View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

Coll. Antropol. **35** (2011) 1: 173–179
Original scientific paper

Clinical and No-Clinical Setting Specificities in First Session Short-Term Psychotherapy Psychodrama Group

Aleksandra Mindoljević Drakulić

University of Zagreb, Faculty of Teacher Education, Zagreb, Croatia

ABSTRACT

Modern history of short-term group psychotherapy dates back to the late 1950-ies. From then to present day, this psychotherapeutic method has been used in various forms, from dynamic-oriented to cognitive behavioural psychotherapies. Although it has always been considered rather controversial, due its cost-effectiveness, it has been capturing more and more popularity. This paper presents the specificities of first session short-term psychotherapy psychodrama group through session work with two examined groups: a group of 20 adult women who suffer from mild or moderate forms of unipolar depression and a group of 20 students of the School of Medicine in Zagreb without any psychiatric symptomatology. The results indicate the high importance of having structure in first psychodrama session, of relating it with the previously thoroughly conducted, initial, clinical, interviews, and of the clarity and focus in terms of determining the goals of therapy, especially in a clinical context. This study also confirmed assumptions regarding the need for different approaches of warming-up in psychodrama, both in the clinical and in non-clinical samples. A psychodrama psychotherapist should have good time managing skills and capability to convert the time available into an opportunity for directly boosting the group energy and work on therapeutic alliance.

Key words: *first session, short-term psychotherapy psychodrama group*

Introduction

Modern history of group psychotherapy can primarily span back to the first psychotherapy experiences during and after First and Second World War. However, it wasn't before the mid 1970-ies, therefore decades after, that the first forms of short-term group psychotherapy started being widely used by mental health institutions. During the last decades, short-term psychotherapy has constantly been up against scepticism of psychotherapists and their clients, about whether it's sufficiently effective. Nevertheless, this is how it actually gained its recognition[1].

The well-known American psychiatrist Milton Hyland Erickson (1901–1980) answered the philosophical question of whether short-term psychotherapy is a tautology or an oxymoron, by stating: »Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of an individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behaviour«[2].

The modern history of short-term group psychotherapy began in late 1950-ies. It was a time of first attempts in treating large groups with that form of psychotherapy. This health project was described by the American author Helen Avnet in 1959. The aim of the program was to investigate the effect of short group psychotherapy treatment in relation to emotional problems of patients. The study included 1115 patients of whom the majority (80% of them) had neurotic disorders. The therapeutic work also involved over a thousand psychiatrists. Some of them were doubtful of the expected outcome of therapy. However, despite the prejudices about the inefficiency of short-term group psychotherapy, the results did override the initial negative expectations. Improvement was achieved by 76% of the treated patients, and 81% of the patients maintained the same mental state for one or two years more after the treatment. It was one of the most important short-term group psychotherapy treatment

Received for publication January 3, 2011

programs as it served as an incentive for inclusion of such programs into the »classical« psychiatric programs used at the time[3].

At the same time the English psychoanalyst Michael Balint (1896–1970) was treating patients with short-term group psychotherapy in the Tavistock Clinic in London. With a team of seven doctors and fellow nurses, he used a brief dynamic or focal psychotherapy on 21 patients. Balint would determine the patient's so-called focal point through verbalisation. He would refer to it interpretatively, focusing on the therapy and selectively ignoring everything that was not directly related to the focal issue. The criteria for joining his group were patients' intrinsic and high motivation for treatment as well as an increase of motivation after trial interpretations during initial interviews. He also took into account that the patient should have the ability to achieve lasting object relations[4].

