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Chapter 20

Studies on treatment effects of psychodrama psychotherapy

Michael Wieser

Introduction

Psychodrama as psychotherapy is based on theories of spontaneity, creativity and action. It is probably due to this association that the study of psychodrama's effectiveness, in a controlled and more rigid academic way, has been neglected. Consequently, psychodrama psychotherapy, despite being one of the first recognized psychotherapies, still has a relatively tentative status in the scientific fields of psychology, psychiatry and psychotherapy. Systematic research will provide us with answers with regard to which treatment effect can be associated with which research method and type of measurement.

In this area of investigation, there is documentation in Germany (Burmeister *et al.* n.d.), but there are problems in matching the mainstream standards in evidence-based psychotherapy. The same is true in Switzerland, in the meta-analysis developed by Grawe *et al.* (1994). (Meta-analysis is where existing studies in treatment effectiveness are systematically compared; Wieser 2006a.) Similar studies, conducted outside German-speaking countries (Kipper 1978; Schramski and Harvey 1983; Kellermann 1987; Greenberg *et al.* 1994; Kipper and Ritchie 2003; Elliott *et al.* 2004) also point to problems with research design.

Psychodrama psychotherapy has been accredited by the government and social insurance systems in Austria (Ottomeyer and Wieser 1996), in Hungary (Pintér 2001), and by the European Association of Psychotherapy (Wieser *et al.* 2005). However, the scientific status of psychodrama psychotherapy has not yet been recognised by the scientific community at large, since studies done in this field seem to have failed to attain mainstream standards. Nevertheless, a closer analysis of studies on the treatment effects of psychodrama therapy should be carried out on the background of *ICD-10* to identify the constraints of research encountered in this field and to suggest possible avenues for future research. *ICD-10* stands for the *International Classification of Diseases, Version 10*, produced by the World Health Organization (1992). Chapter F00–99 covers mental and

behavioural disorders. This classification is negotiated and agreed worldwide, is culturally sensitive, and insurance systems often ask for diagnoses that reference it.

The aim of this chapter is to explore the kinds of statistical evidence that we have for the effectiveness of psychodrama psychotherapy. This involves a survey and description of existing studies into the effectiveness of psychodrama psychotherapy, shaped as a narrative literature review. A collection of research papers has been grouped according to the systematic categories of *ICD-10*. The analysis is based on statistically significant results regarding the treatment effects of psychodrama therapy.

Sample characteristics

The sample consists of a wide variety of papers retrieved from PsycINFO (American Psychological Association) and PsyNDEX (University of Trier, Germany), and other databases in English and German, going back several decades. These studies are concerned with different aspects of investigation into treatment effectiveness within the field of psychodrama psychotherapy.

The selection process of the sample was not based on a particular topic of investigation, such as age (children, youths, adults, elderly patients), type of disorder (acute to chronic), treatment program (inpatients, outpatients, prisoners), setting (individual, couple, family, group) or length of treatment (one session, weekend, marathon, long term).

The sample also includes comparative studies. These compare psychodrama psychotherapy with other psychotherapeutic methods and pharmaceutical therapy as well as outcome studies (where the main interest lies in the difference between the beginning and end of psychotherapy) and process research (where every single session is of interest). Investigations of cost efficiency analyses are not known in this field at the moment.

Some studies included in this sample do not use measuring instruments that would satisfy high standards. At the very least, studies included here must include a systematic self-report or measurement of interpersonal relations by means of sociometry. Drop-out rate in psychotherapy and research should be noticed and reflected, but was not part of the selection criteria for studies reported here. In addition, most of the subjects/patients must have a diagnosis included in *ICD-10* (as opposed to self-referral where there is no diagnosis). Psychodramatists do not typically use a manualized approach as some cognitive behaviour therapists do, so there is no requirement for manualized treatment for studies to be included here. The studies included here are both published and unpublished, e.g., as a manuscript. All together, there are 52 studies included. Eight studies are randomized clinical trials, 14 are controlled studies, and 30 are naturalistic studies.

