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A Comparative Evaluation of Group Treatments in an Adult Correctional Facility

Thomas G. Schramski
Clyde A. Feldman
David R. Harvey
Marj Holiman

This paper describes a comparative evaluation of Psychodrama with three other group treatments (Anger Therapy, Values Clarification and Decision Making) and a control group in a medium-security prison for adult males. The results support the overall benefit of Psychodrama and the other group treatments when compared with the control group. Psychodrama in particular facilitated significant improvement in resident attitudes toward the institution and a reduction in distressing symptomatology. Other results suggested that the treatment groups had differential positive impact on resident behavior. The relationships between these effects and characteristics of the treatment environments are discussed.

Group therapy and counseling have become widely used methods of treatment for adult residents of correctional institutions (Arnold & Stiles, 1972). Psychodrama and related action methods in particular have frequently been utilized in pursuit of the general goals of institutional and post-institutional adjustment (Wolk, 1963; Maas, 1966).

The purpose of this paper is to report the findings of a comparative evaluation of Psychodrama and other group treatments conducted at an adult, medium-security prison in the spring of 1982. This report presents a detailed study of four group treatments and evaluates the impact of each on the individual adjustment of residents.

Literature Review

Studies on the effectiveness of Psychodrama and other group treatments in correctional institutions have yielded mixed results. A review by Slaikeu (1973) presented 23 experimental studies that were cautiously positive regarding the effectiveness of group treatment, while other reviews have been even less enthusiastic (Parloff & Dies, 1977; Bednar & Kaul, 1978).

The differences in results may be attributed to a number of factors which tend to discourage replication of findings. First, a large number of studies are either anecdotal or rely on the use of posttest differences, without a control group comparison. Second, specification of treatment content and group composition factors related to treatment outcomes are inadequately described. Third, many of these studies present their statistical analysis without reference or formula. In combination, these shortcomings contribute to positive but dubious results. Psychodrama outcome research in particular has been confounded by these problems and others (Kipper, 1978).

Given these findings, prospective evaluators and researchers are presented with a familiar dilemma: in attempting to provide appropriate group counseling, the counselor seems impelled to violate the rules of experimental design. Vague and anecdotal reports prevent experimental replication; experimental inflexibility, on the other hand, can lead to ethical difficulties, such as denial of services to residents who desire and need treatment.

The following pages present a methodology that attempted to incorporate the treatment needs of correctional residents within a replicable, quasi-experimental framework.

Methodology

There were two primary purposes for this research. First, this study proposed to determine whether or not Psychodrama and the other group treatments were more effective than no treatment over an identical eight-week period. Second, if a significant treatment effect existed, the results would be analyzed to identify the differential nature of change for each group treatment.

Resident Characteristics

The group members were 66 male residents who volunteered to participate in a group treatment program. Group members were ethnically distributed as follows: Anglo (N = 31, 47%); Black (N = 20, 30%); Hispanic (N = 13, 20%); and Native American (N = 2, 3%). Marital status of these group members was as follows: married (N = 7, 12%); single (N = 54, 83%); and divorced (N = 3, 5%). Fifty-two group members (79%) had

received previous counseling. Residents were characterized according to type of offense: violent (N = 32, 49%); nonviolent (N = 25, 38%); and sexual (N = 9, 13%). These characteristics suggest that this sample of counseling participants was representative of the institutional population of this facility at the time of this study. Mean age ($\overline{X}$ = 22.5, S.D. = 3.5) and educational level ($\overline{X}$ = 11.2, S.D. = 2.3) for all subjects were evaluated for differences among the groups.

Results of analyses of variance among groups indicated no significant differences existed for any of the demographic characteristics, with one exception. The Psychodrama group participants were identified as having completed significantly more years of education than either the Decision Making or control groups ($p < .05$). On demographic characteristics other than education, these groups were viewed as equivalent.

Therapist Qualifications

A description of the therapists who provided treatment is as follows:

- Psychodrama. Two male therapists with Ph. D. and M. Ed. training in counseling respectively. One therapist had completed certification as a Practitioner; the other therapist had several years' experience in using action methods.
- Anger Therapy. One female Ph.D. and one male M.Ed. therapist. Both therapists had received anger therapy training and had several years of group therapy experience.
- Values Clarification. One female counselor with M. Ed. in counseling. This therapist had two years of group therapy experience.
- Decision Making. One male counselor with M. Ed. in counseling. This therapist had several years of group therapy experience.

All counselors had moderate to advanced levels of group treatment experience, though the nature of experience differed. The differential impact of two counselors (Psychodrama and Anger Therapy) versus one counselor (Values Clarification and Decision Making) was not assessed in this study. Since no treatment was provided to the control group, there were no counselors for this group.

Group Selection

Residents registered for eight group sessions with selection based on minimal information, specifically the group titles. The control group was comprised of residents who responded to a written request by the correctional staff for minimal treatment group participants. Random assignment of subjects to treatment group, therefore, was not made, because of ethical

considerations, including the limited availability of group treatment and the residents' right to treatment.

Group Treatment Procedures

Each treatment was described in writing by the respective group leader prior to the initiation of treatment. These descriptions follow, including reference to group purpose, theoretical perspective and techniques to be employed:

- Psychodrama. The purpose of this group is to help residents systematically evaluate their thinking, feeling and acting through the use of action techniques. Techniques will emphasize continuous action by all group members, using role playing, role reversal, doubling, mirroring, sociometric exploration and other psychodramatic techniques. Action techniques will also be used as role training to help residents rehearse behavioral strategies for problematic encounters with staff and other residents in the institution.
- Anger Therapy. The purpose of this group is to provide residents with an opportunity to express their frustrations, resentments, anger, hurt and losses. The group will encourage residents to practice appropriate physical and verbal expression of emotion, both in and outside the group. Group members will be expected to set individual goals on any of these personal issues, and group members will practice behavioral planning, gestalt experiments and role playing.
- Values Clarification. The purpose of this group is to help group members examine values that influence past, present and future behavior. Presentations and structured experiences will consider individual value conflicts, as well as those which are interpersonal, in order to clarify and provide members with an opportunity to change.
- Decision Making. The purpose of this group is to examine critical elements in the decision-making process, both for the individual and the group. The focus of the group will be didactic presentation of various problem-solving strategies that are concrete and effective. Homework assignments will include goal setting and practice.

Validation of group differences was tested by evaluation of the *Group Environment Scale* (GES) (Moos, 1981b) completed by each resident at posttest. This instrument is described later in the Methodology section.

Measures

The Correctional Institutions Environmental Scale (CIES) (Moos, 1981a) is a 90-item, true/false measure that has been utilized in a large number of

studies assessing resident and staff perception of the social climate of correctional institutions. This study employed the CIES, Form R, which is composed of three dimensions (Relationship, Treatment Program, System Maintenance), with three subscales (Involvement, Support, Expressiveness; Autonomy, Practical Orientation, Personal Problem Orientation; Order and Organization, Clarity, Staff Control) in each dimension. Comparison of all five groups at pretest showed equivalency at intake on the CIES. One-way analyses of variance between groups indicated no significant differences among the groups on the CIES subscales.

