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DIAGNOSIS IN PSYCHODRAMA?

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Hominum discrimen, people differ.

Yes, it goes without saying. But how do we delineate the differences? What kind of nosology, or diagnostic classification system, if any, would best suit psychodrama? Does diagnostic evaluations help or hinder psychodrama treatment?

Traditionally, diagnosis in psychotherapy consists of a clinical description of a patient based on symptom clusters, distinguishing various mental disturbances according to a descriptive and atheoretical approach. Most commonly, clinicians employ the terminology used in the diagnostic and statistical manual of mental disorders prepared by the American Psychiatric Association, recently released in a fourth version (DSM-IV; 1994), or the classification of mental and behavioral disorders published by the World Health Organization (ICD-I0; 1993).

It is my experience that psychodramatists usually feel uncomfortable with such a standard nosological system. While it may be useful in many clinical settings, such a disease-oriented system seems inadequate within the methodological framework of psychodrama. It simply makes little difference to most psyehodramatists if a protagonist is diagnosed as suffering from depression, anxiety, paranoia or a personality disorder. They will not conduct the session much differently for any of the se disorders, nor will the diagnosis be utilised for its prognostic or etiological value. As a consequence, it is rare for psychodramatists to evaluate presumptive clients through preliminary intake interviews, engage in history taking and administer psychological tests prior to treatment (though many practitioners in fact do some pre-group evaluations to determine group suitability). The information gathered by the more elaborate procedures, they say, is unnecessary because relevant clinical data will anyway by revealed during the psychodrama itself.

This rejection of diagnosis started with J .L. Moreno who simply did not believe in labels (Zerka Moreno, 1994, p. 42). Though psychodrama itself was described by Moreno (1972) as “a method of diagnosis as well as a method of treatment (p. 177), he always felt strongly against using the ideology underlying psychiatric formulations and instead offered a new way of looking at human suffering which was based on health rather than on pathology (Bustos, 1994, p. 69). Yalom (1975) shared this view, finding psychiatric diagnosis spectacularly useless as an indicator of interpersonal behavior (p. 243) in a group setting. Subsequently, contemporary psychodramatists continue to protest against the portrayal of human beings as a collection of static traits and propose instead that people should be viewed as emerging in a dynamic and unpredictable manner. Psychiatric disorders, they say, are the product of social forces that operate upon people in a self-fulfilling manner. The individual who is labeled and treated as if he or she is disturbed, increasingly becomes more disturbed and later permanently adopts the role of mentally ill. They tend to agree with Thomas Szasz that mental illness, as described by clinical psychiatry, is an illusory myth, and in

order to prevent bias, they prefer to be happily ignorant about their participants' psychiatric labels before commencing treatment.

Instead, some psychodramatists prefer to view symptoms as part of the natural expression of feelings within a general system. Like some family therapists, they prefer to “re-frame” or “re-label” a disturbing behavior into a functional and “healthy” one, instead of reinforcing its divergent expression. For example, a mute boy may be praised for his ability to speak without words. In this way, positive labeling becomes a part of therapy in terms of the various roles distributed within a family system, and within the system of the group-as-a-whole. As feelings in one family or group member reverberate the feelings of the other members, any clinical description of one single individual would be a simplification and reduction of the complex and multi-dimensional levels of actual bio-physiological-emotional-cognitive-social systems. These are all well-known arguments against the uses and abuses of clinical psychiatric nosology. A complete abandonment, however, of all diagnostic evaluations in psychodrama, might have serious negative consequences. Most importantly, it prevents any preliminary evaluation regarding the suitability of candidates for psychodrama therapy, precluding comparative outcome research, thus making it impossible to establish the specific indications for psychodrama as compared to other treatment modalities.

Further, whether we like it or not, as psychodramatists we are regularly involved in some process of clinical assessment of protagonists. Is this protagonist happy or sad? Is he suicidal? Or psychotic? Should he be hospitalized? Could he gain something from a psychodrama session? Though seldom outspoken, those questions frequently arise and they demand immediate answers.
In all such instances, categorization is inevitable and diagnosis becomes invaluable in making behavior seem less complex. Abstaining to give a name to our observations, or avoiding to view them as pathological, does not interrupt our natural tendency to personality judgment, nor does such relinquishment of assessment make the ailment less disturbing for the protagonist or bring us closer to finding a suitable remedy for them. The mute boy naturally needs to be correctly evaluated prior to the initiation of a suitable treatment plan.

Furthermore, without some differentiation and classification of the people involved, even the most basic conclusions of when and with whom to use psychodrama would be impossible. As third-party payers have become increasingly concerned with the cost-effectiveness and accountability of mental health treatments, the lack of any assessment places psychodrama outside the reach of major patient populations. By refusing to use a standardized and generally accepted nomenclature, psychodramatists unwittingly isolate themselves from the mental health establishment and academia and indirectly obstruct the cumulative progress of knowledge that may be achieved only in cooperation with these institutions. This separates psychodrama from the rest of psychiatry, and prevents it both to draw knowledge from and to contribute to it, and as a result, the growth of the profession at large is retarded. I therefore hold that some diagnostic evaluation is imperative for the proper utilization and development of psychodrama therapy. Clinical raw data must be arranged in a way which is suitable and understandable both for psychodramatists and for the outside world. Naturally, such diagnoses should be used not merely for the sake of labeling people, but to provide prognostic information, as well as clues for the director regarding possible strategic interventions. Clearly, it should make a difference if a protagonist is

diagnosed as suffering from, for example, depression, anxiety, paranoia, or a personality disorder and the psychodramatist should of course conduct the session differently for each of these disorders, if at all accepting the patient to psychodrama treatment in the first place.

