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Multiple Family Psychodramatic Therapy

CLAUDE A. GULDNER

This article provides a description of multiple family psychodramatic therapy. Systems-oriented family therapy and psychodrama are the models of therapy used in the approach. Two case studies are presented in depth to show process and to highlight family structural issues focused on in the therapy. Outcome study results are briefly presented. The use of therapists in training is also discussed.

Systems-oriented family therapy and psychodrama have been my two primary interests during the past 10 years both in clinical practice and in training others. I struggled for some time as to how one might best integrate these modalities. My clinical case load got so heavy in 1974 that I decided to experiment by bringing together four families and doing classic psychodrama. When I had been involved in psychodrama training at Beacon under J. L. and Zerka Moreno, I remembered that the instruction was to use encounter methods when there were present the actual participants of a protagonist's drama. During that experimental year I worked with the standard warm-up methods which tended to be more individual- and group-focused than family centered. Out of the warm-up a person emerging with a problem would become the protagonist. Whenever possible I would use the actual people present with whom the protagonist was involved. I used auxiliary egos to enhance the drama. At the end there was sharing with the protagonist which also would involve some sharing with other family members. Throughout that experimental year I was uncomfortable with the process. Although there seemed to be some individual gains made, it was not having much effect upon families as an organizational system. I was searching for a better model when I was asked to do a 10-day family enrichment

at a summer camp. It was during that experience that I hit upon the model that I have used for several years. The model feels right for me as therapist-director and outcome studies indicate that it has been beneficial for families who participated in the process. It is this model that I want to discuss in this article. Dr. Moreno in the third volume of *Psychodrama* stated: "Husband and wife, mother and child, are treated as a combine rather than alone, often facing one another and not separate, because separate from one another they may not have any tangible mental ailment" (Moreno, 1969, p. 246). What Moreno was implying here is that the family is an organizational system and without understanding the nature of that system one cannot understand or work with family pathology.

General systems theory brought a radical shift in the understanding of problems within a family in contrast to psychodynamic theories. The latter theories saw pathology within the individual and so the therapeutic task was to work with the individual to bring insight and behavioral change. Systems theory is not focused on the individual apart from the person's interactions and transactions with other key elements of his primary system. Thus the therapeutic process is to work with changing the organizational structure of the family system. Multiple family therapy has been practiced and theorized by a number of therapists in the family field (Laqueur, 1968; Bowen, 1976 (a); Bowen, 1976 (b); Laqueur, 1976; Laqueur, 1980; Durkin, 1980). Despite the research evidence of these practitioners that the outcomes of multiple family therapy are as good as those with individual families, the practice has not had wide acceptance by family therapists. Many therapists feel overwhelmed with one family let alone attempting to work with three or four. Multiple family psychodramatic therapy provides a structure which is a combination of education and therapy. For the practitioner who has both psychodrama and family therapy skills, the use of the following model may help reduce the anxiety involved in working with a grouping of families.

Multiple family psychodramatic groups are composed of four or five families with children over nine years of age. Although I have worked with families with younger children I find that most benefit comes when they are able to conceptualize and integrate at a more developed level. They also do not become so tired in the rather long therapy process. Families are selected by availability and commitment following a general assessment session. During this assessment I learn something about the nature of the presenting problem, and how family members are responding to it. I also gain some observational knowledge about the organization of the family's system. I do not attempt to be selective by problem, socio-economic or intellectual level, etc. I find that this may create a bias in the method of conceptualization about families and in the style of working. Thus I put into the groups any family that is willing to make a commitment to the process for at least a four-session contract. The groups are open-ended in that families come into the group and move out of it as they achieve

their goals and as these are reflected in feedback from other family units as being accurate. The average stay in the group is about 12 to 14 sessions. The group meets for two and one-half hours one night a week. Since I believe that systems therapy is essentially the therapy of subsystem units I do not require that everyone in the family always be present. Thus if father is away on business the rest of the family can still come and participate. If a youngster has homework he must do, he can make the choice to stay home. If absence persists then it is confronted with the family by therapists and other family units.

The Structure of a Typical Session

The evening begins with a learning-oriented warm-up process. This is what I learned in the family enrichment camp that was helpful. Families are often in difficulty because they lack information and/or alternative information. I saw the warm-up as being an educational opportunity. Thus the warm-up is geared to enhancing learning for individuals, subsystems and full family units. At times I or one of my therapists in training provides a mini-lecture which offers information we think is important for family functic ng. This is followed by experiences that are in keeping with the lecturette theme. For example, one lecturette is on the value of dyadic communication in the family: learning to talk to individuals rather than "spewing" it out to a nebulous group of people. This is followed by a communication exercise in which a family must negotiate an evening out and do so by engaging with dyads and then summarizing the information highlighting differences and agreements.

Other warm-up experiences are to have the kids advertise for ideal parents and the parents to write ads for ideal children. These are then shared. In another the kids pose a problem and then take it around the room and get interaction with each set of parents present. We have kids fishbowl in the center with parents around the side. The kids express concerns about families, growing up, family rules, sex, etc. Then parents reverse and fishbowl with the kids on the outside. The parents deal with their concerns, anxieties, fears regarding the issues their kids shared. Generally we have each family do a genogram early in the life of the group. These are shared and then are maintained and put up on the wall each evening so that they can be referred to throughout the life of the group when we want to track down some past generational data. Family of origin sculptures are also done by the parents. This is very revealing to children who often do not know much of the emotional history of their parents, especially their parents' relationship to their own families. We do sculptures of the emotional space that each family member experiences with each other currently and how each family member would like it to be at this time. This often emerges as a theme for a psychodrama.

There are literally hundreds of warm-up experiences which we have found are helpful to families in expanding their repertoire of awareness and information

concerning the nature of family process and structure. We find that in follow-ups families often rated the warm-up exercises as very significant in their understanding and change process. These warm-up experiences often take from forty minutes to one hour. This is followed by a fifteen-minute informal coffee/juice break, an important time-out for it brings about more "natural" groupings. Dads talk with dads and moms with moms. Boys not yet into associating with girls gather together and those boys and girls who are comfortable with each other get together. We find this process is an important "breather" for all involved in the experience.

After the break I check out with the group concerning who wants to work and what the topic or theme is of the work. Generally I find that at least three to four individuals have warmed up to a theme. It may be a need for more independence on the part of a late adolescent, a real fight that took place in a family that week, a father who claims his wife counters his interaction with his kids, or a mother who says she feels too alone in her parenting of her children.

The protagonist is selected by myself as Director. I often use sociometric methods to aid this selection, such as which of the persons or themes is the rest of the group most warmed up to. I will then go with that person or theme. However, I often select the protagonist for the theme that I "hunch" is most in need of work by this particular group of families. Often families will collude to avoid themes as a means of maintaining system homeostasis.

The Manner of Conducting the Psychodrama

The next major change which I made from the previous experience with multiple family psychodramatic therapy was in the manner in which I conducted the psychodrama. I moved away from the encounter process and worked with the protagonist's perceptions of the people in his/her family system and his/her interactions with that person. I had found in the past experience that the use of multiple protagonists resulted in a process more akin to traditional therapy. Also I found that not being involved directly in a family member's drama, other members of the family could see or have "mirrored" their process. This "seeing from a distance," as we came to call it, enables them to better recognize the structures of the system and to make resolves for change or to follow prescriptions given to the families by therapists or other families in the group. Since each individual sees his/her family or members of it from a distinct perceptual stance, I felt it was important to work with those perceptions by use of auxiliaries rather than by using present family members. This resulted in more flexibility in the use of the group, more role learning as well as role identification, and maintained an important space function for the protagonist. It became his or her psychodrama and thus served as a unique form of differentiation of that person and his/her perceptions from the rest of the family system. Frequently

when all the family members are involved they will collude to work against change as a means of maintaining the previous system homeostasis. When working with one family member and using auxiliaries from other family units who may not covertly strive to collude for homeostasis, the protagonist is able to move through the drama, with the aid of the Director, in those directions that are leading from within for change. This change then can produce change back in the family system. In systems thinking we believe that if any one part of the system changes it can have an effect upon all the other parts. We do not need to work with the full family unit then to effect change within that system.

Before I give some case examples let me complete the process of the evening. Following a psychodrama which may last from 45 minutes to an hour, the group as individuals may give feedback to the protagonist. This allows for any sharing of strong positive or negative feelings. This takes place over a ten-minute period. Then each family forms as a unit to discuss the implications of the psychodrama on their family system. The protagonist re-enters his/her family system with the instructions that the family is to take what they observed in the drama and deal with that information, NOT to get into discounting the protagonist or defending their own family role. After ten minutes of this sharing the protagonist and his/her family take the center. They share what the drama means for them and a homework task for the coming week that has emerged from their discussion of the drama. Then each family has five minutes to share the important elements of the drama that apply to their own family functioning and to indicate a homework task that they will work on which the drama stimulated for them. This homework is to be behavioral in nature, that is, one could see it in operation. This serves to reinforce the power of the therapy sessions in the span of time between sessions.