The *Hopkins Symptom Checklist,* Revised Form (SCL-90R) (Derogatis & Cleary, 1977), is a widely used, 90-item checklist designed to evaluate client complaints on nine symptom dimensions (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism). Comparison of these symptom dimensions with similar Minnesota Multiphasic Personality Inventory (MMPI) scales has reflected high concurrent validity for the SCL-90R subscales (Derogatis, Rickels & Rock, 1976). These nine dimensions are incorporated in three global indices: Global Severity Index (GSI) (combination of symptoms total and intensity); Positive Symptom Distress Index (PSDI) (average symptom intensity); and Positive Symptom Total (PST) (number of symptoms identified). The SCL-90R has been recommended in surveys of available outcome measures (Waskow & Parloff, 1975; Beutler & Crago, in press), though it was not reported as applying to correctional groups in the research surveyed by these authors.

A one-way analysis of variance among groups indicated no significant group differences at intake on the SCL-90R.

The *Group Environment Scale* (GES) (Moos, 1981b) is a 90-item, true/false measure that has been used to assess the social climate of varying social, support and treatment groups. The GES has been used in a variety of environments, including correctional institutions (Waters, 1978), to measure resident perception of group settings. The GES is composed of three dimensions (Relationship, Personal Growth, System Maintenance and System Change) and ten subscales (Cohesion, Leader Support, Expressiveness; Independence, Task Orientation, Self-Discovery, Anger and Aggression; Order and Organization, Leader Control, Innovation). The GES was administered only once, at the completion of the eight-week treatment.

Analyses and Results

Statistical analyses and results bearing on the original purposes of this study are presented in this section.

Strategies for Analyses

Prior to analyzing pre/post change scores, a decision was made to use percent change scores, in contrast to difference scores, in the analyses. Correlations of pretest scores with pre/post difference scores on the CIES (r = .33 to .59) and SCL-90R (r = .46 to .77) subscales were found to be significant in the intended direction (those with pretest advantage evidenced smallest relative change). Therefore, the percent change formula was used to analyze all subsequent data. The CIES percent change formula was (pre-post/max-pre) × 100. Because of its inverse, MMPI-like scoring the SCL-90R formula was (pre-post/pre) × 100.

A factor of statistical importance was the significant difference ($p < .05$) between the groups in their years of education. The impact of this difference was analyzed by incorporating educational level in a preliminary analysis of variance as a covariant. Correlation coefficients indicated that educational level covaried significantly ($p < .05$) with three subscales: the CIES subscales of Autonomy (r = .27) and the GES subscales of Expressiveness (r = .27) and Leader Control (r = .39). The regressions of education and those three dependent scales were found to be sufficiently linear and homogeneous among groups to meet the primary assumptions of the covariance model. For these three scales all subsequent treatment group comparisons were analyzed with the covariance test, while reporting main treatment effects.

The Impact of Group Treatment

Results of analyses of variance among all five groups indicated significant ($p < .05$) differences on all CIES subscales and on eight of twelve SCL-90R dimensions on global indices (Tables 1 and 2). Specific group comparisons on these significant subscales revealed further that one or more groups improved consistently over the control group on all CIES and SCL-90R subscales. The magnitude of change for the control group was generally minimal and in a negative direction (14 of 17 subscales), while the remaining subscales each evidenced less than one percent positive change.

In one case the control group appeared significantly different when compared to the Values Clarification group. In this case the control group was essentially unchanged on a SCL-90R dimension (Psychoticism) while the Values Clarification group showed a relative increase in disturbance.

The relative effectiveness of each group treatment when compared to the control group is summarized as follows:

- Psychodrama. The Psychodrama group evidenced very significant improvement over the control group on all subscales of the CIES. Magnitude of comparative percent change over the control group rang-

Table 1. Analysis of Variance for Treatment Groups on CIES for Percent Change

		Treatment Groups[a]					
CIES Subscale	F[c]	Psycho-drama (PD)	Anger Therapy (AT)	Values Clarifi-cation (VC)	Decision Making (DM)	Minimal Treatment (MT)	Significant[b] Pairwise Comparisons
Involvement	2.91*	6.00	−0.77	3.80	3.64	−4.31	PD > MT
Support	3.34	13.06	5.77	7.60	2.35	−1.81	PD > MT, DM
Expressiveness	6.63***	24.50	3.55	16.10	3.21	-6.82	PD > MT, DM, AT VC > MT
Autonomy[d]	3.87**	9.44	4.78	−4.90	−1.00	−6.91	AT > MT PD > MT, VC
Practical Orientation	7.54***	15.44	−1.67	−13.90	−2.71	−8.75	PD > VC, MT, DM, AT
Personal Problem Orientation	5.49***	13.75	12.33	−4.80	0.50	−3.19	AT > MT, VC, DM PD > MT, VC, DM
Order and Organization	7.48***	13.56	1.33	2.30	−5.00	−8.06	PD > MT, DM, AT, VC
Clarity	6.43***	14.12	−0.33	1.90	−2.71	−6.06	PD > MT, DM, AT, VC
Staff Control	4.22**	−18.69	−9.56	−8.80	−2.79	0.00	PD >MT, DM

[a] Positive treatment group values indicate improvement, with the exception of the Staff Control subscale

[b] Duncan multiple range test (alpha = .05)

[c] df = (4,64)

[d] Comparison based on residual after covariance with educational level

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

Table 2. Analysis of Variance Between Treatment Groups on SCL-90R for Percent Change

SCL-90R Dimension/ Indices	*F*	Treatment Groups[a] Psycho-drama (PD)	Anger Therapy (AT)	Values Clarification (VC)	Decision Making (DM)	Minimal Treatment (MT)	Significant[b] Pairwise Comparison
Somatization	—	—	—	—	—	—	—
Obsessive-Compulsive	4.41**	5.50	9.11	2.30	0.43	−4.13	AT > MT, DM PD > MT, DM
Interpersonal Sensitivity	4.25**	9.13	5.56	1.80	−1.07	−1.81	PD > MT, DM, VC
Depression	8.07**	16.06	9.56	13.20	12.21	0.94	AT > MT; PD > MT VC > MT; DM > MT
Anxiety	—	—	—	—	—	—	—
Hostility	—	—	—	—	—	—	—
Phobic Anxiety	—	—	—	—	—	—	—
Paranoid Ideation	6.01**	12.63	3.78	11.30	11.43	−1.31	DM > MT, AT PD > MT, AT VC > MT, AT
Psychoticism	2.80*	−0.88	0.44	−14.10	−5.86	−0.31	AT > VC; PD > VC; MT > VC
GSI	7.11**	12.00	3.11	−2.70	2.88	−0.75	PD > VC, MT, DM, AT
PSDI	3.56**	17.19	8.11	3.60	9.21	−0.63	PD > MT
PSI	2.73*	4.69	0.78	0.70	−3.28	0.25	PD > DM

[a] Positive treatment group values indicate improvement

[b] Duncan multiple range test (alpha = .05)

*$p < .05$

**$p < .01$

ed from 10 percent (Involvement) to 31 percent (Expressiveness). Psychodrama also made significant gains over the control group on 6 of 12 dimensions or global indices, and on 6 of 8 dimensions where the overall *F*-ratio between groups was significant. Psychodrama demonstrated decreased symptomatology ranging from 9 percent (Obsessive-Compulsive) to 18 percent (PSDI).

