

# Combining Schema-Focused Cognitive Therapy and Psychodrama: A Model for Treating Clients With Personality Disorders

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**ABSTRACT.** In this article, the author reviews the historical interface between behavior therapies and psychodrama, noting their mutually enhancing elements. She proposes an integration of those elements as a vehicle for providing brief, yet intensive therapy for difficult-to-treat clients, such as those with personality disorders. With a review of relevant principles of psychodramatic practice, she clarifies the compatibility of the 2 types of therapy with basic learning theory concepts. The author provides an overview of schema-focused cognitive therapy, including findings on the validity of Young's schema questionnaire. She also presents and discusses a model for the presentation of schema-focused cognitive therapy through the medium of psychodrama.

**Key words:** cognitive therapy, psychodrama and cognitive therapy, schema-focused therapy, treating personality disorders

IN THIS ERA OF MANAGED CARE AND LIMITED RESOURCES FOR BEHAVIORAL HEALTH TREATMENT, brief therapy approaches are receiving significant attention. The notion that briefer is better, or at a minimum, cheaper, appears to be a driving force. Many cognitive and cognitive-behavioral approaches are brief therapies, and there is empirical evidence of their efficacy. With difficult or personality-disordered clients, however, brief therapy does not address pervasive underlying factors that contribute to poor functioning. In a review of recent practice in cognitive-behavioral approaches, I found indications of significant use of psychodramatic techniques (Linehan, 1993; Mahoney,

1991b; Young, 1999). Linehan (1993) advocates role playing and behavioral rehearsal in her Dialectical Behavior Therapy for borderline personality disorders. Mahoney (1991b) lists psychodrama and role playing as useful techniques in the cognitive therapists repertoire. Young (1991) suggests the use of role reversal in his point-counterpoint technique. In the model described in this article, I suggest that the cognitive integration of schema principles be used through psychodramatic techniques in a group therapy format.

A model for brief, intensive intervention emerges when the therapist uses cognitive-behavioral concepts that were developed for use with personality-disordered clients, and implements those through psychodramatic and experiential techniques. Young's (1999) schema-focused cognitive therapy (SFCT) is a working theory that is comprehensible to clients and that addresses deeper constructs that underlie their behavior. The schemas are the lenses through which humans see and construe their worlds. Clients who identify and examine their schemas can choose and develop the skills to maintain more adaptive schemas. The treatment approach works well with difficult-to-treat clients but takes more sessions than short-term cognitive therapy. In this article, I suggest that modifying Young's individual therapy format to a group experiential approach marries two compatible concepts: the exploration of schemas through the medium of psychodrama.

### **The Historical Interface Between Behavior Therapies and Psychodrama**

J. L. Moreno, the originator of sociometry, sociodrama, and psychodrama, based his conceptualizations on several common themes. Moreno's concept of mental health involved the multirole personality, meaning that the person has a large role repertoire and can act flexibly in any given situation (Fox, 1987). Moreno proclaimed that the development of optimal role-flexibility occurred in action. He suggested that our perceptions of the world were nurtured in action, and they are most amenable to modification in experiential modalities.

Moreno developed his approaches in reaction to Freud's analytic techniques, which he felt neglected the potential of face-to-face and group therapy and overemphasized verbal interventions. A surprising compatibility with behaviorism emerged as the field of behavior therapy developed in Moreno's later years (Kelly, 1978). In 1958, Moreno noted, "a constructive rapprochement is possible between psychodramatic techniques and some of the current therapeutic philosophies, not only with psychoanalytic theory but also with Pavlovian conditioned reflex principles" (Moreno, 1958, p.127). Moreno went on to note his agreement with some of Hans Eysenck's behavioral conceptualizations (Eysenck, 1967). He agreed with Eysenck that it is more useful to look at a client's relevant learning history than to conjecture on his dynamics; that behavior must be liberated from unawareness to be enhanced,

changed, or extinguished; and that success in treatment should be defined behaviorally, rather than by a subjective assessment of insight or unconscious operations (Moreno, 1963).