The evening ends with myself or a therapist in training making a summarizing statement that completes the circle by tying the psychodrama to the warm-up exercise and defines the theme structurally. We work with eight broad family structures which we define as system issues for the families. These are: boundary issues, power issues, affect issues, communication issues, negotiation issues, task performance issues, distance-regulating issues (space-time-energy) and self-esteem issues. It is our belief that by enabling a family to better understand its organizational structures its members are then able to operate within these at higher levels of differentiation where rational awareness supersedes emotional fusion.

The following cases give brief examples of the therapeutic process and kinds of changes which took place in the multiple family psychodramatic therapy.

Case 1: The Dwight Family

The Dwight family was referred for therapy by the local school counsellor. David, the 15-year-old son, was doing poorly in school following a very good

school record up until entry into grade nine. When the school counsellor talked with the mother she indicated there were major problems at home between David and his father. At this point the family was referred to me for family therapy. The family consisted of Mr. and Mrs. Dwight, Nancy (18), David (15), and Karen (12). Neither of the girls indicated problems nor did the parents feel they had problems with them. "David and his father argued about everything," the mother reported. Mr. Dwight and David agreed although they could give no clear reason. This arguing had been taking place for years but with David's move into adolescence it had become more open and volatile. The Dwights were in the group for about four weeks before anyone sought to be protagonist. The first to do so was Karen; however she was not selected as protagonist that evening. About two weeks later, following a warm-up of round robin problem solving (where the kids in a family define a problem and take it to each set of parents in the group for negotiation) David sought to be protagonist. The problem he chose to work on was his being kicked off the football team at school. The first scene was a confrontation with the football coach (played by a father of another "angry" teenager). Through the use of a therapist-in-training double, David became very angry and at one point used the words, "You never see me, I'm nothing to you." Since David was also at the point of tears, I stopped him and asked where else in his life he felt that way. He said softly, "With my father." I had David select an auxiliary ego from among the other fathers to play his dad. He picked Mr. Towne, who was probably one of the most open, giving fathers in the group. David set a scene in the family home to show us something of how he and his father relate and through role reversal Mr. Towne created a distant and aloof "Mr. Dwight." In the midst of another conflict between David and his "father" the double used the words David had said earlier, "You never see me, I'm nothing to you." David began to cry openly. He was asked to reverse roles with his father and to have a monologue as his father about why he (the father) was so unable to be open and giving to his son. After giving several possibilities David shared this idea: "Maybe I'm scared to be close. You see my father died when I was 10 and I was raised by my mother and older sisters. I never had a man around as a model. Also I fear that if I were to get close to my son he might also leave me. I'm scared to be close to men in my life." I reversed him back into David and had the auxiliary ego father repeat that last line above David. David again began to cry. The auxiliary was instructed to comfort David. He told David about his fear and agreed with David to work on changing their relationship to one of being more open and risk taking. When the psychodrama ended at that point there was not a dry eye in the room including Mr. Dwight. Several shared with David and then Mr. Dwight moved down by David and said, "I learned more about me tonight than in a lifetime. You know more about me than I do and you are right. I am scared to be close. I still miss my father and I don't know how to be a father." The

two embraced and there were more tears in the room. In the family sharing time three out of the four families present agreed to look at their concerns of being close due to fears of loss. They worked out specific agreements in most families where members wanted more direct closeness or intimacy with one another. The Dwight family agreed that father and son would spend more separate time together learning how to be men with one another apart from the women in the family.

The family structures relevant to this psychodrama have to do with boundaries (lack of differentiation on the part of the father so that he could not relate in a clear father-son hierarchy with his son), affective issues (the inability to share with his son the fears and grief the father had in regard to his own father), and communication issues (the inability to talk openly about present and past events which affect the family system).

Case 2: The Engle Family

The Engle family was referred to therapy by the family physician when Mrs. Engle was not able to rid herself of a depression pattern. The family consisted of Mr. and Mrs. Engle, Tommy (16), Mark (13), and Julie (11). Julie had been having difficulty with school work and had been held back a grade because it was felt she was too immature to be advanced into junior high. Mr. Engle was used frequently as a double or auxiliary because of his outgoing manner and insightfulness. Tommy had also been selected as an auxiliary by a 17-year-old girl to play her brother. I had had Mrs. Engle be an auxiliary ego (in the part of a bitchy grandmother) for that same 17-year-old. I thought this might enable her to get in touch with some of her anger, which she did. She indicated at the end she hated the role and seemed to feel guilty for her portrayal. However, this may have stimulated her to seek to be protagonist at the next session. What she presented to work on was the feeling of isolation she felt within her family. She indicated she felt like a "stranger in an all too well known territory." She was asked to pick from the group auxiliaries to represent members of her family. She then set a scene where she came home from work and no one made a move to recognize that she was present except to demand–supper, clean clothes, the hair dryer, etc. After she did a monologue of her inner feelings and thoughts she was asked to go back into her own family of origin. She put herself at six coming into the home from a very bad day at school. She went first to her mother who was too busy. When father came home she went to him and he put her off. She recreated two other rather similar scenes with her family, including one with a younger sister whom she viewed as more attractive and popular. The sister couldn't be bothered with her. I then put all the men in the group in front of her including her husband. I had her do a monologue regarding what she wanted in selecting a man to marry and what she thought her past history would

unconsciously attract her to. She was very clear in being able to indicate that what she needed and wanted was someone to be close and intimate with, who would be "just her own." She fantasized what kinds of things they would do together through a marriage. She then was asked to indicate what unconscious attractions were also present. She indicated that she would be drawn to a man who was secure but non-communicative, one who distanced himself through work and hobbies and who was also incapable of being close just as she was. She laughed and pointing to her husband said, "That's just what I got, my God." At this point the protagonist was given a double and told to dialogue with the double at any point while her husband created a sculpture of his family of origin. He highlighted a half dozen points of development to give a picture of an overly involved family where mother was too needy and demanding of father and father was too involved to give to anyone and increasingly became a peripheral father and husband in the home. Mr. Engle also began to detach himself from the home at about age 13 so that he would not be caught replacing his father. Following the sculpture the women in the group lined up and Mr. Engle talked about what he wanted from marriage and a family and what he might be unconsciously drawn toward. What he indicated in this latter part was that he was drawn toward a woman who appeared very competent, highly self-sufficient and not demanding. When asked who was like that he indicated his wife was all of those things. Mrs. Engle had commented several times with her double about her husband's process and was asked to summarize that openly at this point. She was then asked to recreate a scene with her family of origin in which she was to share with them her feelings about her programming for marriage from her past to her now. Mrs. Engle quickly got into her anger, almost into rage at her feelings of neglect and abandonment. She demanded that her family be more responsive. She was then asked to select an auxiliary current family and confront them with what she needs. She did this and was clear and specific, making dyadic connects with each as to what she wanted and would expect with each. The psychodrama ended with her getting physical contact and spontaneous words of caring from her auxiliary family. The group sharing was intense. The kids felt the power of past family influence and were both excited and rather frightened by what they had learned. The women tended to identify closely with Mrs. Engle and their need for response, especially as kids grew older. Her own family shared that they had not been aware of her need and the homework task that they agreed upon was that each would attempt to respond to her and she was also to affirm what she needed from each of them. Mrs. Engle's depression lifted following this session. They stayed in the group for eight more weeks. During this time Mrs. Engle and Julie formed a very close relationship which had a lot to do with Julie feeling better about herself and doing better in school. The system structures operating in this family related to distance-regulation (space-time-energy), affection and communication. These in turn had an effect on self-esteem issues within the family.

Discussion

These are only two examples of dozens which could be reported. They are sufficient to give a flavor of the impact of this form of therapy. The Adlerians have done family counselling for years in an open forum model believing that the problems in one family are similar to problems in any other family. Where they work at insight and interpretation, multiple family psychodrama is an intense action-oriented therapy which presents the family members a "picture of their system organization." This picture enables them to see both the weaknesses and the problems of their system, as well as how the organization of the system can be changed. These are structural shifts. Despite the intense feelings often created by the therapy, I believe it is the ability to see behavioral patterns and alternatives which most enables participants to make change. The ability to communicate in a manner that enables each family to create homework tasks week to reflect system change places the responsibility for change on the family where it rightfully belongs and not so much on the therapist or the process. Thus as families work each week on new tasks which come from their own making they demystify the therapy process and come to believe that they have the power to make shifts in their family system which can better provide need attainment for all family members.