- Anger Therapy. Those in Anger Therapy improved significantly over those in the control group on the subscales of Autonomy and Personal Problem Orientation (CIES), as well as the dimension of Obsessive-Compulsive and Depression (SCL-90R). Positive percent changes ranged from 10 to 15 percent for each of these subscales.
- Values Clarification. The Values Clarification group made significant improvements for the subscale of Expressiveness (CIES) and the dimensions of Depression and Paranoid Ideation (SCL-90R). This group demonstrated more than 10 percent improvement over the control group for each of these domains.
- Decision Making. The Decision Making group improved very similarly to Values Clarification on the same subscales.

In summary, the results of the CIES and SCL-90R support a statement that treatment groups, particularly Psychodrama, improved when compared with the control group.

Differential Effects Treatment

A second purpose of this study was to assess the differential effects of group treatment. Results of analyses for the CIES and SCL-90R (see Tables 1 and 2) provide this information. These differential effects are described as follows:

- Psychodrama. The Psychodrama treatment facilitated the largest percent gain when compared with any other group treatment. Psychodrama was significantly more effective than Anger Therapy (on Practical Orientation, Order and Organization, Expressiveness, and Clarity); than Values Clarification (on Autonomy, Practical Orientation, Personal Problem Orientation, Order and Organization, and Clarity); and than Decision Making on all subscales except Involvement. Regarding the Hopkins Symptom Checklist (SCL-90R), Psychodrama was superior to Anger Therapy (on Paranoid Ideation and the Global Severity Index); to Values Clarification (on Interpersonal Sensitivity, Psychoticism and GSI); and to Decision Making (on Obsessive-Compulsive, Interpersonal Sensitivity, GSI and Positive Symptom Total). The magnitude of change ranged from 6 percent on

Obsessive-Compulsive (vs. Decision Making) to 25 percent on Expressiveness (vs. Decision Making and Anger Therapy).

- Anger Therapy. Anger Therapy was also superior to Values Clarification and Decision Making groups on several subscales. Significant improvement on the SCL-90R dimension of Obsessive-Compulsive (over Decision Making) and Psychoticism (over Values Clarification) was apparent from the data.
- Values Clarification and Decision Making. Both of these groups evidenced significant improvement on Paranoid Ideation when compared to Anger Therapy.

Differences in the Environments of Treatment Groups

The final purpose of this study was to assess differences in group environments as a method of contrasting the group approaches characterizing the four treatment groups. Table 3 compares group environments as reflected in the GES subscales. Analysis of variance yielded significant mean differences between groups on six of the ten subscales. Table 3 shows the specific group comparisons between all pairs of counseling groups employing Duncan's multiple range test. The results suggest the following group descriptions.

- Psychodrama. Analysis of the Psychodrama group results suggest that it may be characterized as encouraging group participation (Expressiveness) in creative (Self-Discovery) and spontaneous ways (Innovation). The comparatively low score of Anger and Aggression suggests that action techniques (e.g., role playing) used in the group did not focus on intragroup conflict. Lower scores on Leader Control suggest that though directive, this group environment was not perceived as leader-oriented. As reflected by the Order and Organization subscales means, this group appeared to the residents to be most clearly organized. This perception was derived from the use of numerous structured exercises and warm-up activities.
- Anger Therapy. The Anger Therapy group was most significantly different from all other treatment groups in encouraging the expression of intragroup and individual conflicts. The Anger and Aggression scale does not contain items related to cathartic physical expression of anger (e.g., using batacas), though this was a group activity, as well as "homework" assignments that encouraged residents to monitor and control their inappropriate expression of anger directed at the institution. The Anger Therapy group had the highest mean rating for Cohesion, which suggested that this group activity fostered a high degree of group togetherness. The Anger Therapy was distinctly less oriented

Table 3. Analysis of Variance Between Counseling Groups on GES (N = 50)[a]

GES Subscale[c]	F	Treatment Groups: Anger Therapy (AT)	Psycho-Drama (PD)	Value Clarification (VC)	Decision Making (DM)	Significant[b] Pairwise Comparisons
Cohesion	—	—	—	—	—	—
Leader Support	—	—	—	—	—	—
Expressiveness	6.86**	52.33	60.88	50.60	48.29	PD > DM, VC, AT
Task Orientation	—	—	—	—	—	—
Self-Discovery	2.97*	57.89	59.63	53.50	51.86	PD > DM
Anger and Aggression	8.82**	48.11	35.71	42.20	35.88	AT > PD, DM VC > PD, DM
Order and Organization	5.34**	51.67	63.31	60.70	63.29	PD > AT: DM > AT VC > AT
Leader Control	8.73***	43.67	38.63	45.00	57.43	DM > PD, AT, VC
Innovation	3.97*	56.67	62.75	53.60	52.57	PD > DM

[a] Standard scores were used in the comparison

[b] Duncan's multiple range test ($p < .05$)

[c] Expressiveness and Leader Control comparison based on residuals after covariance with level of education

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

than other groups toward structured activities and leader directiveness.

- Values Clarification. The Values Clarification group differed primarily in placing comparatively more emphasis on Order and Organization (e.g., structured values clarification exercises) and on Anger and Aggression, as in individual expression of anger or criticism. As compared with Decision Making, a similar type of group, Values Clarification deemphasized leader control and directiveness.
- Decision Making. As an educational group, Decision Making emphasized Order and Organization and Leader Control. These results suggest that this group was didactic and clearly structured according to resident perceptions, as well as moderately supportive of resident expressiveness and discouraging of expression of anger or criticism. This configuration may have resulted from both the nature of the group (educational) and its large number of participants ($N = 16$).

In summary, the results suggest that strong differences in treatment group atmosphere existed. These Group Environmental Scale (GES) results also validate the structural differences between treatment groups and differential characteristics responsible for change in resident behavior and attitudes.

Discussion and Conclusions

In this section, the three purposes of this study are discussed as they relate to the results, limitations inherent in methodology, and directions for further research.

