Rose - I can't relax.

Director - Do an aside, say what you're really feeling.

Rose - I can't relax, I'm too cold. I'm hurting from the examination. You're so rough.

Director - Mary, you're her daughter; you be her double. What is your mother saying?

Mary - That turkey doesn't care about me. I'm just meat to him; another number and I'm worthless.

Doctor - Try to relax more, I said RELAX. (firmly and coldly stated)

Director - Use a pillow on the abdomen, so you don't hurt the tumor mass to enact the probing.

Doctor - (Probing the pillow mass and snarl tone) You should have come in sooner. The cancer is beyond operating.

Rose - I suspected as much. (flatly)

Double - Damn that doctor for being so blunt. Damn life for being so short and cruel. I hate this doctor's guts for his superior attitude.

Doctor - You can get dressed and go now. There's not much more I can do for you. Come back in a week for your blood test results. (exits)

Rose - I'll never come back to see him. (firmly-Aside) I hate him.

Double - I'm hurt and angry.

Rose - Yes, I'm angry.

Director - Act anger.

Rose - Strikes out at the pillow and kicks a chair. Take that you bastard. I never want to see you again.

Director - There has been a catharsis and mastery of the problem with group support. Let us share the emotions of the enactment. How did it feel, Rose?

Rose - Damn good, after I struck out. It was as though the doctor was here.

Director - (Asks others to share, then goes on) Okay, now repeat the scene as a role reversal and you play "as if" you were the doctor and say what would have made you more comfortable. (Rose takes place of doctor and son becomes patient.)

Doctor Rose - In kind tone. This exam has been rough on you. If you take a few deep breaths and close your eyes for a few minutes maybe you can relax. Go ahead and relax, I can wait.

Patient - Thanks, that would make me feel better. (breathes deeply.)

Doctor - Now I'm going to have to feel the mass from the outside. Try to relax with your deep breathing. I'll try to be gentle but it will hurt some.

Patient - That's all right. It won't be quite so bad now that I know what to expect.

Doctor - (Probing stomach) I'm going to push in here at the left while you are exhaling. Okay, go ahead and breathe out. Tell me when it becomes unbearable.

Patient - Yes, that's very painful.

Doctor - It looks like you've been uncomfortable for a long time and now operating would only hurt you more and be of little help. We can try some chemotherapy though. You get dressed and we'll talk about it in my office where you can be more comfortable.

Patient - Thank you for your kindness. (Speaking in a soft tone.)

Closure:

Director - How does the situation look now, Rose?

Rose - Much better. I know there are some good doctors out there, I just happened to get the monster doctor.

Director - Do you think you can go to another doctor for treatment?

Rose - (With firm voice.) I know I can now.

Director - Okay, let's all exchange how we felt throughout the production. What were you feeling? (The insight is shared for 10-15 minutes, then a closing ritual may be performed.)

Director - As we get ready to say good-bye, let us join hands as we form a circle and each one state a positive feeling that describes you at this moment. I'll start with "Hope" ...

Future Projection

Projecting into the future and using guided fantasy, in conjunction

with using breathing relaxation and hypnodrama, helps one to ease regrets of missed moments as well as allay fears. Often regrets of, "If only I had" or "If only I could" enter as troubling thoughts.

Thoughts of, "Why didn't I" or "I'll never be able to" haunt a dying patient. Acting out daydreams and/or inducing a hypnotic state with guided fantasy can further a cathartic state. Studies indicate that with the "controlled use of fantasy and imagery in the relaxed state of inward focused attention, a person is able to bring out material that they need to acknowledge and deal with" (Anderson, 1980, p.41).

Fantasy centering is particularly useful for children with terminal

illness, as has been previously noted.

In using future projection or guided fantasy techniques, it is advisable to reinforce the idea that the patient is always in control, this is also true when using hypnodrama. All three techniques need a quiet setting with a soothing, slow voiced dramatist to set a relaxed mood. The dramatist has the patient concentrate on breathing exercises and vocal directions. To relax the patient the dramatist "talks" the patient into a deep relaxed state and mental imagery is introduced in order to bring about behavior change.