A follow-up study was made in 1980 with a sample of 30 families who had been through multiple family psychodramatic therapy since 1975. This sample was compared with 30 families who were seen in individual family therapy by the author during that same period. In response to the question: Following therapy your family has functioned Good–Fair–Poor, twenty-three MFP families responded good, four fair, and three poor. From the control sample eighteen families marked good, six marked fair and six marked poor. When applying a simple t test for significance results are:

	Ratings to the 1st Question			N
	Good	Fair	Poor	
MFP group	23 (76.7%)	4 (13.3%)	3 (10%)	30
CONTROL group	18 (60%)	6 (20%)	6 (20%)	30

The result showed $t = 0.167$ (not significant for $df = 58$)

When multiple family psychodramatic families were asked to indicate what they most liked about the experience, 22 indicated that sharing with other families enabled them to recognize they were not alone with problems and that many problems of others were similar to their own. Eighteen indicated that the warm-up experiences were very valuable in learning about family organization as well

as learning new skills for family living. Twelve indicated that the homework tasks had been most beneficial. In general, the evidence would indicate that multiple family psychodramatic therapy is as good as doing therapy with individual family units. When one takes into account that the therapist can work with four to five families in the same time frame that one usually would see no more than two families then it becomes important to take time and cost accountability into consideration. The outcome data also reflected that families learn from each other, learn from structured group tasks, and learn how to learn from their self-determined homework tasks.

A Word about This Context for Training

Since I am involved with training of family therapists and also conduct psychodrama training on a limited basis each year, I found that having five or six trainees in the group was excellent. It meant that I had available individuals who could be more easily coached in the roles of auxiliaries or doubles. Interns indicated that they learned skills of family therapy as well as psychodrama. Interns also got in touch with a good deal of their own family of origin and nuclear family material in the process. The trainees and I agree that it is an excellent context for learning.

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Cognitive Behavior Therapy Follow-up: Maintenance of Treatment Effects at Six Months

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Thirty-five outpatients with a major complaint of anxiety and/or depression were randomly assigned to one of the following: group cognitive behavior therapy (cognitive restructuring plus relaxation and assertion training); individual cognitive behavior therapy (the same techniques tailored to the specific needs of the individual); or group interpersonal therapy (traditional insight-oriented group therapy). Three self-report questionnaires (Beck's Depression Inventory, the State-Trait Anxiety Inventory, and the Adult Self-Expression Scale) were administered immediately pre- and posttreatment, and six months after the completion of treatment. Maintenance of treatment effects was found for state-anxiety, trait-anxiety, and assertion, but not for depression. No differential effects for treatment modality were found. These results are discussed in terms of possible factors affecting the maintenance of treatment gains for depression, anxiety, and assertion. Suggestions for future studies include: evaluation of the efficacy of booster sessions; investigation of the effects of the length of treatment; the investigation of the effect on therapy outcome of respective durations of the modules within the treatment program; and consideration of patient expectations for treatment.

This study is the second phase* of continuing research evaluating the effectiveness of cognitive behavior therapy (CBT) in preventing or ameliorating anxiety and depression. The primary purpose of this study was to evaluate the maintenance of treatment effects of CBT, in both

*See Shaffer *et al.* in the References on p. 63

group and individual formats, six months after the termination of treatment. A secondary purpose was to compare, at six months after treatment, the maintenance of treatment effects of CBT with the maintenance of treatment effects of an interpersonal group therapy approach.

CBT in this study includes cognitive restructuring plus the behavioral techniques of progressive relaxation (Jacobson, 1962) and assertion training (Lange & Jakubowski, 1976). (For a detailed description of this treatment approach, see A Manual for Cognitive Behavior Therapy in Groups [Shaffer & Sank, 1981].) The central assumption underlying cognitive restructuring is that the "affective response of an individual is determined by the way he structures his experiences" (Beck, 1967). Beck and his associates (1978) describe the techniques of cognitive therapy in detail in their treatment manual. The cognitive behavior therapist helps patients recognize the relationships among thoughts, affect, and behaviors. Patients are then taught to monitor negative cognitions and to examine the evidence supporting them. Finally, the therapist presents ways of substituting more rational interpretations for dysfunctional thinking. Cognitive therapy also includes homework assignments to give clients practice in recognizing, challenging, and modifying negative cognitions.

Several studies have compared the effectiveness of both individual and group CBT with that of waiting list controls and other psychotherapy comparison groups. Generally, CBT has been found to be more effective than the various other treatments regardless of format (Beck, Rush, Shaw, & Emery, 1978). Prior to the present study, only two studies had examined the relationship between format (group and individual) and outcome of CBT treatment (Shaw & Hollon, 1978; Rush & Watkins, 1981). In both of these studies individual CBT appeared to produce greater reduction in depressive symptoms than group CBT. However, both group and individual treatments were associated with significant remission of these symptoms. These results were not conclusive, however, since the Shaw and Hollon study patients were not randomly assigned to treatments and in the Rush and Watkins study the group patients were not part of the same randomly assigned subject pool as the individual patients.

The present study represents a more rigorously controlled comparison of group versus individual CBT. In addition, in the present study CBT was compared with an interpersonal, insight-oriented group therapy approach. The persistence of treatment effects over a six-month time period and the differential effects of the three treatment conditions were examined, and the following hypotheses were evaluated:

1. Treatment effects for cognitive behavior therapy, in a group or individual format, are maintained or increased over time.

2. The maintenance of treatment effects over time is greater for CBT than for interpersonal group therapy.

These long-term considerations were not examined in prior studies exploring the differential efficacy of group and individual CBT interventions.

Subjects were a sample of 35 enrollees of the George Washington University Health Plan, a prepaid health insurance plan (HMO). These subjects, all of whom sought relief from symptoms of anxiety and/or depression, were referred to the mental health unit by their primary care teams. They were screened by a mental health therapist who determined them to be appropriate candidates for brief therapy. The typical diagnosis was adjustment disorder with depressed or anxious mood (8% depressed, 43% anxious, and 49% both depressed and anxious). These patients were randomly assigned to one of three treatment modalities, each consisting of 10 sessions: (1) group cognitive behavior therapy (CBT-gp); (2) individual cognitive behavior therapy (CBT-ind); or (3) interpersonal group therapy (IGT). Subjects were administered three self-report questionnaires: Beck's Depression Inventory (BDI; Beck, 1967); Spielberger's State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970); and an assertion measure, the Adult Self Expression Scale (ASES; Gay, Hollandsworth, & Galassi, 1975). These instruments were administered prior to the evaluative interview, immediately pre- and posttreatment, and six months after the termination of treatment.

Initial therapy outcome results were assessed for the patients immediately following treatment; these results, along with a more thorough description of the treatment modalities, are presented by the authors in a preliminary report (Shaffer, Shapiro, Sank, & Coghlan, 1981). In the preliminary study the hypothesis was supported that CBT in a group format is as effective as individual CBT in reducing symptoms of depression and anxiety and in increasing assertion. These findings recommend a treatment program emphasizing group versus individual intervention for patients with moderate anxiety and depression, a treatment program likely to yield important cost savings for HMOs. All three experimental groups showed a significant clinical and statistical improvement from pre- to posttreatment on all dependent measures; no differential treatment effects were found.

These findings were discussed in the context of (1) the CBT-orientation of the therapists who delivered treatment in all conditions, (2) the low pre-treatment levels of anxiety, depression and non-assertion in this population and (3) the lack of homogeneity of diagnosis which presented a statistical confound.

In addition, inverse relationships were found between depression and

TABLE 1

Paired Comparison t-Tests

	Pre/Post	Post/6-Month Follow-up	Pre/6-Month Follow-up	Pre-evaluation/ 6-Month Follow-up
BDI	4.07***	−2.41*	1.00	2.17*
STAI-STATE	3.67***	.28	3.59***	3.95***
STAI-TRAIT	3.96***	−.39	3.58***	3.99***
ASES	−4.67***	.28	−3.40**	−3.07**

*p < .05 **p < .01 ***p < .001

assertion and between anxiety and assertion. These relationships held constant for both premeasures and postmeasures.

Results

Repeated measures and analyses of variance were computed for all subjects on whom six-month follow-up data was complete (N = 29), covarying sex. This follow-up sample was evenly distributed across groups (CBT-gp = 9, CBT-ind = 10, IGT = 10). Main effects were found for each dependent measure for time of assessment (pretreatment, posttreatment, and six-month follow-up): BDI $F(2,52) = 6.65$, $p < .003$; STAI—state-anxiety $F(2,52) = 6.13$, $p < .004$; STAI—trait-anxiety $F(2,52) = 9.62$, $p < .0001$; and ASES $F(2,52) = 7.12$, $p < .002$. No differential effects were found for treatment modality.

