The Effectiveness of Psychodrama and Role Play for Treatment of Inpatients with Heroin Addiction

Asker A.A.

Abstract

Role play and Psychodrama techniques used as an integral part of the therapeutic community for the treatment of inpatients with heroin addiction in AL Amal Hospital Riyad, K.S.A. Sixty patients participated for 6 months in the program. the findings indicate that there are a significant difference between participant and non-participant groups in emotional states, insight and social skills. Also, it indicated that these methods help members confront the problem, express feeling, increase group interaction and cohesion. It was useful for the treatment team to facilitate their clinical work. Using these methods assisted them to diagnose, follow up the progress of recovery and formulation of suitable treatment programs.

Introduction: To achieve treatment goals in the filed of substance abuse, the therapist tries to select the most suitable psychotherapy approach that makes the treatment process more organized and motivating to the patient and the treatment team.

One of these applied in AL Amal Hospital Riyad. Is psychodrama or psychosynchronic drama and role play.

Psychodrama is a method of psychotherapy that uses action methods therapy, philosophy, and methodology of Moreno (1898-1974). It was developed by Moreno after he came to USA in 1925 to continue his work , since then, largely, because of his efforts, psychodrama has become a worldwide phenomena. Fine, (1979).

Pychodrama has been found useful for treatment of substance abusers. Hannah Weiner (1995), reviewed the literature and discussed the use of psychodrama in the treatment and management of Alcoholism, she worked with 300 alcoholics in over 400 sessions and saw spouses in 50 additional sessions. The psychodrama group used to get interaction, feedback, open discussion and the interest of other participants. After three years in her treatment program, the clients were more accepted by others, more secure and more self accepting, she lists 33 benefits that different authors reported for alcoholics in psychodrama.

In a comparison between volunteer drug-abusers and non-drug-abusers on measures of social skills,. Zeichner, Phill, R.R. Wright and John (1977). Selected 12 drug abusers aged 18-26 yrs and 12 university students who interacted with trained role players in simulated social situations geared to elicit assertiveness and heterosexual dating behaviors, both groups demonstrated basically the same level of nonverbal measures. Preferential social interaction responses were affected by the varied environmental feedback.

Using Gestalt techniques for the treatment of addicts, Zarcone & Vincent (1984) used role play, psychodrama, and role reversals to extensive adaptation in the therapeutic community by allowing patients to focus on the intensity and duration of their emotional states and to observe how those states end in acute behavior or behavior rehearsals. By increasing the ability to adapt in inter personal situation and through their focus on action ad realism, they conclude that

gestalt techniques counter fantasy, schizoid withdrawal and narcissistic injury and regression, facilitating client adaptation of desired behaviors.

In another study Hudgins, Katherine and Joanne, (1984) used Johari window model by incorporated psychodrama techniques with the theoretical Johari awareness model to develop awareness with a group of chemically dependent adolescents. It was shown that by integrating psychodrama principles with the communications focus of the Johari awareness model, the group experiences a great level of risk taking, self-disclosure, and trust. Individually, group members became more aware both of the messages they send to others and their attendant impact and how accurately they decode the messages. Individuals expanded their own awareness of self and others, including the nonverbal aspects of communication, and learned to be more accurate and openly relates to other. Fear is lessened as each group member receives confirmation of shared emotions, behaviors, and thoughts. He concluded that the awareness does not remain cognitive but is added to their repertoire of behavior.

Kolko, et al. (1985) conducted 2 studies to identify the significance of role-play scenarios reflecting interpersonal problems encountered by drug addicts, univariate analysis of variance ((ANOVA) found that 5 scenarios were associated with significantly higher ratings by the addicts. (1) coming home to no dinner prepared by the paramour, (2) dealing with a friend who will not repay a debt, (3) approaching a friend found with your wallet, (4) confronting a friend who has lied about you to your boss, and (5) expressing a different opinion to a friend.