An alliance of psychodrama with schema theory has additional historical precedence. Moreno (1958), Adler (1998), and Vaihinger (1984) shared the common viewpoint that the individual is the creator of his or her personality and an active constructor of life's events (Mahoney, 1991a; Monte, 1995). The notion that people develop "fictions" to make subjectively meaningful interpretations of reality is acknowledged in the work of each man. That culminated in another convergence between psychodrama and behavioral approaches that occurred when Kelly (1955) published his *Psychology of Personal Constructs*. Kelly acknowledged his debt to Moreno for such techniques as sociodrama, in which two or more people enact imagined roles rather than those in their own lives. He saw the potential in those activities to facilitate changes in a clients' "constructions" and "reconstructions" of themselves (Stewart & John, 1991). Thus, Kelly's fixed-role therapy draws heavily from Moreno's techniques.

Moreno would be intrigued with the recent acknowledgment of the power of the experiential process to change human behavior in productive ways (Abele, 1989; Blatner, 1988; Blatner, 1989; Hudgins & Kiesler, 1987; Joyce-Moniz, 1988; Kipper, 1989; Mahoney, 1991a; Skafte, 1987). Moreno, as an advocate of the integration of different theoretical constructs, would have been comfortable with a marriage of apparent opposites. He "had a preference for combining contraries into unities" (Kellermann, 1991, p. 29) that achieved a useful synthesis. Thus, a marriage of psychodrama with cognitive-behavioral theory emerges from a complementary history.

### **Reconciliation of Two Systems: Behavior Therapy and Psychodrama**

An examination of particular psychodramatic techniques in behavioral terms and behavioral techniques in terms of their psychodramatic function (Sturm, 1965; Sturm, 1970) provides an illustration of the advantageous interplay between psychodrama and behavioral theory. I present the psychodramatic techniques in the order in which they are typically used to facilitate a group psychotherapy experience.

In a behaviorist's view of the director's warm-up activity, directors encourage interaction and appropriate self-disclosure, and they present themselves as warm, prestigious, and noncastigating models of those behaviors. In the warm up, directors evoke opportunities for reward and discourage opportunities for punishment. In other words, they create an optimal setting for learning new behaviors by creating a safe atmosphere for spontaneous experimentation without undue fear of punishment.

The problem presentation phase of psychodrama occurs as directors elicit the emergence of a problem for the group to solve. In a sociodrama, the problem is a generic one that is of interest to all, and in a psychodrama, the problem is personal and specific to one member but of interest to all. Directors model appropriate self-disclosure, acknowledging their own unsolved problems. The next step in psychodrama is the self-presentation of a participant's problem. Behaviorally, directors identify salient elements of the cue-response-reinforcement system that appear to be operating as the participant describes the issue. Directors then assist the protagonist with the help of the group and the action, either to develop new responses to old cues or adaptive responses to new cues.

The techniques of role playing are central to all psychodramatic experiences. The protagonist and other members of the group learn new behaviors by assimilating parts of the roles they assume and experiencing selective reinforcement from their environment. Kipper (1982; 1989) describes the use of "actional language" in behavior simulation as a way of "concretizing" cognitive and affective processes. Thus, the role play becomes the *in vitro* laboratory where successive approximations of new behaviors are tested and rewarded in a protected environment. In the language of behavior therapy, Wolpe (1958) and Lazarus (1976) describe "behavioral rehearsal" as opportunities for successful attempts to respond acceptably to anxiety- or fear-evoking scenes.

Doubling also can be a powerful reinforcement experience, because adaptive thoughts and feelings are often expressed by the double. The double is a possible bridge between inner reality and the environment (Hudgins & Kiesler, 1987). The reinforcement cues offered by the double support increased risk taking and self-awareness and reduce any sense of isolation on the part of the protagonist.

