Use of Psychodramatic Intervention with Families: Change on Multiple Levels

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Psychodramatic interventions can promote multiple level changes, changes in both problem definition and behavior. After examining the concepts of first and second order change, the author compares aspects of the psychodrama process and psychodramatic interventions to selected, commonly employed first and second order change techniques from other theoretical orientations, specifically family systems approaches. Parallels are drawn between the goals of each. Brief descriptions of the psychodramatic interventions include examples of how they might produce second order change.

For the sake of therapeutic intervention, families are often viewed as systems (Haley, 1967; Minuchin, 1974). As systems, they present problems for change agents, not the least of which are the complexities and non-linearity of interaction of family members (i.e., there are no simple cause-effect relationships). To provide effective and efficient intervention, approaches that attend to system requirements continue to be developed, employed, and evaluated (Haley, 1976; Madanes, 1981; Minuchin, 1974).

Psychodrama is not a new approach. In fact, many psychodramatic techniques have already been adapted to, combined with, or incorporated in family therapy approaches (e.g., statue building, role playing). However, many family therapists may be unfamiliar with psychodramatic theory and its direct application to use with families. Psychodramatists, on the other hand, may not be conversant with family systems perspectives, which may prove enlightening. Remer (1985) has shown that psychodramatic theory and practice lend themselves directly to systems interventions. An increase in awareness and more extensive

knowledge of both orientations could thus enhance therapeutic effectiveness by providing both a more diverse perspective and a more varied repertoire of interventions.

To introduce readers to psychodramatic concepts and techniques, particularly for use with families, this article will address some basic aspects of both psychodrama and multiple level change. These concepts will be discussed in the context of different levels of change and a variety of change strategies. Comprehensive coverage of all the theory and implications of these orientations to therapy cannot be provided in a short article. The author hopes that this article and those sources to which the readers are referred will provide sufficient encouragement for further exploration of and training in psychodrama and certain family systems approaches, specifically *strategic* (Haley, 1967, 1975; Madanes, 1981) and *structural* (Minuchin, 1974).

First and Second Order Change

The benefits that can accrue in using a psychodramatic approach (or some adaptations) can be more easily seen within the context of the distinction made by Watzlawick, Weakland, and Fisch (1974) between first and second order change. The differences in the level of intervention required to make effective changes of either or both types is useful information for any therapist to have.

First order change is a direct change in behavior. It is straightforward in the sense of being exactly what it seems, a kind of frontal attack on a problem. An example of a problem that might lend itself to a first order change intervention is a parent who hits a child because the slap stops the child from doing something that irritates the parent. A possible first order approach to a solution is teaching the parent to use other effective and acceptable ways to gain the same end—perhaps learning to use time-out procedures. Examples of interventions that are intended to effect first order change are giving information, training clients in the use of communication skills, and employing and/or teaching clients to practice behavior modification techniques. One hallmark of such interventions is that the client can, and usually should, understand and recognize the intervention and its purpose for it to be most effective.

Second order change is a change in perspective, i.e., a change in the way the problem is formulated. Second order change is typically indirect, change on a meta-level. It is not necessarily a direct change in behavior. Some interventions intended to effect second order change are reframing, paradoxing, and restructuring. While these techniques may prove effective with clients directly involved with their use (i.e., being

aware of and understanding the interventions), often their effectiveness relies on the clients' ignorance of the technique's use and, particularly, its intention. If aware, clients may feel manipulated and resist the intervention, consciously or unconsciously, thus rendering it ineffective. As such, second order change strategies may seem like misdirection.

An example of a problem that lends itself to possible second order change intervention, in this case relabeling, might be a parent who almost totally ignores a child's "pawing," viewing this behavior only as attention-seeking. The parent might then be told that the child is trying to love, as opposed to annoy, the parent. This intervention may alter the parent's perspective so that the problem is no longer how to stop the attention-seeking, but how to reciprocate this affection—second order change. This altering may result in the parent paying attention to the child, the child feeling loved and thus feeling secure enough to leave the parent alone more often.

