

Escaping the Blame Frame: Experiential Techniques With Couples

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ABSTRACT. In couples therapy, the therapist often finds it difficult to shift to a more productive process. Experiential techniques can break the destructive pattern and introduce new, more effective ways of communicating. In this article, the author explores couples work through case examples using specific dramatic techniques and considers a broad range of clinical thinking, with particular attention to the challenges of using psychodramatic techniques in a group of three. The author also addresses the question of the therapist taking a role in an enactment.

Key words: blame, couples therapy, psychodrama techniques

PSYCHODRAMATIC GROUPS AND COUPLES who enter treatment come with different expectations. Although group members expect to work actively and on their own problems, the couple arrives with the expectation that the therapist will help them solve their problems by talking while they assume a more passive stance. Using psychodramatic techniques with a couple represents a break in an expected pattern. J. L. Moreno illustrated his work with a couple in a psychodrama group in one of his earliest articles (Fox, 1987). On the West Coast, active techniques were tried early on. Fritz Perls (Perls, Hefferline, & Goodman, 1973) introduced the notion of having couples address each other directly, rather than speaking to the therapist about their problems. Virginia Satir (1972) also discovered that family members were more effective when communicating directly. Thus, the first request to a couple to play a role may have been, "Play yourself," because speaking directly to a partner in a social situation in which one expects to address the therapist is a shift away from ordinary conversation.

Satir developed a technique called family sculpture (Jefferson, 1978), which she incorporated into her work with couples and families. Since then, there has been a widely accepted blend of family and couples therapy and experiential work (Fisher, 2002; Gladding, 1985; Guerin, 1976; Jefferson, 1978; Kipper, 1986; Papp, 1976). Psychodramatists also began to work with families and couples. Zerka Moreno, for example, describes her psychodramatic work with families in a chapter that illustrates the adaptability of role play to the family therapy setting (Holmes & Karp, 1991).

In this article, I consider the ways a clinician who has completed some training in psychodrama or drama therapy can incorporate role playing into work with couples. I explore the techniques that, over a period of 40 years, I and my students have found most rewarding. Because the negative consequences of therapeutic work are so seldom discussed, I also address what may go wrong (Fisher, 2002).

Couples usually enter therapy with each person blaming the other. Taking no responsibility for what has gone wrong, each partner expects the therapist to join in blaming the other person. Without active intervention from the therapist, blame can easily dominate the therapy sessions, and verbal intervention alone is often insufficient.

Couples work is difficult, partly because of its inherent systemic problems (Chasin, Grunebaum, & Herzig, 1990; Fisher, 2002; Papp, 1976; Wile, 1981). As the outsider in a trio in which two members communicate in negative but, at the same time, well-rehearsed, intimate, and protective communication, the therapist may experience frustration, anger, and helplessness, rather like the child of quarreling parents. Through objective identification, a process by which an individual teaches another how to behave in a pattern established earlier (Fisher), the therapist is often induced to join the harmful process. So much recrimination fills the air that the increasingly discouraged therapist begins to want to blame the couple for blaming.

Moreno called sponteneity the ability to respond authentically and appropriately to a new situation and viewed it as the basic building block of mental health (Fox, 1987). When recrimination provides the main content, the therapy has entered what family therapists often refer to as the blame frame, a state in which both clients and therapist have lost their spontaneity.

Often at the beginning of couples work, psychodramatic techniques can make the difference. The therapist's interrupting a couple's demonstration of woe by doubling or requesting to make a sculpture of their relationship can shift a pathological routine to spontaneous interaction.

The following case vignettes are drawn from my own clinical experiences and those of therapists I have trained. Names and identifying information have been changed to preserve privacy, and the dialogue has been edited to make it more readable.

Psychodramatic Sculpture With Stacey and George

Psychodramatic sculpture is a technique by which the individual molds the partner into a shape and expression and then includes the sculptor. It is especially effective with couples because it breaks the couples' expectations of therapy as problem- and content-oriented by asking for active, creative participation. The therapist remains in charge, taking an authoritative role, not as expert advisor but as the director of the sculpture. Directions that discourage talking provide clues to the couples' intimacy that are seldom obvious in talk therapy (Leveton, 2000).