Short-term group psychotherapy has been used in a variety of forms for many years now, and it was in the last decade of the 20th century that its popularity significantly increased. The reason mainly lies in the constant increase of health care costs, sometimes even up to 3 times higher than living costs, which is the case in the United States. In the late 1980-ies the U.S. insurance companies and employers introduced special health care programs based on short-term psychotherapeutic procedures in order to halt inflation and cost growth. So therefore, short group psychotherapy became not only cost-effective but also extremely popular[5]. In scientific literature there are many examples of effectiveness in treating various forms of disorder with short-term group psychotherapy, from the dynamically-oriented to cognitive behavioural. Thus, the Swedesh author Ost and his associates (2001) investigated 45 patients who suffered from claustrophobia. A random selection of patients was divided into 4 groups: one group was subjected to only one psychotherapy session, the other group went to a total of five sessions, the third group was subjected to cognitive-behavioural therapy of also 5 sessions and the fourth group was on a waiting list for psychotherapy. It resulted in all three treatments were equally successful, and that among them there weren't any significant discrepancies[6]. Two years later, in 2003, Stiles, an American author and his associates compared the effectiveness of the initial stages of cognitive-behavioural psychotherapy in depressed patients. Among 135 patients with depression who also had various other psychiatric disorders, similar positive results were delivered in the first few sessions of treatment with different short-term psychotherapeutic modalities. From the 135 patients, 23 of them who felt an improvement at the beginning felt the same at the end short-term group psychotherapy[7]. These results indicate the importance of the first session of short-term group psychotherapy as well as of the specifics that need to be followed right from the beginning of therapy in order to for it to be successful. That's why many group psychotherapists today go to the extent of assuming it's enough to use the so-called single-session psychotherapy. This type of psychotherapy is more commonly used in the modern world, just as time-consuming »marathon-encounter« groups were big in the 1960's[8].

According to data from available literature, initial interviews (which are normally used for group candidate selection) appear as one-hour single-sessions of psychotherapy. Accordingly, in 2004 the British authors McCambridge and Strange questioned the efficacy of one-hour single-session psychotherapy among young drug users of psychoactive substances (age 16 to 20). It turned out that as many as 179 young people out of 200 in comparison with the control group, significantly reduced cannabis, cigarette and alcohol use[9].

In an American study by Russell and his co-authors in 2008, 54 depressed adolescents were subjected to short-term cognitive-behavioural group psychotherapy. The authors detected 14 different behaviour forms of the therapists in the first session due to which the subsequent therapies were successful. The success of therapy is owed to, as the authors emphasize: experiential socialization, therapist lapse, remoralization and therapist responsiveness[10]. These results imply the importance of clear time structuring and short-term goals of group psychotherapy (especially the initial part of therapy and first session) and the importance of a specific, supportive relationship of the psychotherapist and group members. Psychodrama as an action form group psychotherapy is also being used more often in its short form, both in clinical and in non-clinical context.

Chris Farmer, modern psychodramatist emphasizes plasticity and flexibility of group psychodrama in clinical and non-clinical use. It is believed that there is no significant difference in the conduct of the two sessions, but there are some specificities. Psychodrama with depressive patients, according to Farmer, may seem a bit slower with a slower pace warm-up in comparison to psychotherapy with a non-clinical sample. Sometimes it happens that depressed patients have difficulty in deliberate mood shifting or in strengthening their emotional insight. He also explained that they have more difficulty to relax and require more time to build the necessary spontaneity and creativity, than in the case of working with non-clinical samples. Farmer mentioned another specificity in psychodrama when working with the depressed: only a small number of group members tend to volunteer to be a potential protagonist. What can surely restore strength in therapy is the role change technique by which the protagonist who suffers from depression can easily connect to their own inner state of sadness, loss or grief[11]. Due to all the above mentioned, in short-term psychodrama groups with persons suffering from depression it is crucial to structure the first session, especially the warm-up in order to build a strong and empathic therapeutic alliance. Building a strong and positive relationship with the therapist will also strengthen the transfer relations, which may help to further progress in psychodrama psychotherapy, correction of inadequate thinking and behavioural patterns and boost pleasure sources of people with depression.