Paired comparison t-tests were calculated for pretreatment and posttreatment; posttreatment and six-month follow-up; pretreatment and six-month follow-up; and pre-evaluation and six-month follow-up difference scores. These results are reported in Table 1. Maintenance of treatment effects was found for state-anxiety, trait-anxiety, and assertion, but not for depression.

Pearson product-moment correlations for the four six-month follow-up self-report measures are reported in Table 2. Assertion is significantly negatively correlated with both state- and trait-anxiety. In contrast to the significant negative correlation found between depression and assertion at both the pretreatment and posttreatment assessments, depression and assertion were negatively but nonsignificantly correlated at the six-month follow-up assessment.

TABLE 2
Pearson Product-Moment Correlations
Six-Month Follow-up Scores

	BDI	STAI-STATE	STAI-TRAIT	ASES
BDI	1.00			
STAI-STATE	.66 $p < .0001$	1.00		
STAI-TRAIT	.58 $p < .001$	.83 $p < .0001$	1.00	
ASES	−.25 $p < .18$	−.48 $p < .01$	−.58 $p < .001$	1.00

Discussion

Treatment effects for anxiety and nonassertion were maintained during the six months following treatment. However, the data indicate that the level of depression of subjects in the groups overall rebounded to a significant degree ($p < .05$), although not to pretreatment level.

Thus, the hypothesis that treatment effects for CBT in a group or individual format are maintained over time was supported for anxiety and assertion. The second hypothesis of differential maintenance among treatment conditions has not been supported. This parallels the findings of a lack of differential effect at posttreatment. However, the maintenance of treatment effects for anxiety and assertion over a six-month period is encouraging. To date, no studies of CBT treatments have demonstrated this long term effect.

Lasting clinically significant treatment effects were found for nonassertion and anxiety. However, the lack of maintenance of therapeutic effects for depression bears some discussion. Various hypotheses can be advanced to explain this finding. First, there was some evidence that the subjects might have been experiencing some anger at the brief nature of the treatment (10 weeks) and at the number of research forms they were asked to complete. Several of the patients wrote letters to this effect accompanying their six-month questionnaires. The general tone of these letters was one of anger. The content focused on the perceived limitations of the therapy, most notably the brevity of treatment and the focus on coping skills rather than insight into the underlying causes of symptoms.

Patients' expectations of therapy often include a notion of long-term individual treatment which would focus on an exploration of the un-

conscious, and a recapitulation of traumatic historic events, and would foster a close intimate relationship with the therapist. The treatment most discordant with these expectations was group CBT which was not individual, did not dwell on history or explorations of the unconscious, and which impressed upon the patient a sense of self-reliance and collaboration with the therapist. This treatment approach offered a structured curriculum of skill development rather than a discussion focused on specific individual problems and their derivation. These expectations of the therapy process could be partly responsible for anger elicited at six months. Although patients were instructed that the questionnaires were only for research purposes, the inventory of depressive symptoms may have been used as a means of venting this anger and/or asking for additional help.

Secondly, following treatment, the withdrawal of the therapy support system might be expected to result in a slight rebound of symptoms, especially for the treatment of depression where the support function of the therapist may be more important than in the treatment of anxiety. Since symptoms of depression include a sense of hopelessness and helplessness, the patient may be more likely to look to a therapist when depressed than when anxious. It might be hypothesized that over time the presence of the therapist may decrease in importance as the patient recognizes a sufficient sense of self-efficacy to become his/her own therapist. In addition, at the end of treatment, the patient was still physically present with the therapist when the outcome measures were administered and may have continued to feel cared for, supported by, and dependent upon the therapist. At the end of treatment, patients were strongly advised to refrain from seeking treatment for a few months and were encouraged to use this time to apply the skills attained during therapy. Once removed from the therapeutic milieu, she/he may have felt pessimistic or uncertain about using the skills in the absence of the therapist's guidance, empathy, and encouragement. In addition to the feelings of anger due to the brevity of treatment, the withdrawal of the therapist's concrete support may have been very distressing for patients desiring to continue a dependency relationship.

Third, because the entire treatment experience was limited to 10 sessions, it may not have provided adequate time for patients to experience many stressful life events. They may have lacked the opportunity to test out these newly acquired techniques in more difficult problem areas. In the six-month posttreatment interval, there is a greater likelihood that more stressful events could have occurred. In fact, several subjects indicated anecdotally that they had experienced significantly stressful life events—e.g., death, divorce, and unemployment—during the posttreat-

ment interval. Because of the possible need for overlearning of cognitive restructuring and for sufficient opportunity to use these techniques to deal with more severe stress, either periodic, regularly scheduled sessions, or booster sessions should be useful following the termination of treatment.

Also, with the addition of a booster session, patients may still feel involved in therapy six months following the formal treatment program, thus eliminating potential anger at being seen briefly, having to complete questionnaires, and feeling abandoned by the therapist.

We are encouraged by the findings of the six-month posttreatment follow-up in that they indicate lasting significant treatment effects for two of the three problem areas studied. Future studies are suggested by the lack of maintenance in the depression variable. The use of booster sessions and the lengthening of the cognitive restructuring treatment module are two possible areas of inquiry.

In addition, expectations for therapy have been shown to be highly correlated with therapy outcome for depressed patients (Steinmetz, Lewinsohn, and Antonuccio, 1981). Future research could include a more thorough preparation of the group members during the initial screening phase to influence positively the participants' expectations for treatment and treatment outcome.

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Co-Directing: A Method for Psychodramatist Training

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The authors provide a co-directing method which utilizes action principles in training psychodramatists. The co-directing method is described in detail, with specific applications of how the techniques can be employed in training situations. The paper concludes with suggestions for supervision and evaluation of novice psychodramatists.

During the past ten years there has been a creative outpouring of manuscripts on the training of psychodramatists (Blatner, 1970; Hale, 1974; Hollander, 1974; Schramski, 1979; Warner, 1975). Of particular interest to these authors and others are the issues that confound the integration of psychodramatic skills for the novice director. Included among these problems are the novice director's confusion about the use of role reversal, the inability to properly "warm up" the protagonist to the time and place of the role play, lack of selective attention to verbal cues, uncertainty about how to facilitate transitions from one scene to another, and difficulty in continuing to direct a session when a mistake or series of technical errors have been made. These issues become even more critical when student directors make the transition from the forgiving environment of other students-in-training to the practicum of an in-patient or out-patient group.

As a result of experiences at the Western Institute for Psychodrama in Phoenix, Arizona, the authors have developed and refined the use of the co-directing method as a training tool. This paper describes this method, emphasizing specific role-training aspects of becoming a psychodrama director.

Philosophy

Zerka Moreno discusses her preference for a director *tele* relationship with the protagonist over a more analytic, doctoral one:

> Once the protagonist senses the director to be genuinely "with him," the director is free to move again into a more objective position, hence he can survey the further needs of the protagonist and those of other group members. This delicate balance of the subjective-objective relationship is one of the most crucial *sine qua non* demanded of the director for effective achievement of his task. (1969, p. 215.)

We have found this balance to be a crucial aspect of how a novice director views his or her work with both training and patient groups. Therefore, the ability of the novice director to remain in the session as the primary director is most important.

The co-directing method, emphasizing the continuous involvement of the novice director (ND), was developed when the second author was a student-in-training (Morrison, 1981). She discovered that when she left a session as a ND, her learning was hampered. All of the authors found the styles of approaching the ND to whisper directions or to intervene in a similar, disruptive fashion to be unproductive. Therefore, the trainer-director (TD) began to intervene as a double in order to minimize both disruption of the session and the protagonist's anxiety about the direction of the session. This emphasizes the psychodramatic concept that the double, as an auxiliary ego, is an arm of the director.

Method

Co-directing is a relatively simple and straightforward method. It is introduced to students-in-training as a method that has evolved out of practical experience with NDs who find themselves echoing Gerard Kelly's statement that "the technical model outlined by Moreno appears too complex for direct application" (1977, p. 62). The co-directing model is presented as assistance to the ND, using the TD in the role of double to:

1. Give the ND previous cues that the ND has missed or only partially understood.
2. Explore and obtain information the ND has missed, such as age, nature of relationships and personality characteristics of the auxiliaries.
3. Emphasize or underline key feelings of the protagonist that are critical to the evolution of the psychodrama.
4. Organize the various cues into a theme of the psychodrama, rather than haphazardly pursuing a variety of unrelated cues.