The Effectiveness of Group Treatment

A salient finding of this study was the effectiveness of several group treatments provided at the correctional institution. The effect of these treatments, when compared with the nontreatment of the control group, was to consistently facilitate change in a wide variety of areas, according to residents involved in the study.

Resident perception of the correctional environment was significantly modified by participation in one or more treatment groups, reflected by the Correctional Institutions Environment Scale (CIES). This change in perception suggests that group treatment, particularly Psychodrama, was beneficial in helping residents to view the institution in a more positive fashion. The control group changed slightly in a negative direction, which was consistent with the prevailing mood of anxiety and resentment among the residents at this time.

Specifically, the Psychodrama group made significantly positive changes across all domains of the Correctional Institutions Environment Scale

(CIES). These results suggest that Psychodrama was particularly effective in helping residents to view their institution more positively. It is probable to assume that these changes were a product of action techniques, like role training, a psychodramatic technique which allowed residents to practise more appropriate responses to problematic encounters in the institution.

Particularly noteworthy are the positive changes for all treatment groups on the Staff Control subscale. Following completion of a treatment group experience residents perceived the correctional environment as less oppressive and more rehabilitative.

The treatment groups helped residents reduce symptom complaints on four of six symptom dimensions and two of three global indices of the SCL-90R. This was particularly true for all groups on the Paranoid Ideation and Depression dimensions, suggesting that treatment helped residents to become less withdrawn and dysphoric, more energized and hopeful, as well as less hostile, suspicious and grandiose. A construct central to these dimensions may be a personal sense of autonomy, which would have increased as a result of these group experiences.

Psychodrama was most effective in producing positive change as reflected on SCL-90R dimensions and global indices. One dimension, Interpersonal Sensitivity, was less problematic for Psychodrama participants after the group, suggesting that they felt more interpersonally adequate as a result of this treatment. Again, the Psychodrama group emphasis on role playing and other forms of structured interaction were specifically addressed to this concern.

Limitations

Several methodological issues are presented in relation to questions of internal and external validity.

First, this study employed volunteers who were not randomly assigned to treatment. Lack of random assignment generally leads to questions about selection bias. This study attempted to correct for any inherent weakness by utilizing analysis of variance to determine statistical equivalence at pretest on several reported demographic variables. The groups demonstrated strong similarity on these characteristics, with the exception of level of education. This known difference among the groups was incorporated statistically through the analysis of covariance and did not obscure treatment gains.

Second, this study used change scores as a method for assessing resident improvement. Change scores have been increasingly criticized on a variety of statistical grounds (Cronbach, 1970). However, confidence in the use of change score analysis can be greatly increased when the researchers: test for statistical equivalency at pretest on the dependent measures; obtain suffi-

ciently large difference scores which offset errors of measurement; and inspect the relation between the pretest scores on the dependent measure and the pre/post differences to account for strong correlation through the appropriate use of percent change scores. This study applied these three principles within the strategy of data analysis.

In reference to external validity and generalization of results, normative information for the CIES and SCL-90R for this specific institutional population was not available. Norms from similar institutions throughout the United States were used as standardization figures for the dependent measures, but it would be very useful to have had normative data to compare with other medium-security prisons.

Finally, the differential character of the group treatments was based on group leader statements, the formal structure of the group methods, group therapist style, number of group leaders and other group methodological differences. How each of these characteristics may have contributed to the differential effects of treatment is a question for future research. The difficulties in providing a useful and consistent operational definition of Psychodrama, in particular, have been discussed elsewhere (Kipper, 1978). Psychodrama at this prison in the spring of 1982 may be different from Psychodrama at an in-patient psychiatric unit during the same period. In addition, the restricted nature of an institution such as this one necessitates changes in leadership style and the discussion of issues like confidentiality.

The results of this study support the belief that group treatment can provide a valuable service to residents in a correctional institution. Further studies of group treatment in correctional institutions are necessary. The research presented here suggests that evaluation of group treatment will provide valuable information about therapeutic process in correctional environments. The challenge is to evaluate group treatment, particularly Psychodrama, as it normally occurs, in order to provide results that are meaningful for other group practitioners and researchers.

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Address: Tucson Center for Psychodrama and Group Process
927 N. 10th Avenue
Tucson, Arizona 85705

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Thomas G. Schramski is director of the Tuscon Center for Psychodrama and Group Process, and is a T.E.P. and certified psychologist. Clyde A. Feldman is a research associate with the Center and a graduate student in training. David R. Harvey is co-director of the Center, also director of Counseling and Consulting Services, Tucson. Marj Holiman is an associate with Counseling and Consulting Services.

Empowering People in Therapy
—as modeled by *The Wonderful Wizard of Oz*

Barbara Fishman
Robert Fishman

Empowering is a therapeutic process composed of five functions: Understanding the client's objectives, discovering implicit story lines, creating therapeutic goals, delivering empowering messages, and using appropriate therapeutic tools. These functions are interconnected so that every time one occurs the therapist receives information which then affects every other function. This paper also argues that the empowerment of others takes place in a process carefully designed so that the therapist can give the client whatever s(he) desperately wants, but by the time it is given, already has. The Wizard, in the story of Oz, is used as a model of the empowering therapist and his work provides the reader with examples of successful therapy.

Good stories tell us about ourselves. Translating our humanist legacy into modern terms, Frank Baum has woven a tale about frailty and strength, as they exist inside every human being. *The Wonderful Wizard of Oz* is a story about four characters and their search for qualities at first perceived to be external, but ultimately found to be internal. As we read, we follow Dorothy and her three friends during their journey toward a renowned healer who, they hope, can give them each their special desire—a brain, a heart, courage, and home. When they finally reach the Wizard, he asks them to perform a task designed to call forth the very qualities each character wishes to be given. They must kill the Wicked Witch of the West. Once this is accomplished, every one is prepared to receive, and believe in, the magical gifts which a Wizard can give. As a wise therapist, however, Oz *empowers* by creating the context within which he can *give away* what those who come to him want, and he knows they *already have*!

If we look deeply into the work of family therapists, we can find both wisdom and magic. The wise therapist perceives positive qualities within the

person seeking help, no matter how scarce these may be, and so creates a context in which these qualities may develop. This therapeutic tradition is distinct from that of the magician who works with techniques calculated to impact upon the client from the outside, eliminating symptoms or unwanted behavior. In our culture, there is an ongoing conversation between people who represent one or the other of these belief systems, whether they be therapists or fiction writers. In the story of Oz, Baum breathes life into this conversation but ultimately aligns himself with the humanist tradition—the one to which the authors also owe their allegiance.