Method of description

In order to broaden the scope of research, the description involves classification of the studies according to the research method. Three main categories were used. The first consists of those studies which follow the 'gold standard' of the randomized clinical trial. In studies in this category, two groups of patients are chosen at random. Typically, one group is given psychotherapeutic treatment while the other, for example, has to wait.

The second category comprises studies using controlled methods. For example, a psychotherapy group may be compared with a non-treated group.

A third group is made up of naturalistic studies, which investigate patients in normal psychotherapeutic practice. Single case studies are a subgroup of naturalistic studies. They must be systematic in some way and controlled by a qualitative or quantitative method. One of the disadvantages in analyzing single case studies is that they do not lend themselves to statistical testing, since the study is only done on one particular subject.

Comparative studies may be thought of as a subgroup of randomized clinical trials, or controlled or naturalistic studies, depending on their area of focus.

All of the above groups include 'pre- and post' measures (at the beginning and end of treatment) and some include a follow-up (for example, one year after treatment).

In analyzing the effectiveness of psychodrama psychotherapy in each study, the approach in this chapter is to look for positive statistical significance and not for effect sizes. A standard procedure to obtain statistical evidence on effectiveness is through the counting of effect sizes (ES). The parameter is normally set as ES>0.5. However, this procedure poses a problem with this parameter, because not all studies provide necessary information on areas such as change, the scale used, population (n), mean (m) and standard deviation (s_d). This data would be measured before treatment (pre), post-treatment, possibly in a follow-up, and at the same time in a non-treated control group. (Effect size is expressed as: $ES = m_t - m_c / s_{dc}$, where t = treatment and c = control.) Qualitative studies have mostly been excluded because they do not allow for rigorous statistical testing. This does not mean that qualitative studies (Kipper and Hundal 2003) are not scientific. Nevertheless, if psychodrama psychotherapy is to be accredited by states, social and health insurance agencies, and professional and scientific associations, it must use mainstream standards of measurement.

Results

Where studies have found statistically significant effects, these are marked with asterisks (one, two or three according the significance level). In order to have a criterion for what is evidence of treatment effectiveness, there

should be at least one study according to each main category of research methods and classification of disorders.

Organic, including symptomatic, mental disorders (ICD-10 F00–F09)

To date, no studies have been reviewed.

Mental and behavioral disorders due to psychoactive substance abuse (ICD-10 F10–F19)

Four studies report positive results for adults and two of them also for youths (Waniczek *et al.* 2005; Wood *et al.* 1979). The research design is mostly naturalistic (see Table 20.1).

Comment

Mental and behavioral disorders due to psychoactive substance abuse can be treated successfully with psychodrama therapy, as reported by eight statistically significant results. Randomized and controlled clinical studies should be added.

Schizophrenia, schizotypal and delusional disorders (ICD-10 F20–F29)

Four of five studies have good results, even with chronic schizophrenics and people with delusions who are in short-term psychodrama psychotherapy (see Table 20.2).

Comment

Peters and Jones (1951) is one of the pioneer studies. Normally, 1952 is known as the beginning of controlled psychotherapy research. Schizophrenia, schizotypal and delusional disorders are well evaluated by five statistically significant results for psychodrama therapy, and overall support the use of psychodrama with these disorders. A better randomized clinical trial could follow. Under mixed groups of disorders, research has been done by Bender *et al.* (1979, 1981), where schizophrenia and delusion are among the main disorders.

Mood (affective) disorders (ICD-10 F30–F39)

Three studies with good results have been reported in this field (see Table 20.3).

Table 20.1 ICD-10 F10–F19 mental and behavioral disorders due to psychoactive substance abuse

Study	*Research method*	*Measure*	*Findings*
Mann and Janis (1968)	Controlled trial, follow-up (2 weeks, 18 months)	Questionnaire, interview	Less cigarette consumption after emotional role playing* ($p<0.05$, probability of error in percent)
Wood *et al.* (1979)	Comparative with small group therapy; matched with a similar group who did not do psychodrama	Comrey Personality Scales	More trust*, emotional stability*, and activity*
		Mini Mult (short form of MMPI, Minnesota Multiphasic Personality Inventory)	More defensive** and controlled** ($p<0.01$ (better than $p<0.05$))
		State-Trait Anxiety Inventory (A-State Scale)	Statistically not significant (n.s.)
Crawford (1989)	Naturalistic, post; follow-up (2 years)	Questionnaire	Great satisfaction with psychodrama led to good alcohol/drug status*
Waniczek *et al.* (2005)	Naturalistic; retrospective follow-up (1–4 years); comparison group	EBIS-A-sheet (EinrichtungsBezogenes Information System); SEDOS-inquiry-sheet (Stationäres Einrichtungsbezogenes DokumentationsSystem)	Abstinence rate of 72.9%, high general satisfaction of life**