In addition, it has been continually apparent to the authors that a *tele* will develop between the double (TD) and the protagonist, as well as be-

tween the director (ND) and the protagonist. Utilizing the rapport with the TD double, the ND or TD can signal a role reversal and the TD will become the director and the ND the double. This enables the ND to observe the more experienced TD and integrate the cues and thematic material presented by the protagonist, while maintaining a *tele* with the protagonist. At an appropriate time, as soon as possible, the ND double (or TD) will again signal and a role reversal again takes place, allowing the ND to once again direct the session. The immediate, post-session results of this strategy for the ND are more sessions completed, increased self-confidence, and less anxiety about the quality of treatment provided to protagonists.

There are a few basic steps (with many variations) to the co-directing process, that are outlined as follows:

Step 1: The TD and a more experienced ND familiar with the co-directing process demonstrate the method. The ND asks or the TD signals to be a double for the protagonist and the ND utilizes the cues that are emphasized by the double (TD)—an emphasis on a particular feeling, thought or behavior that could be critical to the development of the psychodrama. The TD and ND may reverse roles for the purposes of training, but this is not encouraged. It has been our experience that as a ND becomes more skilled, he or she will rely less and less on role reversal with the TD. It is important that the ND be in the director role at the completion of a session, if at all possible.

Step 2: After the session, part of the evaluation centers on the use of the co-directing model. Attention is given to the mechanics of the technique, how the ND integrates the cues of the double (TD), and how it enables the ND to maintain *tele* with the protagonist without inhibiting the spontaneity of the session.

Step 3: Other students are asked to direct psychodrama sessions and use the TD (and eventually other NDs) as co-directing doubles. Role reversal is again encouraged only when necessary, but in preference to the ND halting a session to ask for group assistance.

Step 4: As the students employ the co-directing method, they are asked to evaluate their own work as director and to double with one another to facilitate their own self-monitoring skills and student-to-student *tele*.

As can be seen in these steps, experimentation within a supporting environment is encouraged. The method is beneficial to the protagonist because it offers a back-up of quality assistance while the ND is develop-

ing his or her psychodramatic skills. Likewise, it is helpful to the ND who feels that he or she does not have to abdicate the role of director while experiencing difficulty in maintaining the "delicate balance of the subjective-objective relationship." Interestingly, protagonists and directors report a minimal disruption in their *tele*, and in fact often report a deepening of their relationship in the process of role exchange and doubling.

Supervision and Evaluation

A final note has reference to the self-confidence and skill of blossoming directors. We encourage all students, in any supervision session, to evaluate their own work with these methods *before* they ask for feedback from their trainers and student peers. We have found the degree to which students are willing and able to evaluate their own skills to be directly reflective of their ability to understand the psychodramatic process.

We also advocate a systematic approach to learning the co-directing method, as well as other sociometric and psychodramatic techniques. Goldman (1981), Hale (1974), Hollander (1974), Schramski (1979) and others have provided general and specific outlines of ways in which student directors can map their theory and technique in order that they might provide better services to their clientele and more cogent explanations of their work to colleagues.

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A Methodology for Existential Psychotherapy: Psychodrama

Howard Seeman

The author points out that historically the major shortcoming of existential psychotherapy has been its failure to formulate a methodology by which to apply its insights regarding human existence. In order to make progress toward developing such a methodology, the author clarifies and amplifies the major tenets of existential psychotherapy so that they are more usable for the *practice* of psychotherapy. He then formulates a methodology with specific psychodramatic techniques, so that these tenets can be applied in actual work with clients.

The origins of existential psychotherapy can probably be traced to the publication in 1926 of Martin Heidegger's *Being and Time.* Through the presentation of a new and comprehensive perspective on human existence, Heidegger gave cause for a new therapy in the service of that existence: existential psychotherapy. Today, among the ranks of practicing existential psychotherapists, we can count Victor Frankl, Ludwig Binswanger, and Eugene Minkowski as prominent. Existential psychotherapy as practiced by Frankl is known as "logotherapy" and it alone has been the subject of 35 articles, four books and at least fifteen films, records, and tapes. Also, the theory of existential psychotherapy has received widespread attention through the publication of *Existence: A New Dimension in Psychiatry and Psychology,* edited by Rollo May and published in 1958.

Yet, more than twenty years later, few therapists identify themselves as practitioners of existential psychotherapy. Even the most successful eclec-

tics do not name the existential perspective as a major influence on their practice of psychotherapy. In light of the praise and admiration that psychiatrists and psychologists have expressed for the insights brought to them by this existential perspective, what is the reason for the absence of this perspective in the actual practice of psychotherapy? I suggest that the answer to this question lies in the fact that existential psychotherapy has offered only that, a perspective, albeit an insightful one. In 1958, Rollo May made the following point:

> Those who read works on existential analysis as handbooks of technique are bound to be disappointed. They will not find specifically developed practical methods. The chapters in this book, for example, have much more the character of "pure" than of applied science. Roland Kuhn wrote, in answer to our inquiry about technique in some of his significant cases, that since existential analysis is a relatively new discipline, it has not yet had time to work out its therapeutic applications in detail. (May, 1958, p. 76)

That was twenty-four years ago! Today, the same situation still persists. In short, existential psychotherapy has offered great sight but little praxis. Even Frankl's most publicized method, "paradoxical intention," is quite limited. This technique, as Frankl (1967, p. 163) himself acknowledges, works best only with clients who suffer from forms of anticipatory anxiety.

In this paper, I would like to make some progress in remedying this state of affairs. In the first section, I shall attempt to present some of the major tenets of existential psychotherapy, perhaps most characteristic of Victor Frankl's "logotherapy." I shall attempt to present these tenets in such a way that they may be better understood as *applied* science than as pure science, and as more applicable to therapeutic practice than to theoretical exposition. In the second section, I shall make specific suggestions for the methodological application of each of the tenets presented in the first section.

Part I

1. Perhaps the most general recommendation made by existential psychotherapy is that therapists revise their view of human nature. In a sense, we are told that as therapists we are not operating on, or working with, human nature, but with human *existence.* This is a significant distinction. As agents, we tend to view human nature as static, as a thing or patient of our agency. Of course we make a great effort to avoid viewing our work merely as an agent-patient relationship; we explain that the relationship is interactive, or we describe human nature as dynamic,

or as mysteriously complex. However, this generous attitude does not satisfy existential psychotherapists, who feel that such descriptions of human nature still miss the mark. Human existence is quite different; it is not sufficient to call it quite another thing. It is not a thing. The point is that humans are special kinds of beings in that each is beyond itself. Existence means "standing out, or beyond" (Heidegger, 1926, p. 42). Each human existence is active *being,* not a thing that can be indicated by the use of "is." Humans are "being-in-the-world," or "being-with-others," or "being-toward- . . ." No description of its present state adequately describes this kind of being. It is the human "being-toward," or "being-beyond," or "constant outward-projecting" that is the essence of human "being." As Frankl sometimes says, *Dasein,* or "being-there" of human existence is in itself *transcendent* (1967, pp. 12, 25, 61).

2. Consequently, existential psychotherapists invite attention to this "towards," that is, the projection of *Dasein* beyond its own "here and now." It must be realized that homeostasis is not the natural (healthy) state of *Dasein.* It must be realized that human *being* is "thrust-directed" from its being (being →) if we are to achieve a better understanding of many neuroses. *Dasein* cares, is concerned with, opens to its world with things at stake, with things that matter, or are at issue for it. In this sense, a growing, healthy *Dasein* is not that being always needing to be brought to resolution or to a state of homeostasis (e.g., through resolution of its conflicts). Rather, *Dasein*'s transcendence must be enabled, or sometimes reinforced. A certain kind of tension must be seen as productive of and a sign of health for this kind of being (Frankl, 1967, pp. 47–48, 50–51).

3. In addition to the above two revisions comes the implied recommendation that, in a sense, we work less with just the being who presents his or her self to us in therapy and more with the *world* of that person's being. In the past, we have had a tendency to operate on the ailing self, or ego, or personality. Or, when we have done better, we have directed ourselves toward this troubled being who is *in* the world. However, if we are to become even more perceptive practitioners, we must rather direct ourselves toward this troubled "being-in-the-world," and we should not focus on its "*being*-in-the-world," but more on its "being-*in-the-world.*" To focus only on the former is to restrict therapy to a therapy of a self, or even worse, a thing with a personality. For example, to follow Frankl's suggestions, we must bring therapy to this "in" the world, this projecting relation toward the world of *Dasein* and to allow this "world" to be counted as part[1] or as an essential aspect of human being.