It is concluded that these preliminary scenarios may serve as role-play information regarding the interpersonal determinants, of relapse occasioned in the natural environment.

By the use of role play to release self assertiveness, level of communication and empathy in adolescent drug abuse prevention Englander et al. (1986) investigated feelings reported by (349) 5th-8th graders when role playing situation, in which they waited to say "No" to Alcohol/drug or to talk to a friend who was "using", they described themselves as feeling good and having high self-respect/esteem only when they said No in an assertive/leveling way. They reported that the most effective way to convince a friend to quit using and/or get help was to express caring ad friendship, and to touch the friends rather than being aggressive/blaming, irrelevant or super-reasonable. This feedback opens conceptual issues relevant to some assertiveness training and drug abuse prevention programs.

In a very relevant study Starr et al. (1989) described action techniques employed by a director of psychodrama in the final sessions of inpatient groups.

Specific psychodramatic methods include future projection, role reversal, the mirror and the "behind-the-back" technique. The found that psychodrama is a powerful technique to prepare the patient and other group members for the experience of termination and the transition from hospital to home.

Blume (1989), used psychodrama and other methods as integral parts of the program for the treatment of addiction in a psychiatric setting and he found that psychodrama is very useful for treatment of addicts, inpatient, outpatient, continuing care and self help groups.

To show the effectiveness of psychodrama in beginning recovery Duffy

(1990) illustrated how the psychodrama method can help substance abusers activity work on the tasks for beginning recovery, based on a psychodrama group conducted at an inpatient drug and alcohol treatment center. The psychodrama group helped members confront the problem, express feelings, explore new solutions, increase self-esteem, examine relationship attitudes and roles, and increase group interaction and cohesion.

Mainly we can not use psychodrama as a single method for treatment of inpatients. The previous study indicted that it is better to us psychodrama as an integral part of a therapeutic community, Manzella & Yablonsky (1991) argues that the use of psychodrama can enhance therapeutic community's effectiveness, and can offer such benefits as releasing significant psychodramatic data enabling the therapeutic community resident to quickly reveal their personalities and the issues surrounding their problems, releasing anger productivity, and clearly defining the clinical issues they need to work on to modify their lives. The authors describe their successful introduction of 105 persons in San Carlo.

According to Adlerian Theory, Dushman & Bressler (1991) demonstrated how psychodrama , when used in conjunction with Adlerian psychology can aid clients.

So, the previous studies indicated that the technique of psychodrama and role play are effective as an integral part of the therapeutic community, for the treatment of substance abusers.

Proposal for Using Psychodrama :
Psychodrama techniques and role play are used to achieve the following treatment goals.
1) To reduce anxiety, depressive feelings and dysphoric mood by changing the psychosocial atmosphere inside the ward.
2) To acquire the skill of verbal expression/motor continuity, self assertion and improve social skills.
3) To reduce anger, dissatisfaction, aggressive behavior towards the treatment team, peers and against the self.
4) To reduce patient's craving and insistence to be discharged early.
5) To increase the motivation for treatment.
6) Relapse prevention and improve follow up in O.P.D. after care program.
7) To improve patients insight into their problems and overcome denial mechanism.
8) to establish a good treatment relationship and help the clinical staff with assessment, diagnosis and prognosis.

Procedures:

Place:
Because psychotherapy ideally occurs best in a setting that allows for a holistic use of body and mind in interaction and co-action with other individuals (fine, 1979 P. 429). It was done in the conference room in the ward, which has enough space for 50 persons where patients and team members are seated to form an open square.

One session is held weekly in the theater for motivated groups to act spontaneously and recorded by video camera and the post-discussions are done by showing home video.

***Time*:**
10 A.M. after finishing the discussion of patient's ward needs, the sessions were held except Tuesday and Friday for 30-35 minutes. Depending on participant's interest and co-operation, an additional 15 minutes devoted to post-discussions, role description and assignment.