"Empowering" is a model for doing therapy which has been developed over about twenty years of clinical work, primarily with middle class people, and is rooted in the family therapy movement. The goal of empowering is to change specific patterns of relationships that do not currently work (Grinder & Bandler, 1976; Haley, 1963, 1976; Watzlawick et al., 1974). Whether people seeking help want to change life situations, specific behaviors or emotional responses, their problems are always conceptualized within social contexts. Empowering is a therapeutic process in five parts: 1) Unraveling the client's objective, 2) Constructing the therapeutic goal, 3) Understanding the story line, 4) Communicating the empowering message, and finally, 5) Using tools which can actualize the therapeutic goal. We will now trace each step in the empowering model as it is practiced by the Wonderful Wizard of Oz, and by a therapist working with a real person in the world of therapy.

The Client's Objective

> "Where is the Emerald City?" [the Scarecrow] enquired, "and who is Oz?"
>
> "Why, don't you know?" [Dorothy] returned, in surprise.
>
> "No, indeed; I don't know anything. You see, I am stuffed, so I have no brains at all," he answered, sadly.
>
> "Oh," said Dorothy, "I'm awfully sorry for you."
>
> "*Do you think*," he asked, "*If I go to the Emerald City with you, that the great Oz would give me some brains*?"

Like the Scarecrow, people come for help because they are stuck and they hurt. They have been repeating sequences of troublesome behavior for years and are usually unable to explain the repetition, or even to note that it occurs. Those who enter a therapist's office for the first time usually identify goals that are vague or global and are framed so that the outside world must create the change (Haley, 1976). Often that very desired goal also negatively labels others, as when a husband or a mother is considered ill or bad.

Sometimes the person seeking help is negatively labeled, as is the case for the Scarecrow who wishes for brains but firmly believes that he is "dumb."

Consider Cathy Roberts. She is a thirty-two year old Catholic woman who was divorced one year ago, a surgical nurse and the mother of two preschool children. Now, she is living with Roy, a new man in her life whom she wishes to marry. Cathy comes into therapy with an objective—actually expressed as a dream which she despairs of ever achieving—she wishes she can "have feelings," especially with men. If a man expresses affection for her, Cathy is pleased but can never respond in kind. Cathy concludes that she is "deficient." She talks sadly and with great tears about losing Roy unless something different happens. It is with self-blame and this mixture of feeling and the inhibition of feeling that therapy begins.

The Therapeutic Goal

> "Can't you give me brains?" asked the Scarecrow.
>
> "You don't need them," [says Oz]. "You are learning something every day. *A baby has brains, but it doesn't know much. Experience is the only thing that brings knowledge*, and the longer you are on earth the more experience you are sure to get."

Oz tells the Scarecrow that the goal of therapy is for the Scarecrow to understand that he already has the equipment needed to acquire knowledge and that all he actually needs is experience. The Wizard will provide him with that. A therapeutic goal is constructed by two people, therapist and client, building the framework for problem resolution together (Wagner, 1970; Berger & Luckmann, 1967). While the therapist begins to lay the foundation, it is essential that the client take part. Therapeutic goals may be constructed in many ways and none of them are absolutely correct. They are inventions which are based on a client's story line and created so that change may take place. The outcome of therapy is, of course, dependent on exactly what those goals prescribe.

Cathy and her therapist take Cathy's wish—to experience feelings with men—and translate it into a therapeutic goal: They will work toward a close relationship between Roy and her. But this can happen only if Cathy can learn a new relationship pattern: to both lose and not lose control. She will need to practice assuming an active role in her personal life at times and at other times allow Roy to do the same. However, Roy is needed, and so will be invited to attend a therapy session to see if this could become a joint project to take place over the next several months. In this way, the therapeutic goal has shifted from solving a problem conceived to be inside one person to a problem in relationship patterning between people who have to go through the therapeutic experience together.

The Story Line

The old crow comforted [the Scarecrow], saying:

> "If you only had brains in your head you would be as good a man as any of them, and a better man than some of them. *Brains are the only thing worth having in this world, no matter whether one is a crow or a man.*"
>
> "After the crows had gone I thought this over, and decided I would try hard to get some brains. By good luck, you came along and pulled me off the stake, and from what you say, I am sure the great Oz will give me some brains as soon as we get to the Emerald City," [concluded the Scarecrow].

The Scarecrow has a history of experiences from which he has developed a story which makes sense of his life. People's lives are stories that are told in actual behavior. Any person growing up in a family lives within a culture, which is itself within a certain period of history. These multiple contexts shape the individual, but he or she is still the author of a life story. Slowly, one develops characteristic perceptual frames or "story lines" which explain the world and offer rules that guide behavior (Wagner, 1970; Berger & Luckmann, 1967). When two people marry, story lines converge and, with time, an amalgam of the two is created. There are many examples of family story lines: "We are moral people," or "We are failures," or "We are happy together." These themes can be seen in the present or heard in talk about the past.

Cathy began therapy by talking about her lack of feelings with men. The therapeutic goal became a better relationship between Cathy and Roy, which itself was based on a hypothetical idea of Cathy's story line. Roy's story line would have to wait until later and that information might radically alter therapy. But for now, we have Cathy to work with and it is relatively easy to see that Cathy believes herself to be sweet and agreeable, a person who goes along with the wishes of others and so avoids conflict. Growing up in a family with an alcoholic father who was abusive to her mother, Cathy tried hard not to be noticed. She became a good girl who never challenged adults, and as she moved through adolescence, the story line developed further. Quiet and unassuming, she had few friends. If she dated a boy, the relationship often failed, as her anxiety became too great to manage. As she grew to be a woman, a troublesome heterosexual sequence developed: a) she would try to be close; b) she felt compelled to please the other; c) she felt out of control, panicked, and finally, d) she withdrew from the relationship. The story line concludes: "I am a failure with men because I cannot feel enough, and most certainly, I cannot feel sexual pleasure."

Relationship patterns are learned primarily in families of origin, and, given the appropriate context, emerge later in life. Therefore, it is essential that therapeutic goals offer opportunities for redoing that story line, freeing a person from habituated and negative responses.

The Empowering Message

The Wonderful Wizard of Oz said:

> "*Hereafter you will be a great man*, for I have given you a lot of bran-new brains."
>
> The Scarecrow was both pleased and proud at the fulfillment of his greatest wish, and having thanked Oz warmly he went back to his friends.
>
> Dorothy looked at him curiously. His head was quite bulging out at the top with brains.
>
> "How do you feel?" she asked.
>
> "I feel wise, indeed," he answered, earnestly. "When I get use to my brains I shall know everything."
>
> "Why are those needles and pins sticking out of your head?" asked the Tin Woodman.
>
> "That is proof that he is sharp," remarked the Lion.

Oz is providing the Scarecrow with a new way of thinking; he now has brains and can function as though he does understand the world.

An empowering message is the basis of a new story line, a different frame which Oz, or a therapist, fully believes, and which the person being helped may also believe. It is a response to a previous story line, discrediting and undermining it. During sessions the therapist looks for examples of client behavior which illustrate the new story line, finding them in the most ordinary of interactions. Repeatedly, the therapist perceives and proclaims that the client has the very qualities needed for change. In the story, the Wizard "tries to help them [the Scarecrow and his companions] understand the solutions at which they have already arrived" (Kopp, 1970, p. 73).