Stacey and George are graduate students in their early thirties. Stacey wants to become a nurse, and George is an art student who paints and sculpts. They are married and have been seeing their therapist for the past month in weekly sessions. George has a serious, somewhat distant air, whereas Stacey fairly bubbles as she talks. In relating the couple's problems, George talks a lot about his resentment of Stacey's need to control him, and Stacey believes that her efforts to take care of George are unappreciated. Both come from large, Irish families; Stacey is the oldest of five, and George is the youngest and only boy in a family of six. When, during the second session, George expressed his anger at Stacey for criticizing his behavior at a party, the therapist suggested that perhaps a sculpture might help bring the argument to a different level.

Therapist: I know that you're angry right now, George, but I wonder if we might try something different because we all know that this is familiar territory for the two of you. Let's not talk it out. Let's do something active and creative. You're a sculptor. I know you usually do more abstract work, but would you consider doing a living sculpture? (George and Stacey look interested.) What I'd like you to try right now, if Stacey will cooperate, is to sculpt her in a pose that expresses how you see her when she's being critical of you. With her cooperation, you can mold her body to the shape you want.

George: Yeah, I could try that.

Therapist: Good. You are to demonstrate a pose by showing her. I don't want you to talk, OK? If you must speak, use very few words. But first, let's ask Stacey. Stacey, would that be OK with you?

Stacey: I guess so. I'd rather do anything than argue this problem all over again.

George: Sounds like something different. OK.

Therapist: Great. Your job, Stacey, is just to be clay and to let George mold you. George, how about it? Is this something you could do?

George: No problem.

Therapist: OK, let's get up and get started. (The therapist rises.)

One of the obstacles, brought up again and again by therapists and students, to the use of active techniques in individual and couples therapy is the diffi-

culty of getting up out of the therapist's chair. Even therapists trained in psychodrama seem to have difficulty initiating action once they have taken on a talk therapist's role. The expectation of being an expert is enough to glue them in one place, talking endlessly. Again and again, participants tell me that, once having got up, the process becomes easy and fun.

The therapist stands back and waits for George and Stacey to stand opposite each other, observing them. George and Stacey stand for a moment, looking at each other. Then Stacey casts her eyes downward, and George starts to raise one of her arms to shoulder height. She has made herself quite passive. He curls her hand into a fist with one pointing finger, stands back and looks at her, smiling. Touch seems to come easily to this couple.

George: Yeah, that's it.

Therapist: (Aware of her own tendency to criticize in her marriage, playing for time.) Maybe you'd like to do a little more.

George: Oh yeah, this!

George takes Stacey's head and cocks it to the side. Then he looks at her sternly, with a gesture that asks her to imitate him. She does so. He looks at her and stands up in a more determined, upright position, again indicating that she should imitate him. She does so. He stands back.

George: Yup. That's it. That's exactly it.

Therapist: Ok, George. That's great. Stacey, good.

(In action work, I find that praise helps clients gain confidence.)

Therapist: I have one more task for you. George, before you finish, I'd like you to fit yourself into the picture.

George: Me?

Therapist: Yes, so if I were looking at this sculpture in a gallery, I would see that it is about relationship.

George: Oh, all right. I get it, like a group.

He squats down in front of Stacey's pointing finger, puts his head down by his knees and both hands over his head so he can neither see nor hear Stacey.

The sculpture is a kinesthetic, graphic version of the couple's problems. The therapist could now begin to explore the relationship by addressing the physical level directly. When emotional states are linked to bodily sensations, awareness is improved (Grinder, 1983).

Therapist (who is experiencing her own guilt about being judgmental in her marriage and is glad she is not taking a role in the enactment): Stay there for just a moment; really tune into yourselves. Don't move. What are you feeling in your body? How does it feel to be in this position?

Stacey and George: (speaking simultaneously) Awful! Ugh! I hate this. No way do I want to stay here!

Therapist: OK, one at a time. Stacey, what are you experiencing?