Selection of participants:
Selection was done according to patient's desire to participate, the protagonist

would be selected first according to the kind of topic, events and actions that center around him using the sociometric technique which was established by Moreno (1960).

To make the patient motivated and cope with resistance, many discussions took place to explain the benefits of group therapy and psychodrama, and teach them the work of therapy and that new skills are not established without practice. The author, as director, followed the principles of motivational interviewing which is summarized as follow:
1- Express empathy.
2- Develop discrepancy.
3- Avoid argumentation
4- Roll with resistance.
5- Support self-efficiency. (Miller & Rrollnick 1991 pp. 51-63)

***Measures*:**

1) Clinical data collected in a survey from the inpatient's files for 6 months and followed by data collection from outpatient progress notes for one year. This data was used to assess the scores of discharge, length of stay, rate of lapse and abstinence, follow up after care programs. Incident reports were collected to assess aggressive behavior and escape.
2) Each participant was asked to respond to state-anxiety scale (Spielberger, 1983) and Beck Depression inventory (Beck et al., 1961) pre and post participation.
3) Social Skills Inventory (SSI), which was designed by Ronald E. Riggio and translated into Arabic and restandardized by Al-Sayed Al-Samanody (1991) was used and a simple modification in scores to become a (6 point scale) to asses the score of social skills pre and post participation.
4) All participants were asked to complete a self assessment questionnaire designed by the author to assess the feedback of participants. This questionnaire consisted of 19 items as self reporting to assess cognitive, affective states and behavioral changes of participants. The scores of response were 0=Never, 1=Rarely, 2=Sometimes and 4=Always.

5) Clinical staff where asked to complete an :Observation Rating Scale" designed by the author to assess the clinical observation and treatment outcomes. It consists of 18 items describing cognitive, affective and behavioral outcome.

The score points were therefore as follows (4) very evident, (3) some what evident, (2) very little evident, (1) minimal.

Statistical analysis:

Non-parametric statistics used to compare the collected data between participants, and non-participants, the percentage values and the significance of critical percent (CP) were computed.
T test of independent samples were computed to compare pre and post participation of anxiety, depression and social skills.

Correlation coefficient wsere compared between participant self assessment and clinical outcome rating scales.

Results and discussion:

Demographic Characteristics:

Table (1) presents demographic characteristics for participants and non-participants. There was no significant difference in mean age, but the range of age was different, the mean of admission was high for participants, the participants were more educated than non-participants. No other difference in demographic characteristics as to marital status and employment.

Sixty patients participated in psychodrama and role play spontaneously, the score of participants was satisfactory as Table (2) shows.

The total patients admitted during 6 months were 174, the percentage of participation was 34.48.

Table (1): Demographic characteristics of participants and non- participants

	Participants N=60		Non-Participants N=114		CP	P<
	mean	%	mean	%		
Age, years± SD	28.3±8.13		27.18±13.2			
Admission	6		4			
Education						
High	5	8.3	2	1.55	2.09	0.05
Secondary	33	55	42	36.84.	2.30	0.05
Prep	16	26.7	39	34.21	1.01	NS
Primary	6	10	20	33.3	4.09	0.01
Uneducated	-	-	11	9.6	2.29	0.05
Marital Status						
Single	31	51.7	60	52.63	.0.117	NS
Married	9	15	13	111.40	0.831	NS
Divorced	18	30	40	35.08	0.772	NS
Widower	-	-	1	.87	0.793	NS
Employment						
Regular work	12	20	18	15.8	0.697	NS
Private work	6	10	14	12.2	0.448	NS
Unemployed	39	65	73	64.03	0.127	NS
Student	3	5	9	7.8.	1.393	NS

Note: The range of age was 21-36 years among participants, 18-49 among non- participants. t. value between age was 0.887. NS

Table (2) The scores of participation's

Participants N. 60	Mean of sessions	% of participants	Total % of participants
14	16	21.6	13.3
15	18	25	15
14	21	23.3	17.5
12	23	20	19.16
6	42	10	35

This indicated that about 35% were motivated for participation through education and discussing the benefits of this program. The difficulties encountered were:
1) Initial poor responsiveness and lack of spontaneity.
2) Non-participants guardedness and suspicion leading to lack of trust. They said that it is " a waste of time".
3) Resistance to projection of conflicts in a group seeing it as shame.
4) Aggressive explosion.