Unfortunately however, many psychodramatists have little knowledge of normal and abnormal psychology and are often insufficiently prepared to apply techniques differently to various protagonists who may need symptom reduction, crisis intervention, conflict resolution, personality change, or anything else that may help them go on with their lives in a more satisfying manner (Kellermann, 1992). It is my experience that psychiatric or psycho-social evaluation is essential in this work; both for clinical convenience and for research purposes. The question is, what kind of nosology, or diagnostic classification system would best suit psychodrama?

What kinds of labels would suit a method of psychotherapy that deals with universal and often normative life events, as well as with crises and traumatic events, which, according to Yablonsky (1976), tend to reflect and chronicle in an understandable microcosmic form the problems and conflicts that masses of people are experiencing its the macrocosm of the society (p. 42)?

Which diagnoses can relevantly reflect the kinds of re-enactments of problematic situations that is so characteristic to psychodrama? Unfortunately, the concepts of personality developed by J.L. Moreno, describing people according to their role repertoire, their conserved or flee-floating spontaneity, their sociometric position within a social atom, and for their tele position with others, seem to be largely insufficient for this purpose. The fact that psychodrama does not directly focus on deviant behavior, which easily can be translated into clinical entities, makes the classification process even more complicated. Psychodrama contrary wise deals with human dilemmas that poets and novelists write about; with love's ecstasy, the pain of death, a woman alone in an apartment building with a bottle of whiskey, a young girl contemplating abortion, a boy finding out that he was adopted, a man standing next to the grave of his dead son who was killed in war. Psychodrama focuses on the active exploration of experiences in school, in the family, with friends, at the working place, and in society at large, in order to learn better, for example, how to choose a career or a spouse, how to deal with failures and separations, how to bring up children and how to let them go and how to adjust to the multitude of difficult strains of every-day life. How is it possible to label these predicaments with a standardized classification system without loosing their essential and unique human qualities? Shortly, what diagnostic system would be suitable for a therapeutic approach that is tuned in on people coping with traumatic life-events rather than on various manifestations of psychopathology? The following three criteria seem to be required in a sound psychodrama tic nosology.

First, such an evaluation system should take into account, not only the individual person in isolation, but the entire situation at hand, viewing each symptom as a reaction pattern to environmental stress.

Second, by incorporating both a protagonist's adaptive abilities and the expectations, challenges, opportunities, constraints and resources of the social environment, the evaluation should make for an assessment of the total person-situation-interaction.

Finally, from a theoretical point of view, any such diagnostic system which deals with adjustment to situations, coping with stress and mastering developmental tasks, should all draw heavily on either inter-actional psychology, ego psychology, stress theory, life cycle theory or general systems theory of personality, or on a combination of these, which in my view corresponds well to the integrative position of JL. Moreno.

While there is yet no diagnostic system which perfectly suits psychodrama, it is my proposion that we adopt the diagnostic and statistical manual of the American Psychiatric Association (DSM-IV) as a diagnostic, prognostic and screening device for psychodrama. It seems to me that the DSM-IV presently seems to fulfill most of the above mentioned required criteria, and it is also standardized, comprehensive, atheoretical, practical and widely used. Most importantly however, as a multiaxial diagnostic system, attention is given not only to a wide variety of common mental (Axis I), personality (Axis II) and physical (Axis III) disorders, but also to aspects of the environment (Axis IV) and of functioning (Axis V) that might be overlooked if the focus were on assessing only a single presenting problem. The specific focus on person-situation-interaction within psychodrama, make axes IV (severity of psycho-social stressor) and V (global assessment of functioning - GAF) especially relevant.

Furthermore, it is my experience that some of the V codes for conditions not attributable to a mental disorder that are a focus of treatment, make up the bulk of problems dealt with in psychodrama, and they can be mentioned on Axis I instead of, or in addition to, a mental disorder. Such condition include, for example, mourning and bereavement (the perhaps most common issue in classical psychodrama), phase of life problems or other life circumstances, problems with going to school separation from parental control starting a new career, marriage, divorce, retirement, marital problem, parent-child problem, family circumstances, sibling rivalry, or some other interpersonal problem. Finally, the GAF (measuring overall severity of psychiatric disturbance, or ego strength) may be a good help in group composition, according to Yalom's (1975) recommendation to keep this selection criteria (in contrast with many others) fairly homogeneous. In sum, though additional information may become necessary for a full personality assessment for psychodrama therapy, the DSM-IV may provide a good basis for a suitable diagnostic system for psychodrama, helping to integrate this method further into mainstream psychotherapy and psychiatry.

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Footnote

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