Guided Fantasy Scenario

June is a 50 year old patient with congestive heart failure. She has always envisioned a trip to Hawaii. Her plans were for a trip at the end of her child's college career. June's illness intervened and now, in the terminal stage of illness, she realizes her dream will not be fulfilled. The patient is remorseful and indicates a desire to participate in a fantasy trip.

Dramatist - (Slow and measured) June, it is time for you to go on your trip to Hawaii. This trip will be one of fun and relaxation. There will be no tiring activities and you will be in control. Close your eyes as you lie comfortably in your hospital bed. I want you to think of your mind as a blank TV screen. You have control of the channels, and the off and on switch. You are in control to make anything happen on that screen that you like. You may find new ways to explore your feelings and your inner actions. Relax. I want you to take a big deep breath and hold it for 3 counts then exhale. Remember what feeling you have as you breathe out, as that is the important feeling of relaxation that you should develop. (Go into breathing exercise for about 5 minutes.) As you release your breath you find a calmness coming over your body and you become more relaxed. Let your body float on top of the bed. Relax.

Dramatist - Pauses, then continues.

As you relax, I want you to visualize on the mental TV screen a happy home situation that you enjoy and that gives you a feeling of contentment. I shall pause for a few minutes while you imagine yourself in your home. (Pause). Now I want you to get prepared for your trip. I want you to tell your loved ones about going on a trip to Hawaii and you can take anyone along.

Talk over your plans with those you love and make the arrangements. Now I want you to start packing for your trip. (Pause) If your attention wanders, don't be alarmed. Just come back to packing as soon as you can. You are feeling relaxed and happy. (Pause) It is the day of your trip and you are boarding the plane. You have been on a plane before so you are relaxed and having a fun time talking to those boarding. As you settle in your seat you feel the anticipation and excitement from the passengers. The mood is exhilarating. The time goes swiftly, dinner is over and it is landing time. As you disembark, you are greeted by Hawaiians singing, dancing and placing leis on the passengers. Everyone is wearing bright and colorful clothing and there is a feeling of festivity in the air. The weather is mild, a warm breeze envelopes you and holds you as you smell the scent of the orchid lei around your neck. It is time to get into the taxi and go to the hotel. (Pause) At the hotel you don't have to sign in as it is all taken care of and the bell boy takes your luggage immediately to your room. (Pause) You are alone or with those who may have accompanied you and you plan to get into swim wear to lie on the beach and sun. The trip has been long so the sun-fun on the beach will be welcomed. You are in your swim wear and relaxing on the beach. (Pause) You are enjoying those around you and the beautiful view of Diamond Head. You will remain on the beach feeling warm, comfortable, relaxed, and in control of yourself. You can do anything on the beach that you desire and as you are finding yourself in control at the beach I will leave you for a few minutes, so you can enjoy Hawaii. (Pause) Now it is time for you to return to the hotel to rest. Tomorrow we will meet again and go to the Polynesian Cultural Center, but for now you will take a few minutes to relax in your hotel suite before coming back to the hospital. (Pause) You are ready to return and you carry with you the relaxed feeling, the happy feeling, and the anticipation of returning tomorrow for a sightseeing tour. And as you slowly feel your body come to attention, you may wish to stretch as you mentally re-enter your hospital room. You may open your eyes when you feel you want to leave the inner scene. (Pause) (Re-entry must be gradual, ending with shared feelings). Now that your eyes are open we can talk over your feelings while on the trip. Were you able to relax? What feelings did you take with you? Etc. End with a counseling interview.

Overcoming Fears

One of the most helpful psychodrama techniques for the terminally ill is the use of hypnodrama to overcome fears. It is in a relaxed state that fears, doubt and suspicions due to change, treatment or degradation

can be met. Neutralizing fears through repeated and directed positive suggestion frees a patient to enter into an enactment for final catharsis. Realizing one's fears enables a patient to actualize the final moments of life with inner calm and independence so necessary at a time when dependence on others takes over the external life.