Materials and Methods

Respondents

The sample consisted of two groups:

- 20 ambulatory female patients from the Department of Psychiatry at the Zagreb University Hospital Center with a diagnosis of mild or moderate depressive disorder, characterized by a first and recurrent depressive episode (DSM IV) and
- 20 female students from the School of Medicine in Zagreb (no psychiatric symptomatology).

The study involved women only, for the sake of sample homogeneity and the established facts about the existence of gender differences in prevalence and clinical manifestations of depressive symptomatology. Therefore, in their research paper from 2002, Croatian author Šagud and his associates explained that the epidemiology of depression indicated that women have a significantly higher risk for developing depressive disorders than men, with a ratio of 2:1[12].

The final selection of candidates was achieved through previous research. After being notified about the »Psychopathology« course lectures at the Medical School of Zagreb it was explained to them that in a month's time, psychodrama-psychotherapy group sessions would start, and that all interested students could sign up by e-mailing the psychodrama group leader. In the letter they had to indicate their general personal data and briefly explain the reasons (motivation) for signing-up.

Concurrently, the ambulatory patients who were attending the day hospital were also personally informed about the groups being formed. Apart from the psychodrama group leader, they could have left their data with the psychiatrist who was personally in charge of them. The psychodrama group leader called all the respondents, students and ambulatory patients, for an initial interview. A total of 75 semi-structured, extensive question based interviews were held with all the potential group members. Interviews were taking place in the same order as the women had signed up. The duration of each interview was approximately 1 hour and a half. All throughout the interviews as well as afterwards, the author was writing down the respondents' answers in a special protocol.

Also, all required anamnestic data was collected as well as all available information on early development and the overall current personal, family and professional life of the women.

The multiple objectives of the interviews were: to develop preliminary confidence and the so-called alliance between the group leader and potential members, to determine how patients independently requested to improve satisfaction with their own life, to discover if there were any sources of pleasure in their life and what these were, to give clear guidelines about the study, to assess eligibility and the initial (intrinsic) motivation for joining the group in order to avoid or minimize any potential dropping-out or giving up and re-confirm the existence of depression symptoms listed in DSM IV diagnostic system (for ambulatory patient group).

The basic criteria for entry into psychodrama psychotherapy group for both subjects (students and patients) were: intrinsic motivation for treatment, the possibility of establishing satisfactory interpersonal communication relations in groups, the chance to experience group empathy, group environment tolerance and group policies, the absence of acute depressive symptomatology, absence of acute suicidal thoughts and absence of psychotic features.

An important criterion for ambulatory patients' entry in the psychodrama group was to have previously completed group psychotherapy at the Day Hospital – Department of Psychiatry.

Procedure

Interviews were organized throughout one month's time, every day of the week in order to avoid a long waiting period from the first interview of the first reported group member to the beginning of the first psychodrama session. During the interview, the respondents were given specified start and end dates of the therapy. During the interview, the respondents had a chance to get all the necessary information on what to expect from psychodrama and a psychodrama setting. After the interview, according to the entry criteria, it was the patients who had started attending the short-term psychodrama therapy that were accepted. The respondents were divided into two groups.

Each group consisted of 20 members, meaning that a total of 40 patients participated. After the groups had been formed and before the start of intense psychodrama work (right before the first psychodrama session), members of both groups filled out the required questionnaires: a notified consent for research (Respondent's notice) and an assent document. The meeting with the two candidate groups was an opportunity to once again go over the research objectives. They were also each given a respondent's notice. In addition, they were reminded of all the rules of the psychodrama group: the discretion principle in the group and goodwill. Both groups filled out the questionnaires separately.

The groups already had a pre-determined setting (the organisation): regular sessions twice a week, on the same days of the week, at the same time and in the same room.

Descriptive statistics

The age range of female students who had joined the group was from 19 to 28. The average student age was 23. The age range of ambulatory patients ranged from 25 to 65, and the average age was 37.