Change on one level can effect change on the other level. For example, the child could stop bothering the parent and the parent consequently could see the need to give more affection. On the other hand, the parent could view the child's need for appropriate attention and respond with the result that the child becomes more self-assured and independent. The outcome is the same, and the order of change makes no difference as long as the problem is resolved. Whether a change in perspective precedes and produces a concomitant change in behavior or whether the change in behavior initiates and influences an alteration in the perception of the problem is of little consequence.

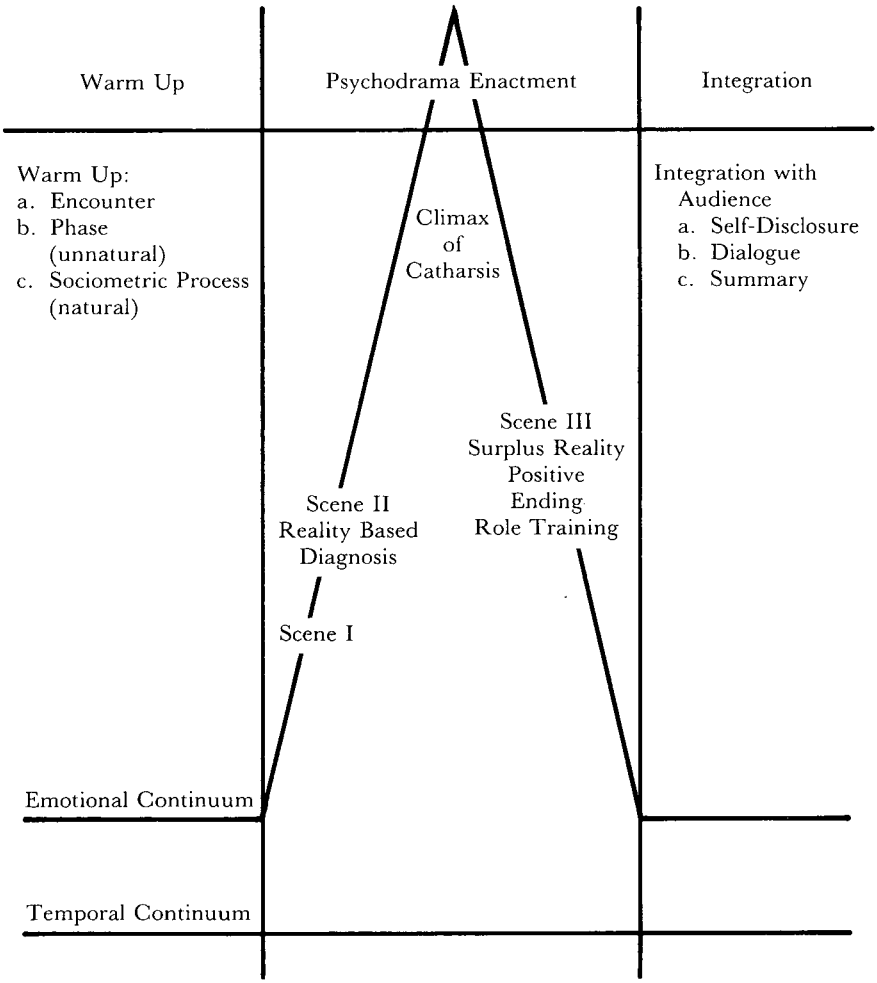
This does not imply, however, that the distinction between first and second order change is unimportant. Quite the contrary. As Watzlawick et al. (1974) indicate, attempting one type of change when the other is in order (e.g., a change in behavior when a problem reformulation is necessary) can be not only confusing to the one attempting to make the change, but also totally ineffective, inefficient, and self-defeating.

The Psychodramatic Process

To understand how the psychodramatic approach and specific techniques involved operate on multiple levels, one must have some knowledge of the psychodramatic process. Without extensive detail, the process is portrayed in Figure 1.

The first and last stages of the process, warm up and integration, are more group oriented as group process is commonly conceived. In the warm up, the theme for the drama is chosen, and the protagonist emerges. The protagonist is the person who represents the group and

Figure 1.—The Hollander Psychodrama Curve



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works through that theme for and with the help of the group. Warm up may occur in many ways in or outside the session proper. In families, one way this stage is addressed is by the "choosing" of the identified patient. In a session, warm up may simply be choosing the topic to be addressed for the week.