4. Existential psychotherapists also emphasize a key Heideggerian point: this essential relation of "being towards . . ." of human existence,

aside from the obvious fact that this relation is directional and projective, is also always temporal. In other words, *Dasein* is always "being-towards-its-world" in *time* or toward time. As such, this relation is a "being-towards-the-future," or, more accurately, a "being-out-of-the-past-presently-towards-the-future" (Heidegger, 1926, Section 69). *Dasein* is usually busy with things or people in order to accomplish specific goals or projects. As a matter of fact, the world of *Dasein* is usually an entire network of means and tools "in order to . . ." (Heidegger, 1926, Section 18). Each doing is "for the sake of . . ." and, ultimately, these all have their origin in a pre-conscious awareness of "being-toward-my-finite-world," or finite existence. To say it more explicitly, *Dasein* is always directed towards its world at least preconsciously with an awareness of its own "being-toward-the-end," or "being-toward-death" (Heidegger, 1926, Section 51).

5. As a matter of fact, it is the human awareness of finitude that grounds this essential character of human existence as leaping, projecting beyond itself (Frankl, 1967, p. 30). It is in this context that we understand *Dasein* as that existence needing to actualize or fulfill meaning within its finite world or mortal existence. A thing that is not *Dasein,* but merely an inanimate object, is never aware, or beyond itself, or able to be concerned *toward*. . . . Meanings are the nemeses only of human existence.

Thus, existential psychotherapists are asking us, in a way, to interpret our clients' "presenting problems" as manifestations of a primordial striving: *Man's Search For Meaning* (the title of Frankl's book, 1970).

6. This above interpretation has further implications concerning our view of clients in therapy. For instance, if a woman comes to us complaining she is upset about being just a housewife, our new perspective might lead us to understand that her complaint extends beyond her restricted role in a sexist marriage or society. We would understand that she is also a *Dasein* whose complaint may be understood as a troubled lack of meaning in her life. And also, that beyond her awareness of the lack of meaning in her present life, she has at least a pre-conscious awareness of her life as finite. In fact, her complaint can be said to make sense only if it is taken as a complaint on the order of "I am living this way; I don't like it; I don't want to keep living this way because I have only one life to live (before I die)." It may be helpful to our understanding of troubled clients if we at least view their reasons for entering therapy, or their "I'm tired of being like this" statements as containing at least a pre-conscious awareness of their own *Dasein* and its mortality. If we do hold this view of our clients, then the relevance of what has been discussed above becomes apparent for our practice of therapy.

7. Together with the significance of meaning for *Dasein*, a further consequence of the existential framework for psychotherapeutic practice is the new perspective gained regarding *action* and *responsibility*. It is in becoming more active and in taking on responsibility that *Dasein* actualizes or fulfills meanings. To be responsible is to care, to care is to move away from mere being and to go out, to project forward with concern into the world. To project oneself toward projects, one actively chooses to make things matter, one chooses to transcend—to be fully human. In this context, it may be that clients are troubled with not *enough* responsibility, or with blocked responsibility rather than with particular responsibilities as such. Further, depression, for example, is not then caused merely by, e.g., loss or repressed anger. Rather depression may be the symptom of a crucial impairment of that activity of human existence (actualizing meanings) essential to *Dasein* itself.

8. Although existential psychotherapy has produced little in the way of technique to be used in the application of its perspective, Victor Frankl has popularized one major method used in his logotherapy, "paradoxical intention" (1967, pp. 143-164). Frankl points out that *Dasein* can make use of the fact that it can take various stands towards its own suffering, and it can choose from among various points of view on its own situation. With this human ability in mind, Frankl applies his method of "paradoxical intention." Specifically, the client is encouraged to try to intend the very symptoms that are suffered (usually as the result of some form of anticipatory anxiety). For example, if a male performer worries that he may shake nervously during a performance, he is urged to *try* to shake as much as possible. Frankl most strongly emphasizes the paradoxical *intention* recommended, and the successful results achieved by wishing for the very symptoms that are un-desired.

This technique is useful in certain instances, but, as mentioned above, it is limited to anticipatory anxiety and takes as its focus the reversing of *intention*. I believe that within this technique is a crucial find, that if made the focus of Frankl's insight, yields greater usefulness. I believe that this find has less to do with *paradoxical intention* and more to do with the wondrous ability of *Dasein* to take, as discussed above, various points of view on itself. It is this that needs amplification if we are to give existential psychotherapy a methodology.

As discussed above, *Dasein* is not simply a self in a world; its self or whole being is best described as "being-in-the-world." Its world, and the things and places and relations of its world, are all aspects of *Dasein*. And *Dasein* is always "being-in-the-world," beyond simply mere being. It is this fact that enables *Dasein* to see itself from various points of view in its world. A man may see himself as other men and women see him.

Or he may see himself specifically as those in his profession see him. He may see his life from the point of view of his past, or from how he will be in the future.

In addition, since *Dasein* is "being-in-the-world," and "-world" includes others and things, he can see his being from any of these aspects of his world. For example, he may see himself as his mother might see him, or how (if it could) his desk at work might see him. Usually, we tend to see the world from the point of view of subject-viewing-object. However, this usual point of view is only one way of viewing our being. *Dasein* may *choose* a point of view, or as therapists we may direct *Dasein*'s point of view.

As therapists, in a way completely separate from the use of the recommended paradoxical intention, we may direct a client to take particular points of view. Here intention, *per se*, may have nothing to do with any direction we may give the client. The significance here lies in the fact that the client usually presents troubles from a being-there that is not as locked into "there" as the client indicates is the case. The neuroses may arise, in part, from this locked-in point of view. That *Dasein* can deal with its world not only from its localized self, but also *from its world* has wide therapeutic implications, as I will explain.

9. Existential psychotherapy has been helpful in identifying a specific neurosis unique to our modern age. It is helpful to interpret some of our clients' complaints from a perspective not only psychological but, as Frankl calls it, spiritual as well. In a way, modern man suffers from living in an existential vacuum, there is a perceived lack of meaning to his existence. Frankl believes that only a life of responsible action, the doing of projects with a sense of commitment, can lead to the resolution of this problem. Unfortunately, humankind often retreats from this task, a task that requires individuality, and falls instead into:

> conformist or collectivist thinking. This shows itself when the average man in ordinary life desires to be as inconspicuous as possible, preferring to be submerged in the mass. Of course we must not overlook the essential difference between mass and community. It is this: A community needs personalities in order to be a real community and a personality again needs a community as a sphere of activity. A mass is different; it is only disturbed by individual personalities, and therefore it suppresses the freedom of the individual and levels the personality down. (Frankl, 1967, p. 119).

This perspective is useful. Most practicing therapists can take this as reinforcement for their efforts to help clients sort out who they are from the pressure of others (e.g., clients; parents). However, again this view as it stands recommends only a limited praxis by which it may be employed. Is there a methodology that can make use of this perspective? I believe

so, and will now present suggestions for a methodology for the existential psychotherapeutic views presented above.

Part II

I take as my methodological base for these amplified views some specific applications of psychodramatic technique. Among existential psychotherapists, it seems that only Frankl speaks of using psychodrama in conjunction with his logotherapy (1967, pp. 26, 33). However, nowhere does Frankl seem to realize how specific psychodramatic techniques might be used to put into practice particular logotherapeutic views. Therefore, we do not find in the literature the mechanism for applying such techniques to logotherapeutic practice. I will therefore now identify some particular applications and suggest ways in which they may be specifically used in the practice of existential psychotherapy in general.

Regarding the existential psychotherapeutic views amplified in Part I above, I will discuss a praxis for Point 1: a human being is such that in its very being it is already *beyond* itself. Therefore, practitioners may direct their clients to show "*where*" they are. Clients can actually get out of their chairs and show us that "I am mostly occupied with this work over here," or "I can't concentrate on my work because I'm really with Sue in California, worried about her." Psychodramatically, clients might role play their being-at-their-work, which is really just the way in which we allow them to show us, and then clarify for them, where they actually, existentially are. As a result, clients' problems are made more concrete and are brought to us in a way that makes them more accessible for therapeutic work.

Regarding Point 2: that *Dasein* is always "towards . . . ," "projecting," and that homeostasis is not its natural state, psychodramatic technique can give impetus to this "being→." We can take significant notice of that "towards which" our clients are concerned, bothered, or have at stake. We can direct our clients to not simply express this move of their "being towards . . ." in words (at best such verbalization is a distortion of the unique animation of caring itself), but also direct them to actually get out of their chairs and demonstrate their moving, a projecting of their being. A client who feels attracted to, or pulled in a specific way can be encouraged to demonstrate this particular pull; or to show us how the pull or concern feels or looks, and we (the therapists) can have someone else (playing the part of the pull or concern) actually pull him or her. More simply, we can direct the client to go (get out of

the chair) toward that which he or she is concerned with, actually becoming the concern (after taking another chair), and to verbalize the voice that is applying the pull.