The use of future projection can be seen as enacted visualization. Experiences that trigger unproductive response patterns can be enacted, and new responses can be identified and practiced. Thus, the repertoire of role-playing techniques strengthens their specific use as a mechanism for useful learning. As Sturm, an advocate for "behavioristic" psychodrama, put it:

Role-playing is a crucial and versatile learning device. It has its origins in that aspect of "play" that is the universal problem solving device in children and animals: In one sense psychodrama may be viewed as an extension of the "natural" learning of "play" that is adapted to solve more complex and difficult problems. (Sturm, 1965, p. 55)

In role playing, when a protagonist is presented with cues that would normally elicit high-anxiety responses and then is required to respond with active, assertive behaviors, Wolpe's principle of reciprocal inhibition becomes operational (Wolpe, 1958). A response that is antagonistic to anxiety occurs and

weakens the bond between the anxiety-provoking behavior and the anxiety response. Similarly, systematic desensitization, in which reciprocal inhibition is alternated with relaxation, has its counterpart in psychodrama. The support of the group, the double, and the director supplant the relaxation imagery.

Throughout the session, the group members participate as part of the reinforcement system, cueing and rewarding each other's behaviors, as modeled by the director. They, in turn, are rewarded with the possibility of exploring solutions to their own comparable problems. At the conclusion of the session, group members share what they have learned from participating in and observing the enactment. Significant reward accrues to the protagonist as he or she sees the benefit for others derived from the "experiment." In addition, the sharing, if properly guided and synthesized by the director, results in additional cognitive integration of new constructs for the participants. Psychodrama without cognitive integration can result in catharsis junkies, who do not learn new skills but merely emote to no useful end (Taylor, 1996).

When the principles of operant conditioning and behavior therapy are used overtly as well as covertly in psychodramatic approaches, those approaches provide multiple opportunities for enhancing discriminative learning. As Bandura and Walters (1963) noted, the creation of actual or symbolic social situations, in which desired responses are rewarded and undesirable responses go unrewarded, is a powerful learning tool. Not only the protagonist but also the entire group observe appropriate models being rewarded in multifaceted ways, a proven intervention that creates rapid acquisition of new behaviors (Bandura, 1986). Hence, psychodrama "exerts an influence on the emotional, cognitive, and behavioral aspects of the participants and connects their past to their present and future" (Starr, 1977, p. xiii). The psychodramatist provides brief, effective cognitive interventions, using principles of learning theory.

### **Schema-Focused Cognitive Therapy**

The concept of the schema as it is used in contemporary cognitive science can be traced to the work of Bartlett (1932). Through a series of elegant experiments, Bartlett was able to advance the notion of an underlying organizational mechanism, the *schema*. In those experiments, he showed that memories and perceptions are shaped by prior expectations. Subsequently, a number of definitions of schemas have evolved, but according to Thorndyke and Hayes-Roth (1979), they share three major assumptions:

(a) schemas are abstract organizations of conceptually related elements; (b) schemas develop gradually from past experience; and (c) schemas guide the organization of new material (Thorndyke & Hayes-Roth, 1979).

Schema theory has proved useful in the explanation of various psychological phenomena and such concepts as Bandura's (1978) "self-systems," Kelly's (1955) "personal constructs," and Abelson's (1981) "scripts" possess similarities to schema theory. In his early work with depression, Beck (1967) suggested that schemas explain the repetitive themes that occur in imagery and dreams. Schemas may also account for the confirmatory bias that causes humans to interpret events in consistent ways, despite evidence to the contrary.

Young (1999) adapted the schema theory for use as a convenient clinical tool to work with personality-disordered clients. Whereas short-term cognitive therapy focuses on the modification of automatic thoughts, cognitive distortions, and underlying assumptions, schema-focused cognitive therapy (SFCT) emphasizes the deepest level of cognition, the early maladaptive schema (EMS). Young notes that personality disorders do not meet many of the prerequisites for cognitive therapy. For instance, easy access to feeling and cognitions, the ability to form a collaborative relationship easily with the therapist, and motivation to complete homework assignments are skills that may be absent in a person with a personality disorder. In fact, inflexibility and persistent self-defeating patterns characterize many personality disorders.