Hypnodrama Scenario

The counselor interviews the patient for details of the fear that need treatment. The patient is asked as to time, place, thoughts, feelings, and circumstances that set up the fear. The patient is then relaxed as in the future projection technique and induced into a hypnotic trance by concentrating attention on an object and the voice of the counselor. After the induction and deep relaxation is obtained, the patient is instructed to clearly and vividly imagine the scene that makes one happy and relaxed. After that scene is held by the patient for a few minutes, the counselor goes to another scene with the same calm, relaxed reinforcement as the fear is introduced. If the patient is distressed he should be instructed to raise a finger. If a finger is raised, the scene is removed for a safe retreat. If not, the fear is enacted through mental pictures while the patient is in a relaxed state. After the fear scene is finished, by the suggestions of the counselor, the patient is taken to another safe and comfortable spot through imagery. As the patient is slowly awakened by counting, one is instructed to remember the calm relaxed feeling that can be used on command. When the patient is fully awake, the feelings and mental imagery is shared and acted out as in regular psychodrama.

Letting Go - Saying Good-Bye

Perhaps the most crucial part of dying for the patient and bereaved is the letting go process. Throughout a life time there are many letting-go processes that one should rehearse for this part. However, the human heart clings to the attachments made with fierce determination and hope. Hospitalized patients have been "extracted" from their home environment from which familiar persons, objects and events are removed and replaced by alien environment. The acting out through role rever-

sal, soliloquy, and role playing with the aid of a double help reconcile the inner transition. This is an area in which the social atom can respond through supportive doubling as the professional atom takes on the new role of establishing a tele communication.

Role Playing Scenario for Letting-Go.

(Cards are presented to players in a simulated situation.)

Care Giver - Your patient is a forty-five year old business executive who has always been in control and self-sufficient. He has been suffering from diarrhea, weight loss and pain in the sacral region. The case has been diagnosed as advanced carcinoma of the colon. You are to tell him about the condition. He must be hospitalized and chances are he will not return home. You must prepare him for letting go and finalizing business arrangements.

Patient - You are a forty-five year old business executive, married with two children, a son age 16, and a daughter age 10. Your business has kept you involved with management control of thirty people and heavy civic obligations. You are highly organized and need to maintain order and control of your life. You are resistant to the diagnosis even though you are in pain, with blood in the stool and diarrhea. Your weight loss has made you tire easily but you resist rest. Your primary concerns are with business affairs and family welfare.

Dying and Death Scene - Termination of life.

To enact the dying and death scene is generally of more value to the bereaved as many people feel they cannot face a loved one dying or as a dead body. This enactment allows one to vent feelings, while at the same time find the spontaneity necessary to be adaptive to the situation. Acting out the scene helps free inner constraints and fears so one can spontaneously express true feelings throughout the dying process. The regrets and self-recriminations over not having said all that one feels or being uncomfortable in the presence of dying are overcome. Positive thoughts and actions that have been established in

psychodrama enable all to participate in the final dying enactment with optimum adaptive responses that allows one to die in an individual way with worth and dignity.

Role Playing Scenario Final Scene

Patient - You are a thirty-five year old man whose wife is in a terminal stage of illness. You are unable to face the problem of final arrangements with the funeral director or funeral services. It is difficult for you to talk with your wife without breaking down. You are seeking help.

Counselor - Directs the husband to do a role reversal as his wife seeing him the last time. Then directs the husband in rehearsing the trip to the funeral home, making arrangements, attending the funeral and cemetery rites.