The last stage of the process is integration. Here the group, in this case the family, works toward the reintegration and support of the protagonist by sharing the responsibility for parts in the theme or problem. The aim is to bring cohesiveness to the group and to direct its energies constructively.

While there are certain techniques that can be generated directly from psychodramatic theory (e.g., statue building and group sharing) applicable to these two stages, most effective therapists have their own approaches (and labels) for the warm up and integration stages. Training in psychodrama can expand therapists' repertoire, e.g., sculpting emotions rather than simply sculpting the family constellation can be used as a concretizing technique involving the whole family.

The aspect of the process most usually associated with the term psychodrama and the stage that may differ most from more traditional approaches to family therapy is the enactment. In this stage, action is essential. To make the transition from the warm up to the enactment proper, the scene is set. Psychological and physical details are represented with chairs moved to approximate the actual configuration of the scene. The representation, understanding, and accepting of the protagonist's (client's) reality is implemented. Then, through the drama's enactment, there is a release of energy previously blocked by defenses, known as the catharsis of abreaction. This phase is followed by the channeling of that energy using newly provided resources—the personal skills, which have been learned, or group cohesion, which has been developed—and leads to a combination of cognitive and affective reorganization, surplus reality. The "insight" thus produced (catharsis of integration) is then supported and, one hopes, transferred to action for change outside the therapeutic setting during the integration stage.

It is through the enactment, using action-oriented techniques, that the psychodramatic approach can accomplish multiple level changes. (See Table 1 for descriptions of the various psychodramatic techniques discussed throughout the article.) During this stage, or actually these phases, the use of psychodramatic techniques can add most to the effectiveness of family-oriented interventions.

One important choice to consider when working with families is the type of psychodramatic enactment to employ. There are three types—classical, situational, and sociodramatic. While all three can be utilized, the most appropriate in family therapy situations is usually sociodrama, followed by situational psychodrama. The classical enactment, in which past traumatic material (the *status nascendi*) is evoked and dealt with, may be extremely threatening to all but the most open "significant others" of a protagonist. Since there is a less formal designation of

Table 1.—Primary Level Change Goals of Some Psychodramatic Interventions

Technique	Description	Other Theoretical Label/Approaches	Primary Level Change Goal(s)	Other Effects
Scene Setting	Describing the physical aspects of the scene in detail, placing props/ furniture to represent reality, portraying significant others	Cognitive rehearsal Active listening Empathic understanding Concretizing	Disclosing Taking responsibility for active change	Creating rapport, empathy, and a supportive atmosphere Understanding the problem from clients' perspective Clarification of parameters of the problem
Auxiliary Ego	Selecting people to portray significant others, instructing them in role, engaging them in the enactment process	Problem clarification Concretizing	Showing interaction rather than talking about problems Providing information	As in scene setting but geared primarily toward interpersonal aspects of the problem
Doubling	Portraying a special auxiliary ego role to express the inner feelings and thoughts of the protagonist, acting either supportive and/or confrontive	Primary level empathy Advanced level empathy Self-involving response Cognitive rehearsal Cognitive modeling	Accepting support to catalyze change Providing information	As in auxiliary ego, particularly providing support to encourage freer exploration from various perspectives

Mirroring	Exaggerating a characteristic or stance taken by the protagonist—usually by a double—for the protagonist to examine more closely	Advanced level empathy Confrontation Modeling	Modeling new behaviors and demonstrating dysfunctional aspects of old behavior	Extending clients' perspectives of themselves and their actions by demonstrating how they can appear to others
Statue Building	Having the protagonist represent a perspective/feeling/other internal construct of the protagonist visually using group members to represent the reality	Concretizing	Providing information Encouraging active exploration	Making the implicit thoughts and feelings explicit
Behind-the-Back	Engaging in a discussion of the actions/thoughts/feelings of relating to the protagonist as if he/she were not present but with him/her as audience	Challenging perceptions Confrontation	Providing information	As in mirroring but with more explicit emphasis on how the client is perceived by others
Role Reversal	Having the protagonist exchange roles with a double or other auxiliary ego	Role extension Challenging perspectives Role rehearsal Empty chair	Learning new behaviors Providing information	Encouraging client to see other perspectives and learn to appreciate differences, experiencing polarities