Table 20.2 ICD-10 F20–F29 schizophrenia, schizotypal and delusional disorders

Study	*Research method*	*Measure*	*Findings*
Sturm and Stuart (1974)	Randomized clinical trial; psychodrama-based role retraining and remotivation group; self-created control group (treatment early terminators); pre-test	Tape recordings, observers; Inpatient Presentableness Scale, raters	No changes in feelings, happiness, thoughts, plans of the five most regressed patients on each unit
Peters and Jones (1951)	Controlled trial	Porteus Maze Test Ages	Difference in the post scores of qualitative errors**
		Mirror-Tracing Test	Improvement
		Rorschach	No report
		Draw-a-Person Test	No report
		Gardner Behavior Chart	No report
Jones and Peters (1952)	Controlled trial	Qualitative Maze scores	Ratio of between groups variance to within groups variance**
		Mirror Tracing Test	Improvement*
		Gardner Behavior Chart	Improvement*
		Rorschach Test	N.s.
		Draw-a-Man Test	In favour of the control group
		Picture Sorting Test	Increase of affective reactions
Harrow (1952)	Controlled trial, post	Role (action) test	Scale of realism*
		Rorschach Test	Improvement
		MAPS (Make-a-Picture Story Test)	Improvement
Parrish (1959)	Naturalistic	Ward observed and rated the behavior	Improvement
		Counted the amount of patients ready to leave hospital	Improvement

Table 20.3 ICD-10 F30–F39 mood (affective) disorders

Study	*Research method*	*Measure*	*Findings*
Pour Rezaeian *et al.* (1997a)	Randomized clinical trial	BDI (Beck Depression Inventory)	Better than a psychiatric group**; not different from a combination group
		MMPI	No report
Pour Rezaeian *et al.* (1997b)	Controlled trial	SLSCT (Sentence Completion Test)	Better than the psychiatric group**; equal with the combination group
Ernst *et al.* (1980)	Naturalistic	Questionnaire	Sociometric choices increased**; well-being improved

Comment

Mood (affective) disorders are effectively treated with psychodrama therapy, as shown by three statistically significant results. More studies need to be done to emphasize the scientific effectiveness. It is worth noting that Pour Rezaeian *et al.* (1997a, b) investigated only mild depression and Ernst *et al.* (1980) was not focused in particular on the kind of disorder.

Neurotic, stress-related and somatoform disorders (ICD-10 *F40–F48*)

In a total of ten studies, more positive than negative results are reported (see Table 20.4).

Comment

Neurotic, stress-related and somatoform disorders are the best validated area for psychodrama therapy, with 23 positive statistical significances. Under mixed groups of disorders, you will find neurosis as well, especially in Bender *et al.* (1979, 1981).

Behavioral syndromes associated with physiological disturbances and physical factors (ICD-10 *F50–F59*)

To date, no studies have been reviewed.

Disorders of adult personality and behavior (ICD-10 *F60–F69*)

To date, no studies have been reviewed.

Mental retardation (ICD-10 *F70–F79*)

Two studies report positive results but are more a kind of social pedagogical psychodrama (see Table 20.5).

Comment

Psychodrama has beneficial effects for people with mental retardation, but more studies have to be done to emphasize the scientific effectiveness of psychodrama psychotherapy.

Disorders of psychological development (ICD-10 *F80–F89*)

To date, no studies have been reviewed.