Most of these difficulties were reduced by changing the atmosphere, the influence of identification and then attraction to begin to get them involved and act with spontaneity.

Most of initial roles started with strong desire to relapse and represented the pleasure of use, the post-discussions focused on insight and motivation to stop, then expressing feelings about an object love, and with the sessions running well, the post-discussions were more interactive between the participants, clinical staff and other audiences who had not played a share in roles, but shared their empathy and experiences with the protagonist.

So, the protagonist and other members were not alone in the dilemma, provided the group members with the opportunity to reflect openly about their involvement in the session and to synthesize their responses.

This process produced group insight, increased cohesion, and enlarged inter personal perceptions. (Yablonsky, 1976).

The effectiveness of psychodrama and role play in decreasing the scores of anxiety, depressive feelings and dysphoric mood, shows in table (3). There are significant difference between pre and post participation's, t=7.70 for state anxiety $p<0.0001$ and for depression t=5.79 and $p<0.001$. This means that this program helped the patients to overcome anxiety and increase self-esteem, self respect and open the way to hope and overcome dysphric mood by changing the pathological atmosphere inside the ward, enabling them to reduce the dynamic stress caused by guilt and shame (Yoblonsky, 1976, Duffy 1990).

About the 2nd goals of this study, the results in table (4) indicate that this technique helped the participants to acquire the skills of verbal expression, motor

Table(3) Patients scores of Anxiety and Depression pre and post participation. N 60

Scale	Pre		Post		T	P<
	$\overline{X}$	SD	$\overline{X}$	SD		
State Anxiety	42.6	7.84	33.2	6.52	7.61	0.001
Depression	14.88	5.18	7.33	8.46	5.79	0.001

Table(4) Comparison between social skills scores pre and post participation. N 60

SS Sub.Scales	Pre		Post		T	P<
	$\overline{X}$	SD	$\overline{X}$	SD		
Emotional Expressivity	29.75	5.69	38.75	13.18	2.81	.0.01
Emotional Sensitivity	31.20	5.40	36.20	10.80	2.22	0.05
Emotional Control	30.05	7.27	45.75	8.93	5.41	0.001
Social Expressivity	35.25	8.84	46.15	11.19	-3.60	0.01
Social Sensitivity	30.50	7.27	38.15	6.66	6.6	0.01
Social Control	37.25	8.84	46.15	11.19	2.34	0.05
Social Mainpulation	41.20	10.69	46.15	7.27	1.20	NS
Social Skill Inventory	253.3	38.43	287.3	39.50	6.20	0.001

continuity, self assertion and improved social skills.

The scores of total social skills indicate a significant difference between pre and post participation's, t= 6.20 and p<0.001, and the sub-scales except social manipulation, has increased significantly.

This means that this program improved the emotional and social expressivity, sensitivity and control. As to social manipulation which showed significant difference between pre and post participation it is explained by the increase of manipulative behavior to exploit or control others, such as weeping, throwing a tantrum, threatening suicide, lying or sceaming to gain special consideration or advantage. However, as Jay Haley (1976) advocates, manipulation is an integral part of human interaction and occurs whether therapies recognize or identify it as such.

On the basis of the above results, it appears reasonable to conclude that psychodrama and role play techniques were effective to achieve psycho-therapeutic goals, and these results are similar to the finding of Englander et al. (1986) Kolko et al (1985) which indicated that this program enabled the patients to increase social skills, self esteem and self awareness, and also to learn coping skills to overcome peer pressure and give meaning for his life. Zeichner et al. (1977).