Stacey: Well, let's see. Oh, I know. I am feeling really, really tense. In the fin-

ger that is pointing, of course, but also in my back and my neck. Real tight. (She pauses, as if asking herself a question, which she then answers.) I know exactly. I feel just like my father. When he used to come home just before dinner time, my mother would tell him everything we'd done wrong. And then he'd call us all into his room and start lecturing and pointing. God, I felt so bad! I usually felt guilty about something and I knew he meant me. There was just no way to get out of it. I hate being in his position now. To make the other person small.

Therapist: So what is that like? Are there any other feelings?

Stacey: Well, whoa, this is a surprise! Wow! I feel strong. I guess that's OK. But not really. I feel so uptight and rigid. I feel like such a jerk, pointing the accusatory finger like that. Oh wow, I wish it weren't so familiar. (She blushes self-consciously.)

Therapist (satisfied that Stacey has arrived at some insight): Good. Thanks. OK, George, how about you?

George (sarcastically): Oh, I love crouching down in fear. It's great! OK, I'll be serious. I actually feel uncomfortable all over. This isn't right. It's awful! I know I was wrong again, but I'm so used to it that I don't even try to find out what I did this time. I just try to cover my ears so I don't have to hear it.

Therapist: Any idea where that comes from?

George: Oh, definitely. That's my dad and me. Every Friday. He'd have a drink with the guys from the office and when he came home, he'd be just spoiling for someone to get mad at. And, of course, my mom would have a note from the teacher about how I'd cut up or not handed in my homework . . . always something. Boy, was I happy when one of my brothers was in trouble.

Both partners were able to respond to the therapist's questions with feeling and introspection. The congruence of their interpretations was startling. Both associated stern fathers with the sculpture. Stacey had identified with hers, whereas George remembered that he had cowered in front of his dad. With some shame, both partners recognized the rigidity of their own roles and resolved to stop repeating this pattern. Both had acquired a new lens through which they could picture the other's situation and empathize with the child who had been trapped in it. The conversation softened; Stacey and George had escaped the blame frame. They became more spontaneous, demonstrated greater role flexibility, and were able to shift their dialogue to important issues and away from the petty squabbles that had alienated them.

Using Doubling With Burt and Ethel

Doubling is a psychodramatic technique that allows unspoken dialogue to become explicit. Psychodramatists vary in the way they apply the doubling technique (Blatner, 1996; Kipper, 2003; Hudgins & Kiesler, 2002; Leveton, 1977, 1991, 2000). I establish two rules. First, the double must use the pro-

noun *I*. Second, because I like to avoid the double being used as a spokesperson, only the client being doubled can hear the double. Therefore, to be effective, the client must repeat what the double says. A client who argues with the double may be voicing an inner conflict. However, a lack of response from the client or a neutral, disinterested response suggests that the double has gone off the track (Leveton, 2000).

Burt and Ethel have been seeing their therapist for about three months. Burt is a well-known lawyer, and Ethel has a cosmetics business. They are in their early fifties with problems that date back to their honeymoon, when, according to Ethel, Burt left her to take her first meal alone in the hotel dining room because he was talking to another couple he had met in the bar. Married 15 years, they are well rehearsed in mutual blame. Ethel's manner is dramatic, self-pitying, and off-putting. Burt is quietly intelligent, rational, and in denial about any responsibility for the marital conflicts. When blame escalated as they recalled the events of a recent dinner party, the therapist began to double.

Ethel: Even though we'd been over and over it, he was one hour late, leaving me with these people I didn't know and the dinner to take care of. I just can't understand why he keeps doing this to me. Why?

Burt: I'm a lawyer, Ethel. I had to stay with my clients. You know I'm working on a corporate problem. What else can I do? You tell me. Tell me what else I could do.

Therapist: (Recognizing that the blaming would continue its familiar tracks, the therapist moves to Burt's side and because this is a new technique for this couple, gives a short introduction.) I'm going to say some of the things that you, Burt, might be feeling or thinking but not saying. If you agree, repeat what I have said. OK?

Burt nods his assent.

Therapist as Burt's double: I'm asking Ethel what else I can do. I wish she would tell me. I wish somebody would tell me.

Burt (with a sardonic smile): Yes, I wish somebody would tell me because I can't seem to get out of this any other way.

Therapist as double (hoping to break through Burt's denial and also expressing some irritation with his persistence at playing the innocent): But I do know what else I could be doing now?

Burt: No, I don't.