Technique	Description	Other Theoretical Label/Approaches	Primary Level Change Goal(s)	Other Effects
Physicalizing	Translating thoughts/ feelings into actions as part of the enactment, representing conflicts actively to be dealt with in that mode	Role exploration Behavioral rehearsal Enabling Affective arousal	Providing information Clarifying perceptions	Encouraging client to experience feelings and actions, rather than be removed from them; overcoming defenses; engaging blocked energy
Surplus reality	Extending the functions of the protagonist and auxiliary ego beyond the limits set in first stages of enactment	Cognitive restructing Cognitive rehearsal Behavioral rehearsal Strength bombardment	Practicing new behaviors Getting feedback Providing reinforcement	Reconstructing cognitive representations to provide new avenues to approach old problems; engaging new resources and strengths
Soliloquy	Having the protagonist step out of the scene and deliver a monologue about the reactions it is producing internally	Disassociation Cognitive insight Cognitive rehearsal Successive approximation	Providing information Speaking thoughts aloud	Allowing the client to get perspective on a problem through distancing from the emotional reactions—the reversal of physicalization

the protagonist in sociodrama, there is more flexibility to work on the family theme from various perspectives.

Technique is critical. What can be presented here is only a brief introduction. Some psychodramatic techniques (e.g., family statue building) can be and are already used by family therapists (Okun & Rappaport, 1980). Full enactments are more powerful and more complicated. Classical may be done effectively by having the "significant other" observe from behind a two-way mirror to prevent disruption of the drama or the problem of multiple protagonists (Goldman & Morrison, 1984).

Multiple Level Changes

While the exposition to this point may have been enlightening, it still has not addressed the main issue of how psychodrama operates on more than one level simultaneously. Drawing parallels between various aspects of the psychodramatic process and some interventions from other therapeutic approaches that attempt to make changes at primary and secondary levels, the first and second order changes, may help clarify how both levels of change processes may be engaged at once.

Second Order Change Strategies

Much has been written about second order change strategies, usually under the rubric of paradoxical interventions (Weeks & L'Abate, 1982). The literature on this topic is too extensive to summarize here in any comprehensive and cogent manner. To give a flavor for these types of interventions and indicate how they relate to psychodramatic process, some of the more commonly used and well-known strategies follow, accompanied by hypothetical examples of psychodramatic actions to accomplish them or similar ends.

Change by Implication

Change by implication occurs with a covert redefinition of the problem (Hoffman, 1981). For example, a therapist suggests to a family that they argue openly in a session. When the family accepts the invitation, the problem is redefined not as fighting but as finding a way to fight constructively. The psychodramatic process includes many changes by implication. One covert change it elicits by actively involving the family in the process is to redefine the situation as one about which something constructive can be done, one about which there need be no fear of addressing.

Simply setting up a scene—perhaps an argument tnat occurred at dinner—and enacting it provides a change by implication. This indicates to the family that "this problem involves everyone, not just X" and "we can take some constructive action, rather than just talking or ignoring the problem." These can be powerful messages aimed at involving the entire family.

Reframing

When a problem is reframed, a shift in the locus of the problem takes place (Grunebaum & Chasin, 1978). The shift may be from an individual focus to one on the family system, from past to present, etc. Inclusion of the family members in the enactment, as well as in the whole process, reframes the problem as one shared by the family rather than one being owned by a single member. The "reliving" of past events reframes the problem as one that can be dealt with and corrected in the present.

Two requirements of the psychodramatic process always reframe the problem (if it needs reframing): the insistence on acting in the "here and now" and the use of family members as auxiliaries to portray the situation. The shift to the present tense—"I'm entering the room. It is dark."—reframes the situation as one to be handled now. The inclusion of others—as in an action family sociogram (Goldman & Morrison, 1984)—reframes the problem as a shared family one, not that of the protagonist (identified patient) alone.