In Summary: (Diagram V)

How can the use of Psychodrama make death more tolerable? In the final enactment, the self-dramatist, creator, having played out one's part spontaneously finds the self-worth and dignity through moment to moment creativity. The ideal objective of psychodrama is fulfilled by engaging a total production of life by creating more reality than living permits. It is in playing one's part, in creating each moment of life and in playing to that moment, that one confronts death. The challenge then becomes for the dying, to give to each moment the most creativity possible. The spontaneous self creates, through enactments of problem situations, an extended dimension to life and a self-expansion through insightful performances. It readily becomes apparent that one can fixate on many aspects of life, and death becomes a prime focus. To overcome the fixations of life, psychodrama can be a therapeutic avenue for the action oriented counselor to bring into reality

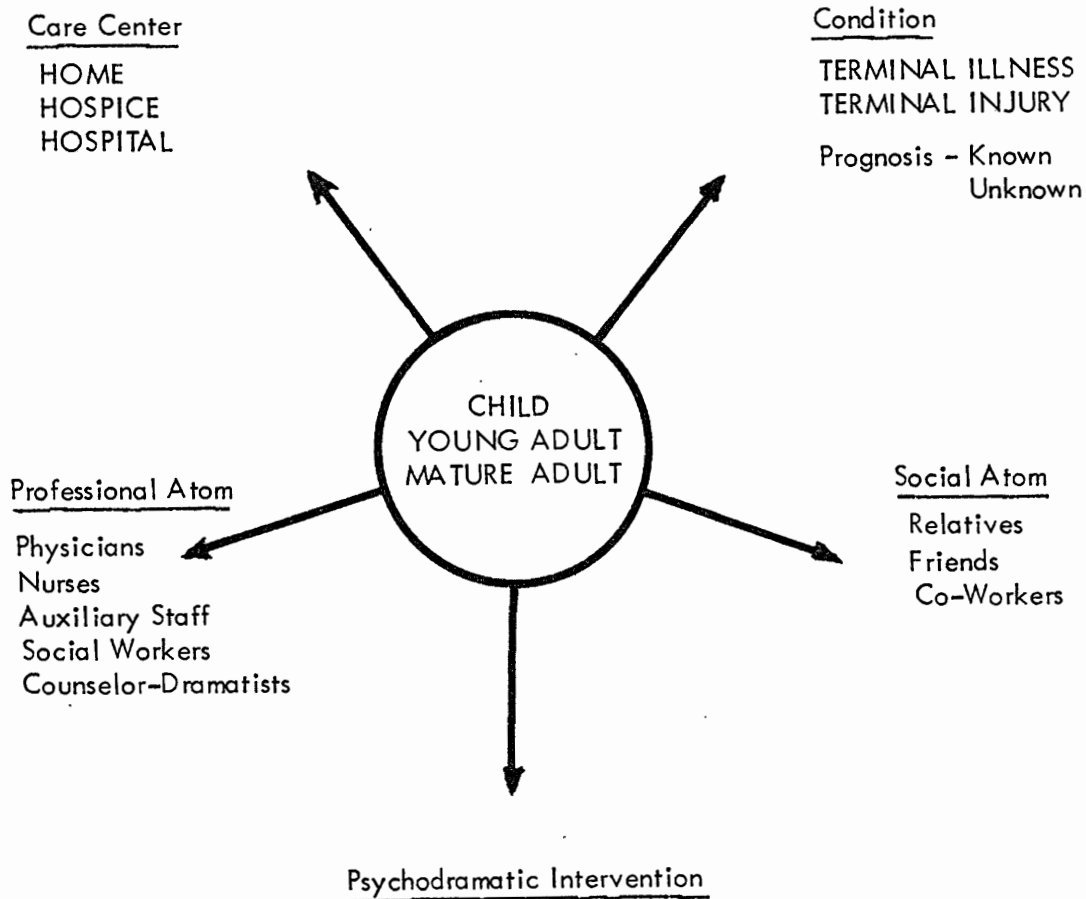
the transitions necessary to face life when dying.

In Conclusion:

Diagram V pulls together the psychodramatic and terminal illness network in showing the multiple interacting forces upon the terminal patient. The problems posed for the terminal patient throughout the phases of dying may be expressed through psychodramatic intervention as in scenario enactments of:

- (1) Adjustment Living;
- (2) Making Amends;
- (3) Overcoming Fears
- (4) Future Projection;
- (5) Letting Go, Saying Good-Bye; and
- (6) Dying and Death Scene, Terminating Life.