Table 20.4 ICD-10 F40–F48 neurotic, stress-related and somatoform disorders

Study	*Research method*	*Measure*	*Findings*
Lapierre *et al.* (1973)	Randomized clinical trial; double-blind (researchers do not know if the patient gets psychotherapy or not. Even the patients do not know. Placebo is, for example, a talking group without a psychotherapeutic aim); matched	Wittenborn Rating Scale; Eysenck Personality Inventory; Ad-hoc scale	Mesoridazine (drug) group as compared with the placebo group had less pronounced affective involvement in psychodrama psychotherapy*
Kipper and Giladi (1978)	Randomized clinical trial	STABS (Suinn Test Anxiety Behavior Scale)	Improvement*** ($p<0.001$); equally effective as systematic desensitization
		EPI-N scale (Neuroticism Scale of Eysenck Personality Inventory)	N.s. (normal range from the beginning)
		Background information form	
Bendorf *et al.* (1976)	Controlled trial, follow-up (3–6 months)	FPI (Freiburg Personality Inventory)	Nervousness**, depression**, sociability**, self-consciousness**, extraversion*, emotional unstableness* and masculinity*
		Well Being Scale (Zerssen)	A normal population (post)
		Interview, rating scale	
Arn *et al.* (1989)	Controlled trial, pre-post, follow-up (three months, three years)	Symptom questionnaire	Decrease of worry and tension*
Eibach (1980)	Naturalistic; qualitative case study	Questionnaire	After two years no further somatization in the whole group

continues overleaf

Table 20.4 Continued

Study	*Research method*	*Measure*	*Findings*
Newburger (1987)	Naturalistic; follow-up (7 months)	Therapist rating	All ten patients symptom free (post); Eight of ten symptom free (follow-up)
Schneider-Düker (1989)	Naturalistic, comparative	SYMLOG (System for the Multiple Level Observation of Groups)	More difficult for psychotherapy groups to enrich the role repertoires
Thorell *et al.* (1998)	Naturalistic; pre-post; follow-up (half year, four years)	Self rating	In art therapy, anxiety-depression improved
		General Health Questionnaire	Improved*
		Blood test in serum uric acid	Psychodrama worse than other kind of art therapy*
Hudgins *et al.* (2000)	Naturalistic; single case study; follow-up (six weeks)	Videotape, evaluator	
		DES (Dissociative Experience Scale)	Improvement**
		TSI (Trauma Symptom Inventory)	Improvement**
		BDI	Improvement*
		BSQ (Body Sensation Questionnaire)	Improvement*
		Narrative writing	No report
Lind *et al.* (2006)	Naturalistic; psychodrama and psychodynamic imaginative trauma therapy; pre-post; follow-up	BSI	Decrease in symptoms**; GSI pre-post $g = 2.2$, pre-follow-up $g = 2.28$ (very strong effect)
		Emotional and Behavioural Changes in Psychotherapy Questionnaire (VEV)	Improvement**

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Table 20.5 ICD-10 F70–F79 mental retardation

Study	*Research method*	*Measure*	*Findings*
Strain (1975)	Naturalistic	Observer, raters	Sociodrama led to more engagement in social play afterwards
Amesberger *et al.* (1993)	Naturalistic	Observer	Improvements in personality development and conflict solution

Table 20.6 ICD-10 F90–F98 behavioral emotional disorders with onset usually occurring in childhood or adolescence

Study	*Research method*	*Measure*	*Findings*
Gelcer (1978)	Randomized clinical trial	RTT (Role Taking Task)	Improvement with role play**
		BSAG-School (Bristol Social Adjustments Guide)	Improvement*
Dequine and Pearson-Davis (1983)	Controlled trial	Norwicki-Strickland Personal Reaction Survey; interview	With drama therapy, more internal control*

Behavioral emotional disorders with onset usually occurring in childhood or adolescence (ICD-10 F90–F98)

Two studies report positive results with techniques related to psychodrama psychotherapy (see Table 20.6).

Comment

Behavioral emotional disorders with onset usually occurring in childhood or adolescence are effectively treated with role play and drama therapy (techniques related to psychodrama), as shown by three statistical significances. More studies have to be done to emphasize the scientific effectiveness of psychodrama psychotherapy.

Mixed groups of disorders

Ten studies report more positive results, and two additional studies report effectiveness in individual modality. Steffan (2000) compares psychodrama

psychotherapy with integrative psychotherapy, Anbeh and Tschuschke (2001) with group analysis and Tschuschke and Anbeh (2000) with eclectic psychotherapy (see Table 20.7).