Relabeling

Relabeling is changing the way the problem behavior is discussed so that there appears to be a possibility for a workable solution (Grunebaum & Chasin, 1978). Usually the shift is from a negative valence label (e.g., living one's children's lives for them) to one with a positive connotation (e.g., caring that one's children are not hurt by their actions). The relabeling may also be from a relatively non-productive term (e.g., clinical depression) to one over which there can be more control (e.g., being irresponsible). The goal in either case is to encourage any movement toward a solution so that modification (shaping) of that movement can occur. Use of many psychodramatic techniques—such as role reversal, provocative doubling, auxiliary ego (particularly "antagonists" during surplus reality)—often help to relabel the behaviors of those involved.

An example of relabeling is what occurs in role expansion by an auxiliary ego during surplus reality. In the case of family therapy, a double

aiding a real, rejecting father might say: "The world is a hard place. I want you to be ready for it, to be tough." This statement relabels the father's actions as caring, but misdirected. This may enable a rapprochement between the father and the protagonist and help the protagonist ask for and get paternal affection.

Another possible instance is when a double senses the hurt feelings of a protagonist who is acting angry. The double might say: "I'm hurting so badly. I won't be hurt any longer." This relabels the feelings as hurt rather than anger, allowing the protagonist to accept support and comforting from other family members as they see and react to the hurt instead of the anger.

Therapeutic Double-bind

Double-binding (Haley, 1975) requires that three conditions be met: a verbal directive be sent; a contrary command be issued on a different level of communication; and an injunction from leaving the field be implied. What makes this situation therapeutic is that gains can be made from following any one of the directives. Double-binding implicitly "challenges the clients' model of the world by forcing them into experiences which contradict the self-destructive limitations of their present model" (Weeks & L'Abate, 1982, p. 7). Suggesting that a family doing well have a relapse can serve such a purpose. If they do not relapse, further evidence is provided of their growth; if they do, they demonstrate that they can handle the situation without dire consequences. This also indicates that the therapist sees them as only human and can accept them and, in addition, adds to the therapist's stature as an "expert." Provocative doubling or multiple doubles actively representing polarities can be used to accomplish these goals, perhaps forcing a choice and "unsticking" the family.

Another, more concrete, example may help make the description clearer. Suppose during the course of family therapy, the therapist encounters a resistant parent, one who actively fights whatever suggestions or comments are made. One strategy could be to tell the parent that this resistance is really a functional behavior, that, in fact, a parent should be skeptical. After all, therapists tend to push too fast at times and in doing so make mistakes. Suggest that the parent slow the sessions down by voicing any personal reservations about the therapist becoming overzealous. A parent accepting this suggestion will become directly involved in and helpful to the therapeutic process. Resistance now becomes the vehicle for constructive involvement upon which other interventions can be based. Even if the parent ignores this sug-

gestion, there will be less active disruption during the session. Either choice facilitates therapeutic movement.

Mirror techniques often fulfill the requisites for therapeutic double-binds. For example, a protagonist who is stuck in a passive stance may find the double curled up on the floor in a fetal position, begging for attention. The two messages involved might be: "I'm so dependent. Help me or I'll die" and also "It looks ridiculous to be so babyish. I must grow up." Being in the scene and pressed to deal with the double provides the injunction not to leave. If the protagonist takes care of the double, she learns to accept and nourish an important aspect of herself; if she rejects the double, she is acting more assertively. In either case movement is promoted, and understanding enhanced. The family may also recognize the bind in which they put the protagonist with contradictory messages and the struggle she is having to become more independent.

Prescribing the Symptom

Prescribing the symptom, a special case of therapeutic paradox, is exactly what the name implies, doing more of what is problematic (Haley, 1976; Weeks & L'Abate, 1982). There are two possible goals: to provide more insight into what the symptom does for the family, how it is self-defeating and/or what needs to be done to give up the symptom; or to force the family to rebel against the prescription, thus giving up the problematic behavior and demonstrating to themselves that they can. One example of this might be having a mother sit with her children every moment they are doing their homework to ensure she is doing everything possible to provide them with an excellent educational experience. This prescription usually leads to the insight that she cannot protect her children from their responsibilities while fulfilling her own. Doubling and mirroring techniques from psychodrama can provide a physical representation of the impact of the symptom, which usually elicits the desired examination and change.