The underlying assumptions of SFCT include the following: (a) early maladaptive schemas (EMSs) developed in childhood are templates for processing later experiences; (b) unconditional belief systems are self-perpetuating; (c) EMSs are perpetuated by behaviors that maintain the schema, avoid the schema, or compensate for the schema; (d) schemas, even the maladaptive ones, were adaptive at one time; and (e) schemas are not relinquished without a struggle because they are tied to the client's core identity. The primary focus of SFCT is the ways in which schemas are perpetuated. An EMS is the opposite of underlying assumptions that are typically conditional, as in, "If I can be perfect, then I am a worthwhile person." An EMS is unconditional and irrefutable, as in, "Regardless of what I do, I am worthless." Whenever a schema is activated, individuals persist in the belief that, at best, they can only delay or hide from the expected dire outcome. That results in such schema avoidance behaviors as "blinking out," blocking, depersonalization, compulsive behaviors, and self-mutilative behaviors. Some individuals avoid events that might trigger their schemas by isolating themselves, evidencing agoraphobia, or failing to attempt work or to assume family responsibilities.

Schema-maintenance behaviors are those circular processes that reinforce the validity of the schema. Cognitive distortions, such as those elaborated by Beck (1967), are used to highlight information that confirms the schema, such as, "I am unlovable." The individual also distorts by minimizing or denying information that negates the schema (1967). Self-defeating behavior patterns that may have been essential to survival in an individual's family of origin,

when applied in adulthood, only serve to reinforce the maladaptive schema. For instance, if a child experienced extremely domineering parents, he or she may have developed a subjugation schema, which strengthened his or her skills for coping in the family. However, as an adult, if that person repeatedly chooses domineering partners or bosses, those choices become not only self-defeating but also reinforce and maintain the schema. Moreover, schemas are sometimes maintained by overcompensation strategies. In those cases, individuals evidence cognitive and behavioral styles that are the opposite of what one would expect from their histories. For example, someone whose needs were not met in childhood may behave in a demanding, entitled way as an adult. In a sense, some attempt has been made to challenge the underlying schema, but the lack of awareness of the underlying issue leaves the individual vulnerable to deep pain when the schema compensation fails. EMSs are familiar and comfortable and inextricably entwined with an individual's sense of self. Thus, as those formerly adaptive behaviors are challenged, they are not given up without a fight. The metaphor of a war is inescapable.

Schema-focused cognitive therapy involves several steps: evaluation of the schema patterns; educating the client about schemas; identifying triggers to the schemas; confronting schema maintenance behaviors; and changing schemas through emotive, interpersonal, cognitive, and behavioral interventions. Young (1999) recommends the use of his schema questionnaire to identify a client's salient schemas. On the questionnaire, early maladaptive schemas are grouped in the following four primary domains: (a) autonomy, (b) connectedness, (c) worthiness, and (d) expectations and limits. An example of an EMS in the autonomy domain is dependence, the belief that one is unable to function on one's own. An example of an EMS in the worthiness domain is incompetence or failure, a belief that one cannot perform competently in areas of achievement, daily responsibility, or decision making. A connectedness EMS is abandonment or loss, a fear that one will imminently lose significant others and be alone forever. An example of an expectations or limits EMS is entitlement or insufficient limits in which one insists that one is able to do, say, or have whatever one wants immediately, regardless of the effects on others.

In a psychometric study of Young's schema questionnaire, researchers found that it possesses convergent and discriminant validity in relation to measures of psychological distress, cognitive vulnerability to depression, self-esteem, and personality disorder symptomatology (Schmidt, Joiner, Young, & Telch, 1995). Of the 16 factors hypothesized by Young, 15 emerged in the clinical sample, and 13 were replicated in two nonclinical samples. Thus, Young's schema questionnaire has significant validity as a clinical tool for the identification of schemas, particularly in clinical populations.

Once the schemas are identified within the context of the therapeutic relationship, the client and the therapist "go to war" against those schemas, using

experiential, affective and standard behavioral techniques to substitute more adaptive schemas. First, the therapist educates the client about schemas and the enormous emotional strength behind them. The therapist may recommend that the client read Young and Klosko's 1993 book, *Reinventing Your Life*, and *A Client's Guide to Schema-Focused Cognitive Therapy* by David C. Bricker and Jeffrey E. Young (1993). The therapist then triggers schemas, using imagery, discussing recent upsetting events or distressing memories from the past, assigning books or movies that elicit schematic themes, or prescribing group therapy to activate interpersonal schemas.