DIAGRAM V
 PSYCHODRAMATIC AND TERMINAL ILLNESS NETWORK



SCENARIOS

ADJUSTMENT LIVING

(Loss of part-Loss of function)

MAKING AMENDS

(Correcting Life)

OVERCOMING FEARS

(Psychological Suffering)

FUTURE PROJECTION

(Fantasy - Escapism)

LETTING GO, Saying Good-Bye

(Separation Grief)

DYING AND DEATH

(Final Scene Enactment)

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APPENDIX

APPENDIX A

AMERICAN BOARD OF EXAMINERS
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PSYCHODRAMA, SOCIOMETRY AND GROUP PSYCHOTHERAPY
A not-for-profit organization incorporated in the District of Columbia

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CERTIFICATION IN PSYCHODRAMA
SOCIOMETRY AND GROUP PSYCHOTHERAPY

(Certification by Examination and Submission
of Credentials)

PRACTITIONER LEVEL CERTIFICATION REQUIREMENTS

1. A minimum of 780 hours of training by a Board certified Trainer, Educator and Practitioner
2. One year of supervised experience
3. Graduate degree in field relevant to candidates area of practice from an accredited university. Or an acceptable equivalent to the graduate degree.
4. Two TEP sponsors who will attest to the candidate's professional competency. A third reference from a professional in the candidate's area of practice.
5. Appropriate professional memberships, activities, publications.
6. Written examination
7. Direct observation of candidate's work by a TEP delegated by the Board. (The observer will not be the candidate's primary trainer.)

TRAINER EDUCATOR, PRACTITIONER LEVEL CERTIFICATION REQUIREMENTS

1. Candidate must have prior certification at practitioner level.
2. Three years of progressively responsible, supervised training and education experience in psychodrama, sociometry and group psychotherapy after receiving practitioner certification.
EXCEPTION: Individuals who were grandparented as certified practitioners will need three years of such experience beyond that experience which was credited toward their certification as practitioners.
3. Candidate will design, implement and evaluate a training program under close TEP supervision.
4. Direct observation, by a TEP designated by the Board of Examiners, of a training session conducted by the candidate.
5. Professional community evaluation of the candidate.
6. Written examination
7. Appropriate professional memberships, activities, publications.

Application forms will be available in September 1980. If you wish an application please send your name and address to the address below.

direct communication to: 39 East 20th Street, 9th floor New York City, N.Y. 10003
212-260-3860 (after 1:00 PM)

I'D PICK MORE DAISIES

If I had my life to live over, I'd pick more daisies. I'd try to make more mistakes next time. I would be sillier than I had been this trip. I would limber up. I know very few things I would take seriously. I would take more trips, travel lighter. I would be crazier. I would be less hygenic. I would take more chances. I would climb more mountains, swim more rivers and watch more sunsets. I would eat more ice cream and less beans. I would have more actual troubles and fewer imaginary ones.

You see I am one of those people who live practically and sensibly and sanely, hour after hour, day after day ... Oh, I have my mad moments and if I had it to do over again, I'd have more of them. In fact, I'd try to have nothing else. Just moments, one after another, instead of living so many minutes ahead. I have been one of those people who never go anywhere without a road map, a thermometer, a hot water bottle, a gargle, and a raincoat.

If I had my life to live over, I would start barefooted earlier in the Spring and stay that way later in the Fall. I'd play hookey more. I would do more water and sun-fun things. I'd turn more somersaults and roll in the grass and go barefoot all over.

If I had my life to live over, I'd spend more time at fun places. I'd try to be more in touch with my Maker and those I love. I'd pray aloud more and not care what people think or expect of me. I'd give more of me and take more of you. I'd just be me more and more...

...Yes, I'd pick more daisies next time. ---Author Unknown