The therapist attempted to break through Burt's denial and avoidance of responsibility by doubling. When she challenged him with the statement, "But I do know what else I could be doing now," hoping to shift the level of his response, he rejected the challenge, possibly responding to her impatience. Realizing that she had made an error, she addressed his resistance by changing course and led him to explore Ethel's state of mind, guessing that he was

quite capable of empathizing with his wife but avoided doing so because he would have to face his own feelings of guilt.

Therapist as double: Don't I know how Ethel was feeling?

Burt: Of course, I know. She's upset and mad. What else is new?

The therapist then gives words to his denial.

Therapist as double: And I don't want to hear about it.

Burt: And I don't want to hear about it.

When the therapist doubled for Burt's frustration with Ethel's complaints with those words, she was moving toward a more emotional level. She discovered that Burt needed to express more negative feelings.

Therapist as double: I don't want to hear about it. But I can understand it.

Burt: Not really. We've been married for 20 years. She knows this could happen.

Therapist as double: I wish she were different. But I do understand she's kind of left holding the bag here, don't I? It's hard for me to admit because I don't want to justify what she's blaming me for but—

Burt (breaking in): OK, OK, that's true. I don't want to be blamed.

Therapist as double: And I forget that she's in this too, and she was probably feeling—

Burt: overwhelmed. Yeah, OK. Otto and Helen can be a pain, I guess. And they don't know her all that well.

With Burt's acknowledgement of his own fear of blame and his beginning empathy for Ethel's dilemma, the therapist could start to work with Ethel's side of the complaint. Although she had hoped that Ethel would be able to elaborate her own feelings without blaming Burt, Ethel was not yet ready to do so.

Therapist: So, Ethel, is that right, did you feel overwhelmed?

Ethel: Sure! That's just the beginning, though. He just has no idea how complicated my life is with all this stuff that he expects me to do and then . . .

Therapist (sensing Ethel's moment of sadness and moving to her side): Let me try the same thing I tried with Burt, OK? (Ethel nods).

Therapist as Ethel's double: (she gives expression to Ethel's depression): I just don't have a lot of hope left, that's all.

The double was taking a chance, hoping that Ethel would be able to acknowledge her own depression, instead of blaming Burt.

Ethel: You can say that again.

Therapist: (Therapist drops out of the strict doubling role for a moment) If it fits, you say it.

Ethel (sighing): I don't have much hope. It's been so long.

As the doubling continued, Ethel could answer the double's questions with a new ease and softness. Had the therapist intervened with a similar question without doubling, she believed that Ethel would have continued the blame game, disqualifying earlier positive experiences.

Therapist as double: (Therapist is relieved that Ethel could express a deep feeling.) And that makes me feel?

Ethel: Really, really sad. Sad, Burt. (Ethel looks at her husband.)

Therapist as double: Because it was different earlier in our marriage?

Ethel: Oh, yes. Burt is so much more social than I am, and I used to love it when he brought people over.

Sensing that the ground had been prepared for Burt to do some internal work, the therapist introduced the soliloquy (Blatner, 1996).

Therapist: Burt, how would you feel about exploring this business of being blamed a little further? We'll still use doubling, but we'll just be thinking out loud about what's going on inside you, not Ethel. This is called a soliloquy.

Burt: Oh yeah, like Hamlet, sort of. That's OK. Go ahead.

Therapist rises and gestures to Burt to do the same.

Therapist: Let's just walk around the room together for a bit. That way you're not looking right at Ethel, and you can concentrate just on yourself. You can talk this out, just as you might think it out, and I'll help you where I can. (Both are walking now) Why don't you start by saying, "Sometimes I just don't want to listen because I'm so afraid of being blamed." Talk about what blame means to you.

Burt: OK. It's true. I'd do anything if I could just come home late sometime and not hear what I already know.

Therapist: (doubling Burt for a moment) I just can't stand all that blaming.

Burt: Oh, blame. Well, I hadn't thought about it for a while, but I guess my mom was the world's expert on this.

Therapist: (still doubling) I had a great teacher.

Burt: I used to try to get away from the dinner table just as fast as I possibly could just to avoid hearing my mom lay it on my dad.