Cathy's therapist took many opportunities to tell her that she could be close, sometimes staying in control and sometimes losing control. For instance, when Cathy talked about feeling disconnected during a sexual experience, the therapist concluded that if she felt excited, she ran the risk of losing the chance to determine what would happen next. It was, he said, possible to do both: be excited and sometimes be in control. As Cathy got more involved in solving the control puzzle, she left the disconnected feelings behind. Maybe the therapist was right, maybe she could at times be close to a man and still be in control. After all, wasn't she feeling close to a

man within the clear cut boundaries of a therapeutic relationship? These are examples of the many ways that the therapist said, "You can be, and indeed you are, close to others." And so the empowering message was delivered, continually challenging the client to believe in the qualities she already had.

The Therapeutic Tool

> "I am only a Scarecrow, stuffed with straw. Therefore I have no brains, and I come to you praying that you will put brains in my head instead of straw, so that I may become as much a man as any other in your dominions. . . ."
>
> "*I never grant favors without some return*," said Oz; "But this much I will promise. If you will *kill for me the Wicked Witch of the West* I will bestow upon you a great many brains, and such good brains that you will be the wisest man in all the Land of Oz."

Tools are those actions taken in order to attain the therapeutic goal and they take various forms. The Wizard fashions his tool in the form of assigning a task.

Dorothy and her friends are filled with fear as they set off on their mission. They are sure that the evil witch will force them into slavery. But by the end of the adventure, it becomes clear that it is fear itself that is the problem. The witch literally dissolves in nothing but a little water which Dorothy accidentally spills. She and the others have the experience of using their various abilities to achieve success. They have come to believe the empowering message. While the link between the therapeutic goal and the tools being used in therapy may not always be apparent to a client, both are integrally related.

During therapy with Cathy, tools were used to unlock the control puzzle. In concrete behavioral fashion, a process (tool) was created in which Cathy would give up control and then quickly take it back. Actual assignments included: a) listening to colleagues talk, then tuning them out to have her own thoughts, and then listening to them once again; b) talking on the telephone to a friend while doing the dishes; c) allowing Roy to caress her sensually, but not sexually, each knowing beforehand that she would ask him to stop when she felt she no longer wanted it; d) translating task (c) into a sexual context. As Cathy and Roy performed these tasks, slowly they developed a cooperative relationship and in the process experienced intimacy. This therapeutic tool is called behavioral repatterning. The tool was fashioned by all the participants, and designed to change a specific relationship sequence.

Like the man called Oz, therapists in our culture are often assumed to be wizards capable of unexplainable feats. Indeed, therapists themselves can assume that role and actually perform magic. The power of a social context

is so great that when therapist and patient share the belief in magic, it can occur. And when it does, the person being helped is impacted on from the outside, and so has less experience of his or her internal capacity to make change happen. The therapist performing magic is also affected: knowing the power of the Wizard but not the power of the human being struggling with the human condition. In the second half of this paper, each of the components of the empowering model for doing therapy will be discussed and examples used to further clarify the process.

Client Goals

People come to therapy with several kinds of requests. The first group states their wishes in general terms: "Help me," these people say, "I'm depressed," or, "I'm crazy," or again, "I'm a total failure." Without going further in any personal exploration, this group typically feels overwhelmed by the enormity of the trouble (Haley, 1963, 1976). They are unable to see the importance of breaking the trouble into more discrete issues which, once resolved, could have an impact on the larger whole.

The second group coming for therapy presents a series of complaints about others. "Help me change my children," is a common request, often masking, "Help me change my wife." For the younger person still living at home, the wish can be, "Stop my mother from controlling me." Rather than dealing with the complexity of interpersonal relationships when they go wrong, why not simply see the other as at fault? Lines of action then become clear. If a husband is unsatisfactory, leave him. If a mother wants to control, run away. Often the results of such action are problems in themselves but the simplicity of blame is still attractive.

Finally, there is that group who comes to see a therapist with more specific goals. One person might say, "Help me; I have to learn how to live with this man," while another could say, "I have got to stop using drugs." The person who wants to live with her husband may also need to avoid intimacy while the drug user may be maintaining a dysfunctional family system. While these goals have the advantage of being more concrete, they still need to be framed so that they are likely to succeed.

If a person's goals are unattainable it is because they are the end point of a story line, the outgrowth of patterns of relationship which may have worked in the past but do not work in the present.

The Therapeutic Goal

This invention, it will be remembered, is based on the client's objective, and story line, and also the availability of the real life tools needed to accomplish the goal. A goal is satisfactory if it is an achievable target—one

that a therapist can work toward competently with a client, and one that a client can conceive of as possible. For instance, when an initial objective is stated globally, "Make me less depressed," one of the many possible therapeutic goals might read: "We will work together, with your husband as well, so that you can look for employment in addition to your homemaking job and then you will be less depressed." For those who place the blame on others, a request like "Change my wife" might become: "You and your wife can learn to work cooperatively so that you can create a better sexual relationship and in the process both of you will change." And finally, for those who come in with more concrete goals, the statement "I have to stop using drugs" might result in: "In a step by step process you and your wife can reduce your drug intake but not eliminate it."

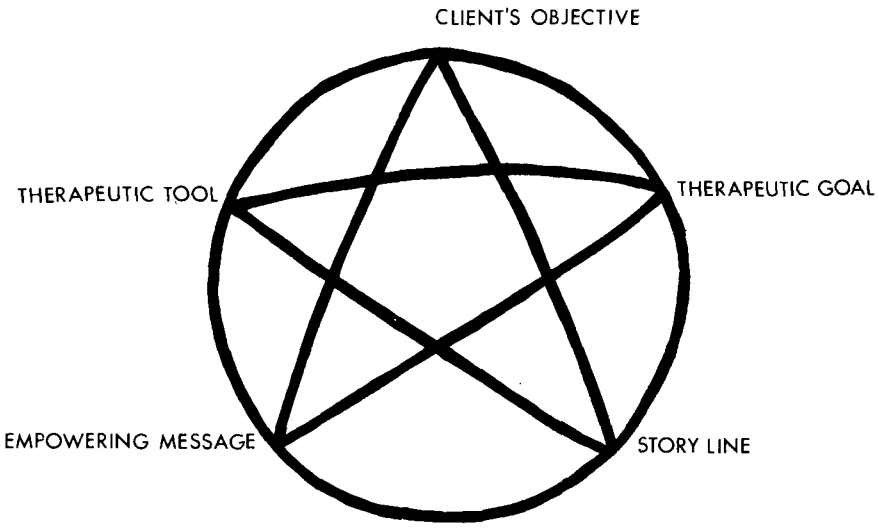
In all these examples, a client's goal changes or is framed so that it is something that can happen between people while still undoing the story line. The therapist needs to be sensitive to the differences between these new therapeutic goals and the original client objectives, which themselves are reflective of powerful story lines. These ways of viewing the world are potent and need to be approached with considerable respect for the repeated life experiences that produced them. When people have learned that it is only what the other can give that is valuable, the therapist reframes the goal implying that there are some things that are valuable to give to oneself. When someone has learned that to be male is to be powerful and independent, the therapy is designed to create situations where personal needs are directly asked for and satisfied by someone close. With those who have learned that to be vulnerable is to be laughed at, goals are established which allow them to be slightly vulnerable with a special person. Sometimes, however, the reframing does not happen. Either the therapist has missed some part of the process or the client cannot let go of the original belief systems. It is on this issue that therapy can fail.