These techniques have the further advantage of not merely resolving conflicts, but of also clarifying and strengthening what we earlier referred to as productive tensions. If human existence is naturally transcendent, then homeostasis may not always be its goal. We may wish to help manifest in our clients those energies that mobilize. Too often when clients are busy structuring reality into frozen syntax through their verbalizations, and toward a resolution, they ultimately bring themselves as well as their problems to an unhealthy, static, resting state. Too often such rest, like the use of most tranquilizers, is abused. The above technique can mobilize, not just resolve. We often need to enhance this existential tension of human being→, not always calm it.

Let us apply some praxis to Point 3 above: *Dasein,* or human existence is not just a self with a personality. Its being includes its *world* and the *how* it is "being-in-the-world." Therapists can direct clients once again to leave the chair (the localized site where the "mere" self is interrogated) and demonstrate their world. "Where is your desk if this is your office?" "Where is the phone, where are the windows?" "Show us!" "Who is here in this space?" "Where does she sit?" "Show us how she sits, what she is likely to say." "Now, from your seat, is this how your world feels?" "Oh, do you feel more distant from her than that?" "Then, put her chair where it seems that she is." "You feel small in this office?" "Here, sit low down in this small, low chair." "Is that how you feel?"

These directions are valuable in that the client's world is brought into the session in a more concrete way than is usually the case. Instead of the self talking about a world as subject to object, the world of the client is presented phenomenologically, as it is felt and as it appears to the client. The world is presented as that which the self is immersed in, concerned with, where now the self is merely the force field (or better, the care-field) concerned, fully spread out toward and among its world. In our "everydayness" (the term Macquarrie and Robinson have used to translate Heidegger's "alltaglichkeit" in his *Being and Time,* Sections 26 and 27) that *is* how we are with the things of our world. It is only when we objectify and remove ourselves from our concerns that we break off our selves from our worlds. But, this latter sight gives us only *the world* for study, not *our* world (*my* world) that is, viz., our *lived*-world. Using the above techniques, the therapist can work with the client's world as *lived,* and is not limited to the study of the client's world as something over against a self that is reported by a subject.

These techniques have yet another advantage. They get the client out of the chair of the localized self. As we have already mentioned, in most neuroses, what is complained about is accompanied by a feeling of threat. Often, it is this threat that drives the client to cling even more strongly to his localized point of view. A skilled psychodrama director can urge a client to present himself from various aspects of his world with enough guidance and support to dislodge the set from which our client persists in his problem.

Frankl points out (1967, pp. 50-51) pleasure and self-actualization are not accomplished by focusing on either the pleasure or the self. The former is usually an *effect* of focusing away from the pleasure (for example, on the process of love-making rather than on the orgasm itself). The latter is only achieved when the self attends to the activity toward which it is directed, not by focusing on its self or on the object of its pleasure. The psychodramatic techniques illustrated above give the therapist a method with which to enable self-actualization or pleasure, if either or both seem appropriate goals at a particular time. The therapist can direct the client toward the *activity* of the pleasure, not at the pleasure itself, or toward the particular project or goal, and away from the self. These activities or projects can be imagined and placed in an empty chair on the other side of the room. By directing the client toward them, the client becomes less self-focused and more project- or activity-focused, and thus more apt to work out the desired effect.

Some therapists, however, would argue that the above technique is not relevant to them because they are more concerned with the client's "will to power" than any "pleasure principle," or "self-actualization." However, Frankl points out that "power is not an end but a means to an end" (1967, p. 21). Clients do not attain a sense of power by focusing on "power" *per se*; they attain a sense of power by moving toward (working on, bothering with, lifting, caring, trying, and so on) a chosen project. Clients attain a sense of personal power in working on their projecting towards achieving, putting out energy, caring, making an effort. Through the use of psychodramatic techniques, we can direct our clients away from themselves or their concern for power, and more toward their projecting (getting off their chairs, getting to work, doing something) and, thus, help them better achieve a sense of personal power. "You feel powerless with your son?" "Well, he's over there in that empty chair." "Get out of your chair, stop sulking, and go over there to him." "Move, talk to him, grab his hand, even lift him if that's what you need." "Try it, I'm with you, I'll help." "As you go toward him, talk about what feels so difficult for you here."

Let us now discuss a methodology to be applied to Point 4: *Dasein*'s

"being towards . . ." is also a temporal relation. Our clients experience their present as out of the past and towards the future. Our clients are in the world, and are already involved toward things, in order to . . . , for the sake of . . . , and so on, *beyond* the present. We come from our past, but we are presently concerned with the future. In this sense, our clients are "being→future." Even our clients' preoccupation with past or present is usually due to some conscious or pre-conscious perception about what they are worried about that may, will, or should happen. With the use of psychodramatic techniques, therapists can make these concerns take concrete form, and can even have clients speak as from the future. "You say you are worried about your job, about going to work on Monday?" "O.K., pretend that it's Monday, 8:00 A.M." "What's the date?" "What are you going to wear to work?" "How do you feel this morning?" Through the use of such "future projection," the future that is impinging on the client's present state can be brought more concretely and actually into the session. Since human existence (being) is not only present, but future, these methods allow our clients to work on their "being→" more directly. Our clients may also try on, step into, choose future alternatives and possibilities. "O.K., it's Monday, do you want to tell your boss that you're angry?" "Go ahead, try it, it's Monday and he's here." "No?" "O.K., try being nice to him." "How does that feel?" As when dreams are therapeutic, without the consequences of waking reality, psychodrama (especially future projection) allows the client a laboratory setting, also free from the consequences of reality, in which to test behaviors and feelings. Even better than dreams, the client can be helped to feel un-alone in the awake, yet dream-like psychodrama, and can exercise more control than when in the dream state.

As was also discussed in Point 4, *Dasein* is also always directed toward its world, at least pre-consciously, with an awareness of its "being-towards-the-end" or "being-toward-death" (Heidegger, 1926, Section 51). If *Dasein*'s preoccupation with its world is "in-order-to . . . ," then each goal is actually a network of "in-order-tos. . . ." These networks have as their horizons felt limits regarding time. Usually, we are bothered only with the time-limit of a particular project, such as "I must get this done by Friday." However, there would be no sense to these situational time limits if life itself were not limited in terms of time. Those clients who come to us for help saying something like "I don't want to live this way any longer," are at least pre-consciously concerned with, and aware of, their lives as that which will not last forever. It is sometimes useful for us as therapists to understand the influence of this perspective, although our clients may never explicitly express it. Sometimes we may

find it useful to express this perspective *for* our clients in an explicit manner. "Mary, how old are you?" "How would you feel if you haven't done anything about this by your thirtieth birthday?" "How will this feel when you are fifty?" "Would you want to be remembered by your children this way?" Our awareness of our own mortality can often be the incentive we need to work on our lives. The above techniques help our clients focus on meaning for their lives (see point 5). It is because our lives end that we seek to invest them with meaning. Such techniques as we have illustrated here are useful in dealing with problems of the type presented by the housewife in Part I, point 6.

Psychodrama is also particularly well-adapted for working on Point 7: that the existential perspective emphasizes meaning accentuates the significance of *action* and *responsibility* for healthy human existence. Psychodrama can be used as a laboratory for experimenting with choosing and acting. "John, over here is the car you want; over there is the work you will do if you want to buy it." "Talk to each of these." "Go over and sit in the car." "Now, go over there and feel the work." "Now, come back to your chair and look at each of them again." "Talk about how this choice feels." The therapist can also point out that not choosing is a choice to remain in the chair. "How does that feel?"

In asking the client to use role reversal and to take an empty chair and talk to *himself,* the therapist helps the client with responsibility. "John, reverse roles and sit over here." "Do you see yourself over there?" "Well, how do you feel about his choice?" "Tell him." "You say that he is being lazy in his choice?" "Tell him." "You say he's being irresponsible?" "Well, reverse roles (back into the original chair)." "John, answer him (yourself)." "He said you're being lazy and irresponsible." If human existence is enhanced by the existential tension of cared for meanings, and if meanings are actualized in responsible action, then such methods aid in the growth of full human existence.

In Point 8 we mentioned that the practical insight within Frankl's "paradoxical intention" is *Dasein*'s ability to see itself from various points of view. In this area, psychodrama is particularly helpful. With the proper direction from the therapist, a client may become any aspect or person in his or her world, past, present, or future. From any of these points of view, the client might then try acting, feeling, or working on any other aspect of his or her world. "John, come over here and be your mother." "Mom, what do you think about what John has been saying?" Or, "John, be your T.V., over here." "John's T.V., has John been watching too little of you, or too much?" "T.V. (John) what do you think?" Certainly, from any of these points of view John might try a paradoxical *intention,* might employ sarcasm, or might do the whole role

non-verbally. But what is of more use here than the application of paradoxical *intention* is the ability psychodrama gives the therapist and client to use this wondrous fact and ability of human existence: that such being is "being-in-the-world," and thus can see itself from any aspect of its "in-the-world."