The therapist confronts the client's schema-avoidance behaviors, such as somatic symptoms or going "blank," and identifies such schema-driven behaviors as self-defeating patterns that reinforce the schema. As Young (1999) describes them, those "partially reinforced responses" are an essential ingredient in the clinical assessment of the client. Once the therapist has identified the primary and secondary schemas and the schema-maintenance behaviors, he or she presents the information to the client for feedback so that they can cocreate a battle plan.

As the therapist and the client begin to modify the schemas, Young (1999) recommends several interventions. Early in the process, the therapist uses emotive techniques to expose the schemas and to identify the constructs that underlie them. As the schema becomes reflected in the client-therapist relationship, the therapist uses interpersonal techniques. Cognitive techniques give the client an arsenal of cognitions with which to fight the schemas, whenever they arise. Young reports that the last stage, which is behavioral change, requires the most time because the self-defeating behavioral patterns are intensely ingrained in the client.

Thus, schema-focused cognitive therapy is lengthier and more confrontational and involves more childhood issues than short-term cognitive therapy. It reflects its cognitive heritage in emphasizing the therapist's active role, an organized approach, homework, and an empirical emphasis on the analysis of evidence. Young (1999) has taken up the challenge of adapting cognitive-behavioral approaches for work with long standing maladaptive patterns and has developed a comprehensive approach.

### **A Model for Schema-Focused Therapy Using Psychodrama**

In this section, I propose variations to Young's approach, describe a typical group format, and outline a sequence of possible group experiences. The primary modifications to Young's schema-focused cognitive therapy that I propose cluster in three arenas. Those include the group therapy format, the use of primarily experiential methods, and the avoidance of pathological language in the presentation of schemas.

Rather than following Young's (1999) one-on-one approach, I maintain that learning takes place in a group and in action, rather than in a didactic format. I ask group members to show, rather than to tell. Each 2-hr group follows a similar sequence: (a) begin with group-building warm-up activities for approximately 15 min, (b) move to sociodramatic or psychodramatic action for 40 to 50 min, (c) allow for cognitive integration of the action by having the protagonist relate the action to his or her EMSs for 15 min, (d) have the director give a brief closure to the action, (e) share the effects of the action on the rest of the group members for 20 to 30 min, and (f) end with a 5-min closing ritual. Productive closing rituals include such activities as choosing props to represent EMSs and putting them in safe places, or having the group recite an affirmative mantra. Although I assign homework as needed, the predominance of the work is experiential. Group members commit to 8 to 10 sessions.

In the last modification of Young's approach, I place greater emphasis on the adaptive nature of early schemas. Rather than label them as early maladaptive schemas, I prefer to call them early schemas. I highlight the adaptive nature of the schema in protecting a vulnerable child. I intend that strategy to minimize the clients' further self-criticism and devaluation. As the group members decide which schemas are no longer productive for them, they label those unproductive schemas. They then strive to acquire the productive schemas that they have identified for acquisition.

It is possible to present this approach to schema-focused cognitive therapy in a variety of nonpathological ways, including as an enrichment class for the general public, with a schema club in a day program of a psychiatric hospital setting, or with a specialized group for outpatients. The therapy is appropriate for personality-disordered clients because the experiential components are powerful, and the group support teaches the usefulness of social support for behavioral change. A mix of clients with varying ego strengths are ideal candidates. If the group members evidence high levels of nonproductive behavior, the group leader increases the safety components of the group as needed. The addition of an assistant or of coleaders, extension of the course of the group, and integration of the input of an individual therapist are ideal safety components.

At the first session of a prospective group of 6 to 10 participants, the focus is on building sociometric connection through the use of warm-up activities that elicit commonalities and build cohesiveness. One technique is to create a series of dyads from the group members in which the two share their reason for attending, one thing they want to change, their favorite song from high school, and so forth. The group leader provides an overview of schemas, using volunteers from the group to illustrate several common schemas and types of schema-maintenance behaviors. The therapist gives the schema questionnaire,

available from Young's Web site at <http://www.schematherapy.com>, as the homework assignment.