Comment

In psychotherapeutic practice, most patients have mixed disorders and not just one. That is why it is important to report results in this field of research. The effectiveness of psychodrama psychotherapy is shown by 20 positive statistical significances.

Area of disorder unknown

Seventeen studies were included with more positive results. Three investigated the psychodramatic double technique. Petzold (1979) is concerned with elderly people, and two other studies deal with youths (see Table 20.8).

Comment

A lot of controlled and naturalistic studies are a kind of basic research. Due to length restriction, there will be no detailed description in this paper.

Conclusion

In the area of organic, including symptomatic, mental disorders (F0), behavioral syndromes associated with physiological disturbances (F5), disorders of adult personality and behavior (F6), and disorders of psychological development (F8), there is still a need for basic research into the effectiveness of psychodrama therapy (see Table 20.9).

In the studies described above, there is a wide variety of measurement techniques. However, it should be noticed that some of those tests were written 50 years ago, and different ways of measuring may be in use today. There is a strong need for a consensus on the kind of measurement instruments that apply best to psychodrama, which would allow us to compare psychodrama studies with each other and even with other psychotherapeutic methods. This is a key task of the psychodrama research group of the International Association of Group Psychotherapy (IAGP), which is working to improve the quality of psychodrama research. Kellar *et al.* (2002), Kipper and Hundal (2005) and Christoforou and Kipper (2006) have developed instruments to measure spontaneity which investigate an important part of psychodrama theory. Independent of a psychotherapeutic method, the Brief Symptom Inventory (BSI, Derogatis 1993) is used in different languages.

Table 20.7 Mixed groups of disorders

Study	*Research method*	*Measure*	*Findings*
Bender et al. (1979)	Randomized clinical trial; follow-up (9, 10, 22 weeks)	AMDP (Working Group for Methods and Documentation in Psychiatry)	Decrease pre-post*
		MMPI	Paranoia and schizoid*
		SAF (Social Adjustment Questionnaire)	In the whole and in the scale leisure*
		EWL (Adjective List)	Emotional irritation*
		Giessen Questionnaire	Social power (for neurosis)
Carpenter and Sandberg (1985)	Controlled trial	Jessness Asocial Index	Reduction between and within subjects**
		High School Personality Questionnaire	Ego strength between subjects and pre to post-test**
		I-E (Introversion-Extraversion) Scale	Became more introverted**
Bender *et al.* (1981)	Naturalistic; comparative, pre-post; process, follow-up (three months)	MMPI	N.s.
		EWL	Well-being* (neurotics); worsening* (psychotics)
		Bf-S (Well-Being Scale)	N.s.
		SAF (Social Adjustment Questionnaire)	N.s.
		Giessen Questionnaire	Amenability*
		FPI	N.s.
		AMDP 3	Psychopathology*
		Goal Attainment Scoring (100mm line)	N.s.
		Therapy Assessment Scale	N.s.
		Video-recording and questionnaire	Protagonist improvement*