The most important thing is that, the participants learn How to search for a meaning to their life plan a project for their future, and how to solve their own

problems through sharing the problems of other. The main topics of many sessions were "Help others to help yourself".

The results in table (5) illustrate that there are significant differences between participants and non-participants in verbal aggressive behavior against staff and peers, but no significant difference in physical aggression against staff, also the rate of aggressive behavior against self (e.g. hurt, suicide attempts) decreased among participants, this indicated that this program was successful in providing the opportunity to act out and exercise a deep feeling of hatred without anyone actually becoming the psychical victim of this aggression, this confirm the finding of Yablonsky (1967, 1976) which indicated that the advantage of acting out aggression in psychodrama is that the protagonist can do it in a form of cinematic slow motion, thus enabling him to understand the experience and learn from it in each frame of the action.

Mainly the participants were satisfied with the therapeutic situations, felt happy and learned how to control their own aggression and switched it to other activities such as occupational therapy and sports.

About the treatment outcomes. The results in table (6) indicates that there were significant difference between participants and non-participants in the rates of discharge, the length of admissions, relapse, and following up after-care programs, participation in self help groups and attending Narcotic Anonymous meetings for one year.

Table(5) Comparison between the percentage score of aggressive behavior among participants and non-participants. N 60

Aggressive behavior	Participants		Non-participans		CP	P<
	N	%	N	%		
Verbal aggression againt staff	8	13.3	32	28	2.19	0.05
Physical aggression againt staff	2	3.3	9	7.8	1.15	NS
Verbal aggression against peer	4	6.6	20	17.5	1.98	0.05
Physical aggression against peers	2	3.3	15	13.16	2.8	0.05
Aggression against self	3	5	18	14.03	2.40	0.05

Table(6) Comparison between participants and non-participants behavior changes outcomes

Behavioral outcomes	Participants		Non-participans		CP	P<
	N	%	N	%		
Dicharge against medical advice	3	5	25	21.9	3.338	0.01
Length of stay						
6 months	12	20	-	00	4.99	0.01
5 months	3	5	-	00	2.41	0.05
4 months	5	8.4	-	00	3.26	0.01
3 months	9	15	3	2.7	3.05	0.01
2 months	10	17.6	6	5.3	2.45	0.05
One month	15	25	32	28.1	0.437	NS
Less than 30 days	3	5	48	42	5.096	0.01
Escape rate	-	-	6	5.2	1.78	NS
Lapse rates during 6 months	18	28	62	54	3.27	0.01
Follow up after care program for 8 months	22	36.6	23	20.2	2.34	0.05
Participation in self help groups and Narcotic Anoymous for one year	12	20	2	1.7	4.230	0.01

About 65% of participants accepted to stay 2-6 months and 70% of non-participants were discharged after one month and less than 30 days, 21.9% were discharged against medical advice, the multi assessment diagnosed these cases as lack of insight and lack of motivation for treatment, like those patients who failed to cope with peer pressure and craving. So they used splitting mechanism and manipulated their families to ask for discharge A.M.A., thus increasing the rate of relapse and escape among non-participants.

All these treatment outcomes confirmed the previous studies which investigated the correlation between length of stay and inpatient treatment outcomes, most of these studies reported positive correlation between long say and positive treatment response and outcomes. (Simpson, 1979, Finney et al. 1981, Mclellan et al. 1982).

This indicates that this program increased participants insight and motivation for treatment and also plays an important part in relapse prevention.

Patients did not become completely rehabilitated to the community, but their institutional adjustment was much improved, the ward became a suitable place to stay, and most of other therapeutic activities were running smoothly.