Once the members make the initial connection between themselves and the basic educational process, the therapist uses psychodramatic modalities to deepen the change process. For example, in successive sessions, the members achieve the identification of salient schemas through such exercises as "Walking a Lifeline." As a group member lays out significant events in his or her life, the double and the director assist in linking those events to current nonproductive schemas. The director and double support the group member in identifying the usefulness and the formerly adaptive nature of the schemas.

To identify the costs and benefits of early schemas, the therapist can use a variation of the "Magic Shop" exercise (Leveton, 2001). In that exercise, the group members brainstorm all the benefits associated with holding on to their schemas, and the director marks those on a flipchart as items that can be sold to the Magic Shop. The group also brainstorms a list of payoffs associated with developing a more productive schema, which can be purchased at the Magic Shop. In short vignettes, each member visits the store and symbolically relinquishes a benefit of an old schema to purchase a reward for a new schema. Group members select someone to impersonate the old schema and dialog about the negotiation with each member. The director serves as the proprietor of the Magic Shop.

After describing the principles of schema maintenance, avoidance, and compensation, the group members sculpt the particular ways by which they hold on to their early schemas. They talk with those "behaviors," discussing where and how the behaviors are triggered, what obstacles they plan to use to evade change, how they experience the behaviors physically, and so forth. Playfully concretizing resistance to change defuses its power and eliminates its potential for further undermining a participant's confidence.

As needed, group members keep diaries of triggers or emotions to identify skirmishes that occur outside of the group. The participants can sociodramatically play out generic scenes common to several group members, or they can play out an individual's experience psychodramatically. As additional behaviors emerge that need to be developed as part of a more productive schema, the therapist can use role training to increase the strength of a habit. In a role-training experience, the director sets a scene and when the protagonist evidences a need for new skills, asks group members to come into the scene with suggested behaviors. The protagonist and the entire group are thus exposed, *in vivo*, to numerous models and can acquire the behavior that best suits them.

As the group progresses, the therapist discusses with them the possibility of a relapse and frames it not in pejorative terms but as a visit with an old,

familiar friend. The discussion can include action, in which the protagonist discusses the “old” behavior, reviewing what it was like to experience it again, identifying its costs and benefits, and stressing the new alternatives. In dyads or with the group as a whole, the members develop relapse-prevention strategies and put them on flashcards for easy-access in emergencies. The entire group process models effective, supportive reparenting and conveys a metamessage to the members that invalidates early schemas.

The termination of the group should also convey positive reparenting, as the group members are unlikely to have experienced appropriate closure. Reminiscences, testimonials, and the director’s reflections about separation are appropriate material for termination sessions. Whenever possible, each group member should keep some concrete representation of his or her effort and progress as the group ends.

Presenting schema-focused cognitive therapy in a group therapy format that uses psychodramatic approaches has a synergistic effect. The benefits of group process broaden the impact of the therapy, and psychodramatic approaches address the behavioral and modeling aspects of changing deep-seated patterns. Moreover, shifting to nonpejorative language increases the palatability of a challenging task.

### **Discussion**

A few caveats are in order. For this type of intensive group-therapy experience, experienced directors of psychodrama are necessary. The methods are powerful, and a safe environment must be created by the group leaders to avoid deleterious effects. In addition, an overly homogeneous group, such as clients with extremely loose boundaries, is unlikely to provide enough appropriate models for the experience to be beneficial. A variety of levels of functioning is the ideal for a group. Severely compromised clients require the additional support of an individual therapist to complement the group experience. Caveats aside, the model presents a cost-effective, brief alternative to long-term individual intervention for personality-disordered clients.

The use of a group modality to implement a model developed in individual therapy is not uncommon. When the issues are predominantly interpersonal or when the scarcity of resources precludes individual therapy, group therapy is frequently considered as an alternative. In this model, however, an attempt has been made to choose specific approaches that have sound theoretical underpinnings to construct a valid method. By carefully attending to the learning-theory scaffolding that supports much of psychodrama, one can make a cogent case for the use of psychodrama with cognitive models. Thus, with this model, I avoid watering down SFCT and concentrate its concepts where they will have the greatest effects.

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