As far as their educational status, most of the students were mainly in their third-year of university (13 students), ranging from first to sixth year, while 6 patients were ambulatory with a university degree, 4 were graduates of various faculties, and 10 had a high school

diploma (shopkeepers, accountants, laboratory assistants, administrators, etc.).

There was only one (single) mother with a six-year old child in the student group. The rest of them lived with their parents. In the patient group, 11 of them were mothers and 9 of them were either married or in a cohabitating relationship (one of them had an adopted child). Three were divorced single mothers, of which the oldest among them had a grandson. The remaining 9 members of the group had no children and were either married or in a cohabiting relationship (four members), living with their parents (four members) or alone (one member of the group).

Results

In this paper we tried to find and discuss the specificities of first session short-term group psychotherapy – psychodrama in relation to clinical and non-clinical settings. During the initial interview, the student group did not show signs of psychiatric symptomatology, nor a particularly strong internal motivation for group attendance. The group of women with mild to moderate unipolar depression showed a significantly higher level of motivation for attending and most of them had previously been scarred with negative and traumatic family experience in early childhood. Both groups had relatively weak potential for coping with stress, but with enough capacity to participate in the intensive short-term group psychodrama. As for the expectations of attending therapy, the student group had higher expectations in terms of wanting to gain better self- adjustment, the desire to build and trust their own strength, more self- confidence, a better overall image of themselves and a clearer understanding of others. A part of the students also had more specific goals such as achieving cessation of conflicts in communication with parents and / or siblings, to reduce shyness in interpersonal relations, to establish their first mature heterosexual partnerships, to reduce their own »aggressive« outbursts, etc. Expectations of the other group (ambulatory female patients) were much more modest and they didn't ask for any ready made help »recipes».

The expectations were primarily related to gaining experience of unity, friendship and connection, reducing feelings of loneliness and getting help in finding the meaning of life after having gone through depression. The latter group showed a lower degree of ambivalence to start therapy and they had less expectations of the therapist. As some of the members from both groups had been interviewed by the psychodrama leader a month before the group sessions started, with Christmas and New Year holidays in between, the leader sent them another notice of the group start date.

Overview of the first session of short-term psychotherapy psychodrama group with female students

From a total of 20 students, three were absent from the first session. Two were sick and one called in to say she'd come next week. One of them didn't turn up nor previously justify her nonattendance. One student was 5 minutes late and apologized. The group started on time upon my warm welcome and going over the basic group rules, the agenda, goals and other organisational matters. The group was notoriously excited. I encouraged the members to introduce themselves within the circle and briefly explain their motives (reasons) for joining the group. After that, they were asked stand up and do some physical warming up with various types of non-verbal greetings in order to relax, get acquainted with the area and the group, as well as to welcome spontaneity. The group performance was full of cheerful movements such as; jumping, screaming, laughing, hugging, kissing, shaking hands or even crawling, and it appeared that the vast majority enjoyed this way of reducing stage fright. The group members presented themselves in the so-called Gibberish language in order to enhance the emotional state they were in and to pay more attention to the nonverbal communication and behaviour. Afterwards, the group was placed in a circle and they briefly shared impressions from the ice-breaker warm-up, which then inspired the group to be creative. I then asked them to imagine and form a line which represented the following questions: »How keen am I on going through the psychodrama therapy« and »To what extent would I like to be the first protagonist and break the ice«.

The student I (28) who arrived late volunteered to be the first of potential protagonist. Two more followed right after, D. (23) and F. (25). The first session of psychodrama now had three potential protagonists.

D. wanted to work on the subject of recent breakup with her boyfriend, and the group had just chosen that same topic. D. was visibly frightened and sad because of the breakup. She was on the edge of tears, but refrained. We performed a short 1-scene psychodrama vignette. I asked the protagonist to play the role of her former boyfriend. D. presented him as a man who wasn't very outspoken, who was calm and self-confident. I suggested that once she was ready, she told him in form of surplus reality, everything that she didn't have a chance to say before. D. said: »Although I miss you, I will not falter and I will hold my ground.« At that point it became more and more challenging for the protagonist, so she left the scene. I told her to imagine that she only had a minute more to talk to him, in which she had to say goodbye. I asked her: »How would you do this?« D. once again turned to her ex-boyfriend and said: »I feel like crying, I would love to hug you but then I'd fall apart.« When I asked whether she wanted to hear his response, the protagonist stated that she didn't want to. She hugged him in the end.