Concretizing situations, particularly with exaggeration, can produce the effects of prescribing the symptom. In effect what is said and done is an exaggeration of the situation so that the protagonist learns how the symptom is of benefit, how it can be controlled, and/or that the symptom is no longer needed. Having the members of the family actually hang on a father who complains of exhaustion or overwork can put him in touch with his strength, indicate how the only way he can allow himself to let the family down is by physically collapsing, and/or provoke him into shaking them off so that he can care for himself. He and they can also experience members' strength and tenacity so all realize the family members are able to take care of themselves.

"As If" Paradoxing

The "as if" paradox, which might also be termed double-thinking, is discussed in detail by Madanes (1981). In part designed in reaction to the manipulative aspects of the traditional therapeutic double-bind, playing "as if" allows clients to gain directly by dealing with the real problem or indirectly by handling a situation that only represents the "real" problem. The representation does not have the same threat value as reality. Double-binding goals are achieved without the same sense of coercion as may be experienced in the "straight" therapeutic double-bind. Psychodramatic process fits these requirements exactly. Role playing the representation of the "real-life" situation, role reversals, exaggeration, mirroring, and a host of other aspects of the process lend themselves readily to implementing this type of change strategy in psychodrama.

Having a protagonist reverse roles and act through the role of the other family member produces the "as if" situation. The protagonist acts as if she were the other, the point being that even though she is pretending to be the other, it is really she who is acting (i.e., doing). Having a daughter who has difficulty expressing anger reverse roles with her mother because the mother can be angry allows the protagonist to learn how to express the anger she has. If she can do the role, she sees she has the skill in her repertoire. If she has trouble doing so, it is not entirely her problem; it is her "mother's." So she learns it is not always easy to express anger, even for someone who appears facile at it. Again, in either instance, there is a therapeutic gain.

Restructuring

Restructuring the family's physical relationships in a session as a representation of a deeper restructuring of the family's relationships to each other in other situations is a secondary change technique employed by Minuchin (1974). Similar ends can be accomplished in a family psychodrama through the use of role reversal with doubling, statue building, or physical manipulation of the scene elements by the director (therapist).

Restructuring can be done in a number of ways: directly as part of the session by directing family members to sit in a designated configuration to role play a certain situation; through a series of role reversals between family members or between family members and therapists; by sculpturing the family situation as perceived and then as changed to how it might be preferred; or by using some combination of these. For

example, a distant father can portray a scene with his estranged son. A double for either or both can be added to change the structure further. In another example, having a mother and father role play an interaction between them without a triangulated daughter present can take her out of the middle and show the family (particularly the daughter) what is going on. Even the choice of where the director sits during the sharing can alter the structure.

While these examples certainly do not cover all the possibilities, they give the reader a feel for the second order changes and their relationship to psychodramatic intervention. Other parallels or adaptations are left to the creativity of the individual therapist. However, in the best spirit of the definition of spontaneity, it should be noted that such interventions take analysis of the situation, planning, and practice to be most natural and effective, i.e., they are based in some conserves.

First Order Change Strategies

From what has been discussed so far, the impression may have been created that the psychodramatic process operates only, or at least primarily, through second order change processes. The stress has been on second order change simply because those aspects of the approach may be less obvious to those not familiar with the concept or to those unfamiliar with the psychodramatic approach. Almost every aspect of or technique used in psychodrama has a primary change component as well. Indicating parallels to techniques from other orientations again can serve as a way to demonstrate the inclusion of first order change processes. Only a few of these similarities will be mentioned and will be sufficient to illustrate the point.

Some of the techniques used in psychodrama, a brief description of each, some of the primary level change goals they can attain, and some techniques/labels from other theoretical orientations to which they are similar are presented in Table 1.

There is not enough information presented here to allow complete mastery of the use of these tools. For more background in psychodrama theory and intervention, the following texts are suggested: Moreno (1953), Hollander (1978), Goldman and Morrison (1984), Blatner (1973), Leveton (1977), Corsini (1966), Greenberg (1974), Starr (1977), and Yablonsky (1976). Some books and articles dealing with family systems theory have been mentioned with the discussion of family systems techniques. In addition, training and supervision in family therapy and/or in the use of psychodrama is highly recommended.