Therapist: (Therapist switches back to the therapist role) There's that dinner table again. What did she blame him for?

Burt: For swearing about politics or for not complimenting her on the dinner. You name it, she could blame it! Hey, I made up a rhyme!

For the first time, Burt was metacommunicating, talking about blaming rather than doing it. To deepen and anchor the experience, the therapist decided to shift to a role reversal and to explore the relationship with his mother. She was satisfied that she knew enough to portray Burt's mother while simultaneously doubling Burt; in addition to her new role, she needed to keep in mind Burt's original process with his mother and Ethel's reaction. The therapist's goal was twofold: to help Burt understand his fear of blame and to show Ethel that Burt's avoidance had roots that predated their relationship.

The therapist decided to stop the doubling and shift to role reversal so she stopped the walk and faced Burt.

Therapist: Let's talk to her about that. But first I'd like to meet her. Could you take the role of your mom for a minute and let me talk to her?

Burt: I could try, I guess.

Therapist: (She shifts to the interview technique) OK, so you're Burt's mom. Was he easy or hard to raise?

Burt, as mom: Oh, he wasn't that hard. We really saw to it that he did what he was supposed to do, and most of the time, he did it.

Therapist: How did you do that?

Burt: (He drops out of the interview and speaks for himself in the present.)—and boy, could she be disappointed!

Therapist: (She addresses Burt directly.) So you'd like her to know how that felt?

Burt: This is the day for trying this new stuff!

Therapist: OK, where does this take place?

Burt: I know! She's in the kitchen, waiting for me to come home from school.

Therapist: Good. OK, let's start.

Therapist as mom: Burt, did you bring your paper back? How did you do?

Burt: (He drops his role and addresses the therapist directly.) I wish I hadn't come home yet.

Burt is demonstrating that he is not confused. When he needs the therapist to empathize with him, he recasts her in her original role. The therapist then demonstrates her own role flexibility and helps Burt return to the enactment.

Therapist: (The therapist, breaking out of her role, is glad that he could address her when necessary.) I can certainly understand that. You know, you can always speak your thoughts. Just turn your head this way, when you're just thinking aloud (the therapist demonstrates).

Burt: I get it. Oh God, I'm heading straight for her martyred look. She's going to be so disappointed.

Therapist (in her role as mom): Where is it?

Burt: Mom, I don't have it.

Therapist as mom: But you said—

Burt: But mom—

Therapist as mom: Don't tell me. No. Don't tell me.

Burt: Mom, I left it at school.

Therapist as mom: You know your father and I wanted to see it. What kind of grade did you get? I'll bet it wasn't what you wanted. (Burt looks down at the ground).

Therapist as mom: Tell me. Tell me.

Burt (hardly audible): I got a C.

Therapist as mom: Oh no! What does that mean for your course grade? That is so terrible! I'm so worried about what Dad's going to say.

Burt (smiling): Mom, I've got to go to soccer practice.

Therapist (as herself): So at this point you'd be willing to do anything just to get out of there, right?

Burt: Right! Definitely right.

One of Fritz Perls' (Perls, Hefferline, & Goodman, 1973) frequent interventions in his workshops was to use a sentence from a dialogue with a member of the client's family of origin to address a person in the client's present social atom. The therapist now repeated what Burt had said to his mother as a way to address his wife.

Therapist: Could you say that to Ethel, "When I feel blamed, I'd be willing to do anything to get out of there?"

Burt: To Ethel? Oh, yeah. Oh, that fits. When I feel blamed, I'd do anything to get away.

With that insight, the couple could return to the conversation about the dinner party with some understanding and a sense of humor. Ethel expressed her surprise at discovering Burt's fear of blame, because she had always seen him as a pillar of self-confidence. Burt ruefully acknowledged having forgotten Ethel's shyness and showed appreciation for her meeting the challenge of the party. More important, perhaps, was his realization that he had not expressed any appreciation in a long time.

When the therapist talked with the couple about what they had experienced, each credited doubling with their changed views. They developed greater awareness and with that, an ability to comment on the process. As they became aware of how often they lapsed into blame, they were able to stop themselves rather than look to the therapist. Both began to identify the roots of blaming and were able to communicate with greater empathy. More secure with each other after this intervention, Ethel and Burt were able to express fears of abandonment and sadness at missed opportunities.