The group shared their feelings with the protagonist non-verbally and all of them spontaneously came to the scene to give D. a hug. During this sharing Đ. started to cry and said how the story reminded her of her greatest forbidden love. She told the group »I have to tell you that I joined the group mainly because of these topics.« E. also remembered the breakup with her boyfriend half a year earlier. D. mentioned her relationship, which came to a

natural end after 7 years and L. was reminded of all the painful breakups that she had experienced so far. The student who was the last to share her feelings with the group was a young single mother. G said: »I feel so confused because of all the protagonist's expressed feelings I could relate to in such short time.« The group was left bemused at the time of parting.

Overview of the first session of short-term psychotherapy psychodrama group with female patients

All 20 group members arrived on time. Some had even arrived about 30 minutes before and waited at the door before the group leader came. I had opened the door half an hour before the session started and let the members in who had arrived early. Some of the members helped me set up the chairs in a circle. We started on time. After the welcoming, we discussed the general principles of psychodrama, organisational issues, the discretion principle and importance of goodwill in psychodrama. I invited the group members to introduce themselves and mention the reasons why they came. They were very direct while speaking, synthesizing the most important details without concealing or distorting the overall experience. They didn't feel the need to be liked as much as the other group and they were more successful in dealing with the initial stage fright and uncertainty. Upon my call, the group members got up from their chairs and presented themselves by name and body movement, which the rest of the members were mirroring. The warm-up was running slow, as some of the members needed more time to memorise all the names. The body movements for getting to know one another were sluggish and occasional yawning could be heard, but nevertheless a sensation of a cooperative and positive attitude was felt.

The group briefly commented on this type of warming-up and I asked them for feedback on what they'd do if they were the protagonists in the first psychodrama session. After a short moment of silence, three prospective members responded: D. (47), MS. (45) and M. (42).

D. wanted to find out what impression the others had of her as she couldn't identify herself through the mirroring she was receiving from the other members after her presentation. M.S. wanted to work on her sense of guilt for not being with her daughter at the moment, and M. wanted to demonstrate a dream in which she was climbing stairs and continuously feeling nausea. The great majority of the group chose M.

In the discussion M. mentioned that the dream reminded her of having to go back to work soon. She didn't know if she'd be able tolerate such stress and face her female boss so she felt nauseated. I asked what she'd like to gain through this group therapy and M. recalled an important situation that had happened recently. M. revealed that several months ago, she had learned about her son's illness, which had left her completely heartbroken. As she hadn't come across any understanding at her company, she was now concerned about going back to work. I asked her how she was feeling to which she responded: »Even now as we speak, my heart is pounding heavily.«

After revealing this event which really disturbed the protagonist all over again, we first started going through the process that had remained in her, as a consequence of surviving these life scenes. I asked her to get back into the role of her pounding heart and verbalise the current sensations in the heart area. So M. proceeded as she was told and soon after started feeling overwhelmed by fear. A feeling of being trapped appeared, she felt a lump in the throat and her breathing became shallow and rapid. I placed her in the role of overwhelming fear. Therefore, as the fear, M. started walking around herself, i.e. around her auxiliary ego. I encouraged her to maintain the role of her own fear and to loudly express her thoughts. M. began to act as the fear and ominously communicate with the auxiliary ego »I am clutching you and making you completely powerless«. I'm your constant life companion. You cannot escape from me. At this point there was a change of roles. M. went back to the role of herself, and she chose a fuller body member to play the role of fear and at the same time loudly commented: »This fear is an immense wall that imprisons me and doesn't allow me to do anything.« An enactment followed in which, M. bravely coped with fear, began to cry and crossed her arms. I asked her what was happening, and M. remembered at that point, a suicide attempt by reckless driving and passing through a red light. It was several months ago. On the same day she sought help at the Crisis Situations Centre and her husband and 5-year old daughter accompanied her to this first time visit to a psychiatrist.