Limitations

Psychodrama is not a panacea. It has been shown, however, to be a powerful tool, with limitations, particularly in its pure form. The primary problem is engendered by psychodrama being so action oriented. A number of people must be present (at least five, preferably including two trained therapists initially); there must be adequate space for an enactment; and there must be adequate time allowed in a session to permit cycling through the entire process. (These constraints may make its use more feasible in conjunction with multiple-generation or multiple-family group interventions.) In addition, there may be a fair degree of resistance to the approach in the beginning, simply because it is so different from what people have come to expect from "talk therapy"—i.e., the novel aspect of an action-oriented approach, its strongest point, also causes difficulty. To be most effective, clients must be trained in how to become involved in the process either through modeling or instruction. In this respect, it is not much different from other approaches although this approach is perhaps more time consuming and difficult to accomplish.

Both psychodrama and family system approaches require specific training in their use. Explication of theory and description of interventions are not enough. As may be obvious from the reader's reaction to what has been presented here, observation of and supervised experience in the actual use of psychodrama are essential to building knowledge of and confidence in the approach and facility in its application.

Conclusion

Psychodramatic intervention in its entirety and the selective use of its various components can, when employed properly, help effect changes of both first and second order. The similarity of the aspects, techniques, and applications of psychodrama to other first and second order change interventions has been indicated here. In addition, as has been indicated elsewhere (Remer, 1985), this approach offers a unified perspective incorporating theoretical and practical aspects that can address some of the complexities of dealing with a family system. In spite of limitations stated, the gains accrued from use of the psychodramatic approach combined with the family systems perspective suggest that increased familiarity with both may be beneficial to any therapist. The broader the base of knowledge available to the therapist, the better the chance of intervening effectively.

REFERENCES

Blatner, H. A. (1973). *Acting in: Practical applications of psychodramatic methods*. New York: Springer Publishing Co.

Corsini, R. J. (1966). *Role-playing in psychotherapy: A manual*. Chicago: Aldine Publishing Co.

Goldman, E. E., & Morrison, D. S. (1984). *Psychodrama: Experience and process*. Dubuque, IA: Kendall/Hunt.

Greenberg, I. A. (1974). *Psychodrama: Theory and therapy*. New York: Behavioral Publications.

Grunebaum, H., & Chasin, R. (1978). Relabeling and reframing reconsidered: The beneficial effects of a psychological label. *Family Process. 17*, 449-456.

Haley, J. (1967). Toward a theory of pathological systems. In G. H. Zuk & I. Boszormenyi-Nagy (Eds.), *Family therapy and disturbed families*. Palo Alto: Science and Behavior Books.

Haley, J. (1975). Paradoxes in play, fantasy and psychotherapy. *Psychiatric Research Report. 2*, 52-58.

Haley, J. (1976). *Problem-solving therapy*. San Francisco: Jossey-Bass.

Hoffman, L. (1981). *Foundations of family therapy: A conceptual framework for systems change*. New York: Basic Books.

Hollander, C. E. (1978). *A process for psychodrama training: The Hollander psychodrama curve*. Denver, CO: Snow Lion Press.

Leveton, E. (1977). *Psychodrama for the timid clinician*. New York: Springer.

Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Moreno, J. L. (1953). *Who shall survive?* Washington, DC: Nervous and Mental Disease Publishing Co.

Okun, B. F., & Rappaport, L. J. (1980). *Working with families: An introduction to family therapy*. North Scituate, MA: Duxbury Press.

Remer, R. (1985). An approach to evolving family expectations: Social atom theory. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 38*, 96-106.

Starr, A. (1977). *Rehearsal for living: Psychodrama*. Chicago: Nelson-Hall.

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: W. W. Norton.

Weeks, G. R., & L'Abate, L. (1982). *Paradoxical psychotherapy: Theory and techniques*. New York: Bruner/Mazel.

Yablonsky, L. (1976). *Psychodrama: Resolving emotional problems through role-playing*. New York: Basic Books.

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