Doubling is a technique with great range. In this instance, the therapist chose to double because Burt had been using intellectual defenses to distance himself from emotion while his wife Ethel expressed it, a common division of psychological chores that proves unworkable in times of stress. In this instance, the trust established in previous sessions enabled the therapist to use the doubling technique without much preparation. The therapist's self-knowledge, confidence, and sensitivity to the couple's responses are what determines this therapist's timing and particular choices of action techniques. Another therapist or the same therapist with another couple may not have chosen to risk being perceived as intrusive or presumptive (Leveton, 2000) and would have introduced such work by asking permission in a more formal way (Fisher, 2002).

Without straying far from the role of therapist and by using perceptions of the client to time comments and participation, a therapist can use doubling as

a way to access action techniques. As the client experiences the double in a supportive—if at times challenging—role, it is not unusual for the therapist to change back and forth between double and therapist roles. When the therapist takes on the role of someone not in the room, distance from the accustomed role creates a greater risk.

The therapist's role flexibility (Leveton, 2000) can vary for the same therapist and among therapists as a group. Not all therapists feel comfortable with role shifts, nor do all clients. Individuals vary in the amount of structure, direction, and support they need to role play. Although many are able to be flexible, others need to play one role in a setting in which the therapist's role never varies. The therapist must assess each couple's ability to shift as the therapist tries different action techniques. A look of confusion, a question about the process, or an inappropriate response is a sign that more support is needed.

Burt (to the therapist as therapist): I wish I hadn't come home yet. I'd rather be any place else.

Therapist: Ok, let's stop the role play for a moment. I'm not mom now. OK?

Burt: Yes, that's right.

Therapist: So this is hard for you when Mom starts to challenge you.

Burt: Sure. I know I'm not going to have the right answer.

Therapist: Maybe you can let mom know that. Let's go back to the role play. I'm still Mom.

When necessary, the therapist injects added structure, which clarifies the process and avoids ambiguity.

In this case example, the use of doubling was augmented by role reversal and the interview. I have found that one advantage of beginning with the double is that it needs little explanation and can quickly transform a talk session into an action experience. From there, a couple that is inexperienced in experiential work can be introduced to a wider variety of psychodramatic techniques. For the clinician who is comfortable with doubling, its advantage is its range. Doubling can be quiet and close to the therapeutic voice or provide a dramatic, emotional contrast to it. The technique can further inner work, or it can be used to augment an interpersonal dialogue. Although it is a powerful technique that can quickly bring a client to an unanticipated emotional expression, this method can also be used to de-escalate an emotional situation with quiet reflection (Leveton, 2000).

One of the issues often raised in applying psychodramatic techniques with individual and couples therapy is the question of the therapist's taking on a role while working with a couple. In psychodramatic groups, the director does not take a role in an enactment. Although couples therapy is different from a psychodramatic group, relevant criticisms of the therapist's role playing cen-

ter around therapeutic boundaries, transference complications, creating dependency, and the possible perception that the therapist is taking sides. Kipper (1986) suggested that the therapist leaves the scene without a director. These are all valid points for discussion and consideration.

Because a search of the literature has produced very little about these topics, the following is a summation of my own clinical experience and that of my students. In the hands of an experienced, well-trained professional with experience in a wide variety of roles, taking on a role can be an effective intervention devoid of the obvious dangers or pitfalls cited earlier. In my view—and I am aware that this will stimulate controversy—the issue of therapeutic boundaries is resolved not only by following the observable, established roles of therapist and client, of director and protagonist, but also by taking the personality and individual style of therapist and client into account. The therapist's taking a role in an enactment depends on such characteristics as role flexibility, expressiveness, tolerance of expressiveness, and the trust residing in both participants. The dangers, of course, are always there, just as they are with any other form of therapeutic intervention. The therapist must take care to separate personal agendas from the client's material (Hayden-Seman, 1998). The therapist must follow, rather than lead, the client (Moreno, Blomkvist, & Ruetzel, 2000). The therapist must check the intervention against the client's response in order to judge its effectiveness.