We left the scene in which she was surrounded by fear. We discussed how these symptoms were associated with the events she told us about. I suggested that she act out some of the parts she described. M. decided on the scene in which she was in the waiting room at the Crisis Centre, with her husband and daughter waiting for the doctor. At the end of the waiting room there were two tall and strong paramedics as well as two alcoholics in delirium also waiting for their turn. The atmosphere was described as obscure, and I asked her to set the scene. Shortly after M. vocalised all the participants of action but she spent the most time in role of her daughter. In the daughter's role, the protagonist started to cry and vent out her feeling of guilt: »My mother doesn't notice me, as if I'm not there. What's the matter with my mother? I want my mom to be alright! I'm sad about it all. I wish we could all just go home and watch cartoons together.«

I asked if somebody could help her in this situation. The protagonist in the role of her daughter replied: »No, no one.« The situation looked hopeless and the group kept monitoring the scene events with a pretty strong emotional charge.

I set M. aside so that she could view the overall situation in the mirroring. Another enactment of the waiting room followed, while M. observed and listened to the soliloquies of all the auxilliary-egos. I suggested that she change the situation and that she create in psychodrama

what did not actually occur in the waiting room. M. was then determined and ready to take her daughter's hand and place it between her and the father. As if it were a clay sculpture, the protagonist silently took the hand of her daughter and placed it in her dad's hand. She gently grasped her other hand. All three were holding hands and her daughter was sitting in the waiting room between them. There was a big rush of emotion and the protagonist silently looked at her daughter with great warmth. I let this nonverbal moment happen and suggested that she tell her daughter everything she failed to say in reality. The protagonist cried out: »Do not be afraid Mirta. Everything will be fine. Mom will be fine. We'll all be fine.«

In the final part of the so-called psychodrama session sharing, many emotions were shared with the protagonist. Group member K. was reminded of her sister taking care of her completely disabled son. M.S. declared that she felt guilty for not being with her child anymore, especially since she found out that she was sick, while in the role of the protagonist's daughter she felt protected and safe as a baby. B.G. said she felt fulfilled and happy seeing a mother and daughter holding hands in the final scene. L.J. shared a situation from a time when she was acutely depressed and all of her time was spent lying in bed. Then her five-year old adopted daughter, whose biological parents had died, said: »Fuck, don't you die on me too!« The group laughed with a sign of relief. K. S. also opened up and whilst crying about her feeling of being a failure as a mother and quietly mentioned attempting murder of her 20-year old son. B.L. was angry because of the eternally imposed image of a perfect mother, the almost saint type role-model, and added: »We all know that it's far from the truth.« The group parted in a strange bond but without any difficulty.

Discussion

Even during the interviews before the start of group sessions, the students had a lot more fantasies about the potential dangers that would »creep up« in the first session. They inquired as to whether they could drop-out if they didn't like group therapy or if it became too difficult. Also, they wanted to know if they would be »forced« to act if they didn't want to.

Even though all their inquiries were answered, the initial psychodrama meeting was perceived with mixed feelings: on the one hand a desire to participate, on the other, intense fear. The fear was luckily quickly alleviated with ice-breaking warm-up games and current events in the group. They also commented on feelings of shyness, fear of public speaking, the fear of exposure in front of the group. In the patients group, these same topics were entirely lacking, however they looked for more similarity amongst each other than the students.