We come finally to Frankl's idea (Point 9) that "a personality . . . needs a community as a sphere of activity" while guarding against falling into a "conformist or collectivist thinking." A fully therapeutic psychodrama is best done as group therapy. The therapist attempts to create some semblance of group community in the warm-up from which a particular protagonist feels supported enough to work on his or her own self and world. If done properly, the group does not put pressure on the protagonist to think or behave in a particular way, but rather the director *follows* the protagonist so as to help her or him dramatize, concretize how they feel they are "being-in-the-world." Here, the protagonist, with support, decides his or her individuality. Thereby the community (the psychodrama group) has a chance to incubate individual personalities, which comprise a real community, not merely a mass. The psychodrama group can also provide what Frankl says is needed: "A personality needs a community [a supportive group] as a sphere of action" (1967, p. 119). People gathered around a stage, watching a protagonist choose and carve out his or her life, can play the protagonist's mother or boss (these are usually called "auxiliaries," and are only played properly when they are portrayed as the protagonist—phenomenologically—sees them). In the final phase of a therapeutic psychodrama, the audience is invited to share feelings with the protagonist that relate to their own lives. If the warm-up and the protagonist's work have been directed properly, the sharing at the end clearly gives the client a community, "a sphere of activity," and support for these actions in a concrete way. In all of these ways, psychodrama can be a safe training ground, and can provide the methods for our clients' struggles with their "being-in-the-world."

We began with the unfortunate fact that existential psychology is insightful, but for all its wisdom, has had but few suggestions for its practical use.

We can conclude that the descriptive insights of existential psychology need not remain merely descriptive. Each disclosure of human existence can be helpful in the actual *practice* of psychotherapy. I have tried to give the descriptions in Part I a *praxis* to enable a methodology for its *theoria*. In Part II, I have also suggested some specific techniques for this methodology. Therapists can use these techniques to directly help the "world" of their clients, their clients' projection toward the future, their

clients' need to actualize meanings, and their clients' pre-conscious awareness of their own mortality.

Reference Note

1. "Part" is not entirely appropriate because it suggests that *Dasein*'s being is merely parts that add up to a whole. Instead, *Dasein*'s world and its being are one whole along with its relation to its world. No aspect can be understood or is a whole without the other.

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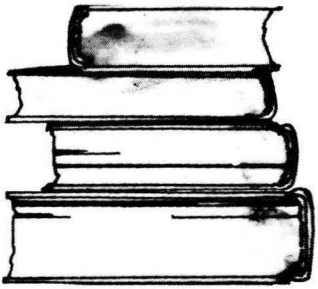


Book Review

ROY NAAR, Ph.D. *A Primer For Group Psychotherapy*

The book is appropriately titled "A Primer" since it is intended for beginning practitioners in group psychotherapy. The author states that the book "is a highly personal endeavor" growing out of his own practice and the practice of others with whom he is closely associated. He does not pretend to have accomplished a thorough or even sufficient coverage of the field. The book is quite short and focuses on common but troublesome problems in group psychotherapy. There is a brief chapter on theory, a very sensitive treatment of the role of the leader, and an anecdotal as well as theoretical treatment of clinical issues.

The major theme of the book centers around the processes of group psychotherapy as *Awareness*, *Closure*, and *Rehearsal of New Behaviors*. *Awareness* is defined as the recognition of alternatives most likely to promote growth. The information constituting the alternatives must be correct and appropriately given. Correct and appropriate are self-defining as that which facilitates growth. The rather complex problem of what constitutes choice is not dealt with at any greater depth. However, the

author addresses himself to practitioners not theoreticians. *Closure* represents a temporary departure from the "here-and-now" focus in order to release the individual from the past to cope more effectively with present problems. *Rehearsal of New Behaviors* is self-explanatory and is set forth as one of the most important advantages of group psychotherapy over individual.

The author does not claim originality for the theoretical concepts he employs and attributes most of the credit to Rogers, Perls and learning theorists. His therapeutic attitude is essentially client-centered. However, he also employs techniques from psychodrama, gestalt therapy, and other more personal sources. His approach might best be described as modified client-centered or even eclectic, but always with great concern for the right of the client to choose.

I do not think that sufficient attention is given to the natural dynamics of cohesive groups. Some of the events described in the anecdotes would be interpreted quite differently from a group dynamics viewpoint. Some of the anecdotes are probably not really necessary since the point illustrated is quite obvious without them.

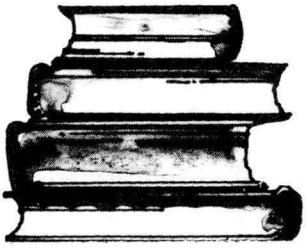
Dr. Naar employs simple, straightforward explications of concepts such as *here-and-now* and *process*. He warns against labeling and dependence on cliches rather than using common language to facilitate understanding the process of group psychotherapy as it actually occurs. He deals very well with the clients' initial expectations and lack of readiness for honest open expressions. His direct approach to some of the controversial theoretical issues (e.g., the distribution of psychic energy and transference) rather deftly puts the arguments aside as irrelevant to the process of treatment.

The addendum entitled *Elements of Psychodrama*, although very concise, appears to be essentially accurate. The author was obviously very impressed, even enthralled, with the personality of Jacob Moreno, and with the highly significant contributions of psychodrama to the entire field of group psychotherapy. Even so, he has been able to take his own view and adapt concepts and techniques from psychodrama to fit into his theoretical framework and personal style. He presents some excellent descriptions and defense of the use of psychodramatic interventions without total classical psychodrama involvement. He presents some criticisms of psychodrama as a total group therapy approach which seem quite germane but are not clearly elucidated. The author seems overly cautious in presenting such criticisms.

The book should be most helpful to beginning group psychotherapists, especially those who contemplate private practice. It also contains useful hints for more experienced professionals, and, for some, it may also

provide a fresh perspective. The author's theoretical constructions are modestly presented with sources clearly identified. There is no hint of grandiosity or the attainment of final answers. He frequently emphasizes that this is what seemed right for him and warns that it may not fit for other therapists. Through his self disclosures and intimate writing style the book comes across as a personal message.

WARREN C. BONNEY



Dr. Bonney is Professor of Education, in the Department of Counseling and Human Development Services at the University of Georgia. His mailing address is 408G Aderhold Hall, University of Georgia, Athens, GA 30602.

It seems to me . . .

PSYCHODRAMATICALLY-ORIENTED THEATER COMPANIES

The purpose of this report is to make an observation and raise some questions based not on one individual workshop, but rather on the presence at the Annual Meeting of a number of workshops—specifically, those presenting the work of psychodramatically-oriented theater.

At the 1982 Meeting, no fewer than six groups presented their form of theater: Family Life Theater, Life Theater, Playback Theater, Problem Solving Theater, Teen Theater, and Clare Danielsson's Production of Goethe's *Lila*. In addition, two of these groups, Playback Theater and Problem Solving Theater, were selected to offer workshops as part of the Training Module Program.

What does this growing presence of theater groups and theatrical approaches signify? I would be very interested in responses to this question. My thoughts are very preliminary, but I have two hypotheses. One is that these groups are working to develop ways to present psychodramatic values and practices in a manner less ponderous and slow-moving than the classical psychodrama session.

The second hypothesis concerns the community aspect of Moreno's teaching—the theater of *our* brothers and sisters he writes about in *Theatre of Spontaneity*. Many community groups do not wish to submit themselves to therapy, but will accept (therapeutic) theater. Thus the theater groups can go where psychodramatists may not. A related point is that there is a strong appeal in the idea of a *company* (Moreno, of course, began with his Stegreiftheater), particularly a company of peers, that the model of a psychodrama director acting alone, or even with a trained assistant or two, cannot match.

Jonathan Fox, Director
Playback Theater
c/o Innovative Studies
S.U.N.Y., New Paltz, NY 12561

DEAN ELEFTHERY
1921–1982

Those of us who knew and loved Dean Elefthery will miss him deeply. He was active in psychodrama since 1962 and continued to serve the Society, his community in Florida, and the world with responsibility, competence, and love. Dean loved his family and always cared for his friends. The world will miss him and it will not be the same without him.

Dean was born on January 21, 1921, in Vancouver, British Columbia; educated in Canada and England. He died on June 21, 1982, in Bruges, Belgium, where he was teaching psychodrama to doctors and psychologists from thirteen countries. He was buried in Ireland, his wife Doreen's native land. He is survived by his wife and two daughters.

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A special form with instructions to authors and guidelines for the format of the papers may be obtained from Helen Kress, managing editor of JGPP&S, Heldref Publications, 4000 Albemarle Street, N.W., Washington, D.C. 20016.

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