continues overleaf

Table 20.7 Continued

Study	*Research method*	*Measure*	*Findings*
Herfurth (1999)	Naturalistic; follow-up (one to three years)	Problem-centred interview	Improvement
		Questionnaire	Transfer problems
		Context journal	Goals of the clinic attained
		Role play	No report
Lemke (1999)	Naturalistic; follow-up	Problem-centred interview	Improvement in therapy success (coping strategies, competency in perception, broadening the room for action)
Petzold *et al.* (n.d.)	Naturalistic; pre-post, process; follow-up (six months)	GSI-SCL-90R (Global Severity Index – Symptom Check List)	ES=0.63
		IIP-C (Inventory of Interpersonal Problems, short form)	ES=0.11
		Therapist questionnaire	Improvement
		Therapy assessment scale	Improvement
		Client questionnaire	Improvement
		Relations questionnaire	Improvement
		Session questionnaire	No report
Steffan (2000)	Naturalistic; comparative, pre-post process follow-up (six months)	Therapist questionnaire	Improvement
		Client questionnaire	Improvement
		GSI-SCL-90R	ES=0.39
		IIP-C	ES=0.52
		Therapy assessment scale	Improvement
		Relations questionnaire	Improvement
		Session questionnaire	No report
Tschuschke and Anbeh (2000)	Naturalistic; comparative, pre-post	IIP	N.s., ES=0.22
		GSI-SCL-90R	Improvements, ES=0.2
		Therapy Goal Attainment Scale	Improvements, ES=0.9
		GAF (Global Assessment of Functioning Scale)	Improvements, ES=0.44
Anbeh and Tschuschke (2001)	Naturalistic; comparative, pre-post	IIP	ES=0.57**** ($p<0.0001$)
		GSI-SCL-90R	ES=0.66****
		Therapy Goal Attainment Scale	ES=2.32****
		GAF	ES=1.28****
Tschuschke and Anbeh (2004)	Naturalistic; pre-post	IIP	ES=0.47****
		GSI-SCL-90R	ES=0.55****
		Therapy Goal Attainment Scale	ES=1.55****
		GAF	ES=1.18****
			Mean ES=0.94

Table 20.8 Area of disorder unknown

Study	*Research method*	*Measure*	*Findings*
Kipper and Ben-Ely (1979)	Randomized clinical trial	Modified Accurate Empathic Scale	After a role-playing procedure, differences***
Hudgins and Kiesler (1987)	Randomized clinical trial	IMI (Impact Message Inventory)	Effects***, positive impacts; higher level in revealingness**
		RI (Relationship Inventory)	Higher empathic understanding**; interviewer statements got more accurate*
		REV (Revealingness Scale)	Higher scores**
Culbertson (1957) Schönke (1975) Petzold (1979) Schramski *et al.* (1984) Joyce *et al.* (n.d.)	Controlled trial		
Toeman (1948) O'Connell and Hanson (1970) Ploeger *et al.* (1972) Enke (1984) Schmidt (1980) Ernst (1989) Geßmann (1994, 1995) Baim *et al.* (1999)	Naturalistic		

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Table 20.9 Overview: studies on treatment effects of psychodrama psychotherapy

ICD-10	*Method*			*Findings*		
	RCT	*CT*	*Naturalistic*	*Negative*	*Equal*	*Positive*
F00–09						
F10–19		2	2		1	8
F20–29	1	3	1		9	5
F30–39	1	1	1		3	3
F40–48	2	2	6	1	4	23
F50–59						
F60–69						
F70–79		2			2	
F80–89						
F90–98	1	1				3
Mixed	1	1	8		11	20

Note: RCT = randomized clinical trial; CT = controlled trial

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Appendix

Moreno's basic concepts

Adam Blatner and Rosa Cukier

Introduction

Dr. J. L. Moreno developed a wealth of concepts associated with his method of psychodrama, and these are discussed at greater length in other books (Blatner 2000) as well as in this volume. Serving only as a foundation, in this appendix we select, organize, and describe Moreno's most basic concepts.

The first point is that, although the focus of this book is on the application of psychodrama in psychotherapy, in fact Moreno's vision was much broader. At a general philosophical level, Moreno's basic concepts spring from his thoughts about how the dynamics of creativity and spontaneity express the way God operates throughout the Cosmos. At the level of the social problems of humanity, Moreno developed ideas about sociometry (in the broadest sense), the place of drama and the arts in culture, and role theory. At the specific level of method, psychodrama functions as a complex of tools for integrating these elements in the service of group problem solving, and at an even more specific level, Moreno elaborated a variety of ways in which psychodrama could serve as a type of psychotherapy. Moreno envisioned this method and its derivatives – role playing, role training, sociodrama and the like – to have applications not only for healing, but also beyond the clinical context, in schools, churches, businesses, community affairs and so forth. This appendix is organized so that the concepts will proceed from the broader principles of philosophy and social psychology to the more specific theoretical constructs involved in psychodrama itself.

Moreno's philosophy

As a young man, Jacob L. Moreno was filled with religious idealism and fueled by ideas from many sources, including various philosophers, Christian and Asian sages as well as from his own Jewish heritage (Blatner 2005). He had a strong intuition that *creativity* was a fundamental way God