While the student group warm-up had a lively and active tone to it, the warming up of the patients was counter-effective. Generally in psychodrama but especially in the short-term groups, it's important to give clear instructions for warming up. For example, if group members cannot hear what the leader is saying, or if the information is confusing, it can trigger resistance that can even go to the extent of the leader being excommunicated by the group members[13]. As far as the topic selection, there was also a visible discrepancy between the groups. The student group was more prone to topics related to the libido, while the patient group inclined more to self-destruction. As many of the patients in the group experienced early trauma, one of the offered topics to work with (in case of patient D) was a paradigmatic situation that tends to happen in the initial stages of group development in a clinical setting. The topic of member D was related to identity issues, such us seeking approval, acceptance and gaining respect. This is a fundamental issue when entering group therapy: Members normally assess each other, search for their »sustainable« role and ask themselves whether they will be accepted or rejected. This is why they feel a certain amount of dependency, which manifests itself in various ways. Therefore, a few (technical) questions were addressed to the leader in the patient group, before the warm-up games. The Questions were addressed so that the »omnipotent«, »omniscient« group leader who »takes care of everyone« could respond to them and reduce the anxiety amongst the group members as well as infuse additional hope. Although the questions weren't answered directly by exchanging roles with the leader of psychodrama, some important fantasies were revealed, which the group member had in the moment of »here and now« about herself and others.

In the first session of short-term group psychodrama it's extremely important to build a good therapeutic alliance. It is a much greater priority to focus on the goals of therapy, classify them, as well as to be a good and active time manager, than in the case of groups of unlimited duration. However, realistic expectations about the outcomes of therapy should be taken into account.

When asked about the expectations in psychodrama, patient KS responded: »This meeting was enough for me to recognise how important it is what I am telling you and to see that someone cares about me.«

This illustrative example shows how the initial interview can affect the future course of psychotherapy even before first session. This is especially important when it comes to short-term psychotherapy. The research done by Marcolino and Lacoponi in Great Britain (2003) implied similar results. Depressive patients who had felt the existence of an empathic therapeutic alliance during the first session, significantly reduced symptoms of depression by the end of the short-term psychodynamic psychotherapy[14]. Group psychodrama psychotherapists must be prepared to put in extra effort when selecting different psychodrama techniques and encourage the group members to understand their condition, which could later on in the sessions lead to improvements/shifts in viewing life. As a limited time frame can act as an energiser of the group, shortness of time is surely an advantage rather than a disadvantage.

Furthermore, in our case it proved to be important to try to externalize the self-destructive tendencies, to concretise their tyrannical, haunting aspects of the scene, but without the sadistic venting aggression towards others. The issue of safety and borders must also be clearly defined, whereby it is important that a member of the group feels free enough to openly work through the conflict. This means that in the externalisation of painful topics (self-aggression, fear, etc.) the psychodrama group should be included and used as a container.

Conclusion

Psychodrama addresses the present-day experience of depression, its context and its origin. Attention flows back and forth in scenes examining these three areas of inquiry, until the protagonist acquires the spontaneity to find new roles to replace old ones, re-edit previous narratives of life and create an area of new possibilities in the future. The results indicate the high importance of having structure in first psychodrama session, of relating it with the previously thoroughly conducted, initial, clinical, interviews, and of the clarity and focus in terms of determining the goals of therapy, especially in a clinical context. This study also confirmed assumptions regarding the need for different approaches of warming-up in psychodrama, both in the clinical and in non-clinical samples. A psychodrama psychotherapist should have good time managing skills and capability to convert the time available into an opportunity for directly boosting the group energy and work on therapeutic alliance.

As the founder of psychodrama Jacob Levy Moreno said (1946): »The moment of birth is the maximum degree of warming up to the spontaneous act of being born into a new setting, to which he must make a rapid adjustment«[15].