Most of the clinical observations and treatment outcomes were confirmed by self assessment of participants as shown in table (7). They reported that participation in psychodrama and role play programs were effective to reduce psychological craving improve verbal expression, self acceptance, sense of belonging, interpersonal relationship, decreased dysphoric mood, shame, anger, anxiety, psychomotor retardation and boredom.

It enables them to discover self productivity, improve self monitoring and self responsibility. Finally gave them

Table (7) Mean and percentage of self aassessment (Participant's feedback) N.60

S	Items	$\bar{X}$	%	Ranking
1	Reduces my psychological craving	3.0	75.00	16
2	Makes my speech more fluent	3.36	84.1	7
3	Let me accept myself	3.1	77.3	12
4	Improves my relationship with others	3.0	75.00	17
5	Decreases my dysphoric mood	3.45	86.4	3
6	Sets me free from shame	3.2	77.3	13
7	Lets me feel and discover that I am creative	2.9	72.7	19
8	I find hidden abilities in myself	3.0	75.0	18
9	Helps me to observe myself	3.1	77.3	14
10	Helps me to observe others	3.36	84.1	9
11	Makes me more forgiving for others	3.55	88.6	1
12	Develop my responsibilities	3.36	84.1	8
13	Decreases my anger and resntment	3.55	88.6	2
14	Decreases my anxiety and tension	3.1	77.3	15
15	Let me feel happy and get high without drugs	3.3	81.8	10
16	Reduce my bordom	3.45	86.4	4
17	Gets me motivated to paticipate in other therapeutic activities	3.45	86.4	6
18	Develop my ability to face peer pressure	3.18	86.4	11
19	Givs me insight of my addictive behavior	3.45	8..0	5

more acceptance of other therapeutic activities, learn coping skills to cope with peer pressure, to have, insight about their addictive behavior hazards.

All these outcomes confirm the previous studies which assume that psychodrama aids the client work more effectively, functionally as dimensions of therapeutic work such as: 1- Cognitive (thought processes, 2- Affective (emotional processes) and 3- behavior (actional process) (Eein 1978, Croce, 1989, Baker et al. 1989).

To confirm the results of participant's self assessment, the rating scale of clinical staff observation as shown in table (8), indicated the effectiveness of this program for treatment of opiate addicts and confirms previous findings.

The close observation assist the clinical staff to diagnosis and follow up the progress of recovery and behavioral modifications. Correlation coefficients computer between these Rating scores and the scores of participants self assessment. $R= 29.32$, $P<0.05$.

Mainly, it indicates that this program contributed to achieve psychotherapeutic goals by increasing spontaneity, verbal communications, self awareness, co-operation, productivity, problem solving skills, motivation, self respect, and de-

Table (8) Rating Scales of clinical staff observations

S	Items	$\overline{X}$	%
1	Stops lying	2.2	55
2	Spontaneity	2.8	70
3	Increased ability for verbal communication	3.2	80
4	Increased ability for non-verbal communication	3	75
5	Self-awareness	2.4	60
6	Co-operation with therapeutic group	3.3	82.5
7	Co-operation with treatment team	3.2	80
8	Increasing of ability and productivity	3.1	77.5
9	Decreasing of dependency	2.4	60
10	Increase ability to solve problems	2.3	57.5
11	Increased motivation for recovery	2.7	67.5
12	Overcome denial mechanism	2.8	70
13	Decreased depression feelings and dysphoric mood	3	75
14	Decreased feelings of shame	3	75
15	Decreased anger	3.2	80
16	Controlling of aggression behavior	2.8	70
17	Increase in self respect	3.2	80
18	Reducing stress of inpatient's stay	3.4	85

creasing depressive feelings, dysphoric mood, shame, anger, stay stresses and controlling aggressive behavior.

Thus, it provides a unique acting out possibility in a concrete form, portraits many social roles and variety of new situations. The existential state, that can only be hinted at in fantasy, can become an emotional reality in psychodrama (Yoblonsky 1976 p.25).