In one of the first family interviews in which I tried doubling, I was worried about the possibility of taking sides when I doubled for an adolescent who had been silent during the initial three sessions. Doubling for her for a good part of the hour, I was afraid that other family members would feel left out or unattended. I was surprised to learn that the opposite was true: The others expressed relief at hearing the adolescent's concerns, first in my voice, then in her own. Further role plays encouraged my joining in the enactments of families and couples when I thought it appropriate.

All therapeutic techniques that deal with surplus reality require flexibility. Perhaps the challenge to the director's role as the expert or the authority figure is most difficult to accept. It flies in the face of convention. A patient without a doctor? A protagonist without a director? But a director who takes a role is still a director, as theater and film, where the shift is also debated, have proven on many occasions. It is possible, with many clients, to shift between directing and participating, just as it is possible, in family therapy, to join the family part of the time and remain outside the family in the role of the observing expert authority part of the time. The question becomes one of ability. Can the director shift back and forth? Can the client tolerate and benefit from the shift? Leaving the couple without a therapist, in the sense of a person who remains obviously in charge of the session and its direction, is definitely a concern. A client who has developed strong

dependency feelings for the therapist may not be able to tolerate a shift in roles. Clients may indeed feel abandoned by a therapist who leaves the expected situation and enters a role play. If the therapist senses that one or both members of the couple need to be working with someone who takes a strong and consistent role, role taking is not advised.

The client's needs must determine the use of any therapeutic technique. There are clients who need the therapist to remain impersonal and in the background; it is unlikely that they would tolerate a therapist's taking a role in a personal enactment. Others look for any signs that reveal their therapist's personality: the greater range of expression allowed to the therapist who takes a role can provide enrichment and relief for such a client. Flexibility is a requirement; clients who have not achieved role flexibility themselves are seldom able to tolerate it in a therapist. Both therapist and client need the ability to play. The therapist must be capable of assessing the client's ability to tolerate a role shift and of understanding the subtle cues that signal trouble. Any sign of disorientation or anxiety when a new technique is introduced should alert the therapist to question its appropriateness. Confusion and anxiety are often related to the amount of ambiguity in a situation. In order avoid confusing the client, the therapist must make a clear shift between behavior as a talk therapist and director, and joining in an enactment. The therapist must be able to vary behavior and language enough for the client to experience a new and different role. There must be a clear signal, however subtle, that tells the client when the role-playing begins and when it ends.

Transference issues may arise. A therapist playing an antagonistic mother like Burt's, for example, may fear that the role will affect the client's view and consequent relationship. Any role taken by the therapist offers the possibility for new transference projections. Countertransference is equally important. In identifying with husband or wife, the therapist must work for awareness of personal agendas. Because role playing provides an avenue of direct, feelingful expression, the therapist must take care to express feelings appropriate for the client instead of using the opportunity to express personal needs.

Like any clinician, I have learned over time to track several levels of the client's experience simultaneously, and have trained my students to do the same. When role playing in couples or individual therapy, the therapist must assess the effects of the role play, much as the actor assesses the audience's reaction. The couples' sense of security, any signs of confusion, irritation, anger, or sadness that fall outside the dimensions of the role play must be noted and filed for later discussion.

One of the advantages of couples therapy is that psychodramatic sharing can be augmented with an ongoing, complex discussion of the role-play. On the therapist's part, openness to discussing process and possible transference and dependency issues is of primary importance in helping to resolve such issues as they

arise. The client's feelings about the therapist's taking on a role can be addressed when appropriate. In addressing the process and helping to bring conflictual issues to conscious awareness, the therapist who works with couples and individuals for an extended time frame has an advantage over the group psychodramatist who often sees clients only once or a few times. Working for longer periods of time also makes consultation possible, an invaluable aid to assessment of the process and, especially, to awareness of the countertransference.

Further investigation of role flexibility on the part of the director is necessary and advisable if therapists want to continue the creative process of developing psychodramatic techniques in the realm of psychotherapy. I chose Doubling and Sculpture to illustrate the effectiveness of using role play to interrupt pathological blaming and promote more productive work on the couple's communication. The question of the therapist's entering the role play is addressed with some of the safeguards that might inform such a move. Because of the sparsity of reports about this possibility in the literature, I propose that therapists participate in further discussion.

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