REFERENCES

1. FUHRIMAN A, BURLINGAME GM, Handbook of group psychotherapy-an empirical and clinical sythesis (John Wiley, New York, 1994). — 2. ZEIG JK, GILLIGAN SG, Brief therapy-myths, methods and metaphors (Routledge, New York, 2009). — 3. KOVAČEVIĆ K, Specificities of initial and terminal phase of the short-term psychotherapy of neurosis. PhD Thesis. In Croat (University of Zagreb, Zagreb, 1980). — 4. BRITVIĆ D, Evaluation of effectiveness of psychodynamic group psychotherapy in war veterans with chronic posttraumatic stress disorder. PhD Thesis. In Croat (University of Zagreb, Zagreb, 2006). — 5. LIEBENLUFT E, TASMAN A, GREEN SA, Less time to do more-psychotherapy on the short-term inpatient unit (American Psychiatric Press, Washington, 2005). — 6. OST LG, ALM T, BRANDBERG M, BREITHOLTZ E, Behav Res Ther, 39 (2001) 167. — 7. STILES WB, LEACH C, BARKHAM M, LUCOCK M, IVESON S, SHAPIRO DA, IVESON M, HARDY GE, J Consult Clin Psychol, 71 (2003) 14. — 8. GRUDEN V, Psychotherapy-basics of psychotherapy (Medicinska naklada, Zagreb, 1992). — 9. McCAMBRIDGE J, STRANG J, Addiction, 99 (2004) 39. — 10. RUSSELL R, SHRIK S, JUNGBLUTH N, Psychother Res, 18 (2008) 15. — 11. FARMER C, The psychodramatic treatment of depression. In: KARP M, HOLMES P, BRADSHAW-TAUVON K (Eds) The handbook of psychodrama (Routledge, London, 1998). — 12. ŠAGUD M, HOTUJAC LJ, MIHALJEVIĆ-PELEŠ A, JAKOVLJEVIĆ M, Coll Antropol, 26 (2002) 149. — 13. TAYLOR S, The warm-up. In: KARP M, HOLMES P, BRADSHAW-TAUVON K (Eds) The handbook of psychodrama (Routledge, London, 1998). — 14. MARCOLINO JAM, JACOPONI E, Rev Bras Psiquiatr, 25 (2003) 78. — 15. MORENO JL, Psychodrama (Beacon House, New York, 1946).

A. Mindoljević Drakulić

University of Zagreb, Faculty of Teacher Education, Savska 77, 10 000 Zagreb, Croatia
e-mail: aleksandra.mindoljevic@ufzg.hr

SPECIFIČNOSTI KLINIČKOG I NEKLINIČKOG SETTINGA PRVE SEANSE KRATKOTRAJNE GRUPNE PSIHOTERAPIJE – PSIHODRAME

SAŽETAK

Suvremena povijest kratkotrajne grupne psihoterapije datira od konca 50-ih godina prošloga stoljeća. Otada pa do današnjih dana ta se psihoterapijska metoda rabi u različitim formama od dinamski orjenntrirane psihoterapije, do kognitivno bihevioralne. Iako kontinuirano osporavana, zbog svoje ekonomičnosti bilježi sve veću popularnost. U ovom su se radu nastojale razmotriti specifičnosti prve seanse kratkotrajne grupne psihoterapije – psihodrame u radu s dvjema skapinama ispitanika: grupom 20 odraslih žena koje boluju od blagog ili umjerenog oblika unipolarne depresije te grupom 20 studentica Medicinskog fakulteta Zagreb bez psihijatrijske simptomatologije. Rezultati upućuju na iznimnu važnost strukturiranja prve psihodramske seanse, povezivanja iste s prethodno temeljito provedenim kliničkim, inicijalnim intervjuom te na jasnoću i fokusiranost u smislu određivanja ciljeva terapije, što se posebice odnosi na klinički kontekst. Ovim su se prikazom potvrdile i pretpostavke o nužnosti različitih pristupa u psihodramskom zagrijavanju, kako u kliničkom tako i u nekliničkom uzorku. Psihodramski psihoterapeut treba biti dobar menadžer vremena i vrijeme na raspolaganju pretvoriti u prednost za izravnije energiziranje grupe i rad na terapijskoj alijansi.