In psychoanalytic terms, this is the problem of resistance to therapy. In empowering terms, the function of resistance is no longer to guard against unconscious impulses but rather to maintain patterns of relationship—ways of thinking and behaving—that feel safe. The therapist's task is to create therapeutic goals that structure the course of change so that it is acceptable. But there are multiple variables operating, and sometimes the right people with the right timing and the appropriate context do not come together and therapy fails.

The Story Line

We have talked about creating therapeutic goals as though story lines are already known, yet at the time when goals are first created, the therapist

Figure 1: The five therapeutic functions represented in this diagram are interconnected so that each function is affected by, and in turn affects, every other function.



may know very little about a person's life. This is not a problem because therapy is not a linear process. The five therapeutic functions outlined in this paper are held together in circular fashion, with each function providing feedback for every other, in a process that doesn't end until therapy is over. Secondly, story lines are so pervasively present that even a small sample of behavior occurring in a first session is enough to create a working hypothesis which is developed over time.

Story lines are actually sets of rules that guide us through daily life. Unlike scientific generalizations, which are developed so that they may be tested experimentally and altered if necessary, these personal themes can remain unchallenged throughout life. A therapist meets someone at a time of great need and so has the opportunity to change a story line. Therapists from many different traditions make use of these idiosyncratic frameworks through which any one person understands the world. Certain therapists have called them "patterns of behavior" and others have used the word "scripts" (Berne, 1969). These story lines have a basic structure which we present using the example of the woman who comes into therapy saying, "I'm depressed."

The Structure of a Story Line

Step 1: This is what I believe about myself.
example: I am depressed because I am a woman and women are not supposed to be accomplished, assertive, and at the same time lovable.
Step 2: But, I want to be different.
example: Even though I am a depressed woman of little value, I want to be accomplished and I also want to retain the love of my husband.
Step 3: This is how I try and fail.
example: I try to please my husband by not tending to my separate agenda and then I yell and scream with frustration and he gets angry, saying that I am too aggressive. So then I feel depressed because I have proof that when I am assertive he does not love me. So I try to please my husband. . . .

Once a therapist is sensitive to a story line, behavior becomes understandable and the therapeutic goal becomes a means of changing the story. For this depressed woman, the story line was undone by creating a new context for her assertive behavior—a job. And, at the same time, her homemaking role served to maintain her marital context, which was also essential. She and her husband could have both: the development of this assertive part of herself and the love that they shared. While this woman's story line was discovered in material from her current life, needless to say it could also be found in past material, dream work, or even in her wishes for the future.

The Empowering Message

The empowering message is a reply to the story line. It is a positive statement of belief in the client's basic value. It may not even be spoken aloud but simply be implied in therapeutic interactions, like the respectful way information is handled, careful listening and the cooperative activity involved in forming a therapeutic goal.

The empowering message heals. Through it the therapist gives the client what he or she already has but does not own: value, goodness, and capacity. Perhaps these qualities are merely nascent but belief in their presence is essential to change. Returning to the Wizard of Oz, the Scarecrow labeled himself negatively: he showed signs of intelligence while fully believing that he was dumb. And the Wizard responded: "You are already smart. You may not know it, but I do, because I see it in your actions." A therapist wages battle against powerful beliefs in the course of therapy and the empowering message is the therapist's most potent weapon. Like the story line

it challenges, it has a form. Using the example of the depressed woman once again, this form becomes apparent:

The Structure of an Empowering Message

Step 1: What you believe about yourself is not the whole truth.
example: You believe that you are depressed because you are a woman and women are not supposed to be assertive and at the same time lovable. *But I believe* that women can be assertive and at the same time lovable.
Step 2: You can be what you want to be.
example: If you want to be assertive and lovable you can.
Step 3: But, you can reach your goal only if you go about it in a different way.
example: You can learn to be assertive and lovable but you cannot be one while denying the other. That doesn't work.

This last step in the empowering message is illustrated in what we believe to be an old Sufi tale. It is about a man who lost a key. It was dark and he was looking for it under a lamplight when a passerby stopped to help:

"What are you looking for?" he asks.

"I lost my key, will you help me?" responds the man.

After looking under the light from some time with no success, the passerby asks, "Where exactly did you lose it?"

"Over there by the doorway," the man answers.

"Then why are you looking for it over here?" the passerby questions.

"Because this is where the light is," the man ultimately answers.

More often clients are looking for change in the wrong place because their story line prescribes wrongly where and how to look. A key to change does exist; a client must, however, look for it in a different place and in a different way.

Therapeutic Tools

Tools are actions, behavioral techniques through which goals can be achieved. Often, in our technologically oriented culture, they assume more importance than they actually have. Therapists and clients have personal reactions to specific tools; one person may feel that a tool is too dangerous to try while another may feel that it is useless, or perhaps immoral. Behavior therapy and paradoxical intervention are tools that lend themselves to impacting on people in a manipulative fashion. They

therefore court considerable criticism, especially in their more extreme forms (Dell, 1981; Farrelly & Brandsma, 1974). Interestingly enough, the empowering therapist often can bend these very tools and use them while still respecting the internal lives of clients. However, the price of using every tool must be calculated when working within the humanist tradition.

Each therapist has the basic responsibility for fashioning tools that produce change. He or she needs a wide array to choose from, and our therapeutic culture abounds with possibilities. At the beginning of this paper, we used the example of a tool called behavioral repatterning as it was used in therapy with Cathy. We have identified several other tools that have been effective in empowering people within the humanist tradition. None are new, but each provides the client with experiences of self-worth.

Modeling

It is often powerful for a therapist to model behavior by enacting it within sessions or by telling stories that illustrate personal behavior in action. One therapist might model by openly expressing feelings like hurt or loneliness or anger, allowing therapist and client to join in appreciation of one another. The client then has a first hand experience of the therapist's handling of such feelings. A second therapist might model with a personal story that embodies problems similar to those of the client and so help to normalize an issue, making it easier to change. In general, modeling allows the client to learn by replicating the therapist's response to similar life issues.