Conclusion: This study illustrate the effectiveness of psychodrama and role playing as an integral part of the treatment program for hospitalized heroin addicts. But it is not suitable for all patients, for many reasons, like history of drug use, education, personality, the rate of previous losses family situation etc. Thus participation, or just attending had particular benefits to establish former levels of effective coping, self-awareness, interpersonal effectiveness and renewed spontaneity.(Fine, 1976, Yablonsky 1976

As Yablonsky 1976 reported. "Participating in the psychodramatic process tends to facilitate the expansion of a person's role repertoire so that everyone can learn more precisely in action what it is like to be another person in another role. In this way psychodrama can help resolve a personal problem, but more general impact can be the enhancement of communication and compassion in large society".
P25.

However, most of therapeutic goals were partly achieved, the findings were similar to recent previous studies in the field of addiction, (Dushmaan et al., 1991; Manzella et al. 1991; Duffy, 1990; Bluma, 1989; Corce, 1987 and Starr et al. 1989).

The mechanism of therapy in this setting was role training, which assumes that behavior can be directly modified when a person who wants to change addictive behavior, is presented with feedback about his behavior and allowed to search out, identify, and practice new behavior.

The participants learned how to deal with craving, passive mood, impulsively and even change their social atoms by increasing their self-awareness, self-esteem, self-assertion and social skills.

They also learned the process of effectively meeting moment-to-moment events through spontaneity training which prepare them to meet their problems. They learned the way or process of meeting all events freshly and effectively.

Thus the motivated participants had the opportunity for corrective emotional experiences, and the groups was like a new family that provides protection, values and behavioral models that encourage experimentation in alternate style of living without drugs, they switched from active addiction to passive addiction and accepted the new situation inside the hospital and became more motivated to attend self-help group meetings and play the normal roles. Further research is needed to investigate the effectiveness of this program for outpatients.

This, and other studies confirm the value of psychodrama in the treatment of addicts, but it is probably better, in practice, to consider psychodramatic techniques as an adjunct to group therapy. The techniques can then be applied by the therapist in a variety of ways where appropriate and adapted according to the therapists school of thought and the needs of his clientele.

It should however, be remembered that psychodrama. in any form, can produce very strong emotional feelings which may erupt in explosive outbursts

and should be only conducted by skilled and trained therapists. Also where psychodramatic techniques are used sufficient time should be allocated in each group for a "Cooling off" period and feedback at the end of the session to ensure that patients are not left in a high state of arousal at the end of the group and are fully released from the role (or roles) they have played.

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Author

Asker A.A.
Assistant Prof. of Psychology, Zagagig University, Egypt and Consultant Psychologist, Al Amal Hospital, Riyad and P.R.C. Al Qassim

Address of correspondence

Asker A.A.
Zagazig University. Faculty of Arts.
Psychology Dept.

فاعلية السيكودراما و لعب الأدوار فى علاج مرضى الهروين المقيمين بالمستشفى

استخدام لعب الأدوارو السيكودراما كجزء من برنامج لجماعة علاجية من مرضى الهروين المقيمين بمستشفى الأمل بالرياض بالمملكة العربية السعورية

وقد شارك ٦٠ مريضا لمدة ٦ شهور فى ذلك البرنامج و بينت النتائج أنه حدث تغير ملحوظ لدى الذين شاركوا فى البرنامج عن غيرهم ممن لم يشاركوا من حيث الحالة الانفعالية و الاستبصار و المهارات الاجتماعية. كما اتضح أن تلك الاساليب تساعد المرضى على مواجهة مشكلاتهم و التعبير عن مشاعرهم و تزيد من تفاعل الجماعة و تماسكها. كما أفادت الفريق العلاجى فى تيسير عملهم الكلينيكى و سهلت لهم تشخيص و متابعة تقدم التعافى وصياغة الخطط العلاجية الملائمة.