Teaching

Sometimes it is helpful to simply teach a client about a particular problem. For instance, when a remarried couple struggles to create a new form of family life like the stepfamily, they are in need of direct information about the differences between this new attempt and the nuclear family. The therapist is then in the role of expert providing information.

Self-Hypnosis

This is a powerful technique and can be used effectively to undo a story line. It entails the use of meditative states to picture personal goals in concrete visual forms.

We specifically include hypnosis because it is usually associated with the work of a wizard who magically impacts on another. However, when a client is taught the technique, to use or not use, it can empower that person to make change happen in his or her own life.

Barter

Clients come into therapy in a "one down" position, often feeling that the therapist is a wiser and a better person. While therapeutic power is essential to therapy, it does not imply that the therapist has more worth than the client. Each has distinct personal value, and skills that have developed differently. Bartering therapeutic sessions for the services of a shoemaker or an architect demonstrates that the client, as well as the therapist, has skills with which to enrich each other's lives.

Defining the Path

If the empowering process is carefully followed, a client begins to make things happen for himself—things that were not possible before therapy. Attention is focused on strength instead of weakness, and negative personal judgments lessen. The process of defining the path may not be as clear as Baum's yellow brick road but it can be conveyed with enough clarity to provide help. It does not hurt the therapy to educate a client about the process. In fact, the more that person knows, the less likely it is that the therapist will be seen as a wizard who creates—or fails to create—change. When Dorothy got angry at Oz for not fulfilling his promises magically, she said that he was a "very bad man." He responded:

> "Oh no, my dear. I'm really a very good man, but I'm a very bad Wizard, I must admit."

The authors hope that family therapy takes the route of an empowering humanism and avoids the route of a wonderful wizardry.

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Date of acceptance: April 6, 1983

Address: Barbara and Robert Fishman
Resources for Human Development
120 West Lancaster Avenue
Ardmore, PA 19003

Barbara Fishman is a family therapist and researcher. She has developed and used this model in the private practice of family therapy.

Robert Fishman is a family therapist and the Executive Director of Resources for Human Development. This model has been developed and used by him for family therapy and organizational development.

Reality, Perception, and the Role Reversal

Linnea Carlson-Sabelli
Hector C. Sabelli

Is it important to sort perceptions from misperceptions in the role reversal, and if so, when and how? Two guidelines are offered based on the view that while objective and subjective reality recursively modify each other, the objective has the priority in this continual process. Application of the guidelines is exemplified with clinical cases highlighting both the possibilities and problems of this technique.

One of the biggest concerns of psychodrama critics and some psychodrama directors is how perceptions are sorted from misconceptions in material produced by the protagonist during the role reversal. Because of this concern, some psychodramatists curtail and even avoid the extensive use of this important technique.

Every psychodrama director at some time has asked himself, "How do I know that the protagonist's perception of reality is correct? Is it important to know what really happened? Is it necessary to sort out reality? When do I do this? How do I go about it?" J. L. Moreno (1975/1959) in addressing this question says:

> The subject must act out "his truth" as he feels and perceives it, in a completely subjective manner (no matter how distorted this appears to the spectator). (p. 234)

His position is clear: what is important in the enactment or re-creation of the scene is the protagonist's perception. However, once enactment has taken place, the psychodrama director is faced with the task of helping the

protagonist find new ways to interact with the important people in his social atom.

"Enactment comes first, retraining comes later" (Moreno, 1975/1959, p. 234). In developing the role reversal technique, Moreno introduced a method whereby misperceptions between people could be identified and corrected, and thus he can be credited with creating not only psychodrama but also family therapy (Compernolle, 1981). His original concept involved two persons reversing roles with each other:

> The patient, in an interpersonal situation, for instance with his mother, "steps into his mother's shoes" while mother steps into those of her son. The mother may be the real mother as is done in psychodrama in situ, or may be represented by an auxiliary ego. . . . Distortions of interpersonal perception can be brought to the surface, explored and corrected in action. (Moreno, 1975/1959, p. 241)

To illustrate the above, Moreno describes a situation where both mother and son are present and reverse roles with each other. This leaves the reader wondering how "distortions of interpersonal perception can be brought to the surface, explored and corrected in action" when no additional party involved in the original interaction is present to correct and validate. Reconstructing past scenes from the perception of one individual creates both problems and possibilities, and raises the issues that are the topic of this paper.

We will first address the question, "Is it important to sort perceptions from misperceptions when teaching the protagonist to interact more effectively with others?" This is not merely a technical question; rather, it is a particular case of a basic philosophical issue. An idealist would contend that what matters most is the protagonist's perception of the other, a view which has some merit because this perception determines the interaction. A materialist, on the other hand, would argue that objective reality exists, whether it is perceived or not, and shapes perception. In our view, objectivity and subjectivity are intimately related and inseparable; each begets and modifies the other. Psychological processes are subjective because they exist only within the realm of human persons, and yet are also objective electrochemical processes of the brain. In the same manner, interpersonal life is colored by transferences from past family relationships, biases due to social and familial position; yet this life is dependent on objective socioeconomic factors as perceived through the biological filter of the individual's nervous system. The psychodramatist who addresses both the subjective and the objective aspects of the protagonist's world has more options in facilitating change than the therapist who focuses on one *or* the other. There may be instances when it is important to find out what really happened and cases

where it may not be necessary. Thus, it is useful for psychodramatists to have some guidelines regarding when it is important to sort out objective reality and how best to facilitate change.

Guidelines

1. *Give priority to objective reality, supremacy to subjective reality.**

The relationship of objectivity and subjectivity has important implications for therapy. Contrary to popular belief, "what you don't know *can* hurt you." Although objective and subjective components of reality continually modify each other, reality determines circumstances to a greater extent than consciousness modifies reality. For example, a child who does poorly in school may be perceived in many ways—stupid, lazy, troublesome. The objective reality may be that he is nearsighted. This makes it difficult for him to pay attention or respond to lessons that are written on the blackboard and underlies behavior that makes him appear as he does. Even if one could change the teacher's perception about the child's ability to do school work, it would not be enough. The priority should be to provide glasses, attending first to the objective reality of faulty eyesight. When an objective reality exists and operates whether it is perceived or not, it *is* necessary to sort misperception from objective reality—to help the protagonist gain insight so that reality can be dealt with appropriately. This means addressing life circumstances before subjective feelings, biological illness before interpersonal psychological disorders, social and family matrices before personal intrapsychic processes, and the facts as they appear before the meaning ascribed to them by interpretation.

The concept of supremacy of the subjective formulates the well-known psychodramatic strategy of meeting the protagonist first in his own subjective world. He must be allowed to fully express his truth: the psychodramatist can never violate the self-preserving need for continuity by challenging *in toto* the protagonist's perceptions. But within such constraints he assists the subject to see those objective realities which, whether perceived or not, predetermine both perceptions and future reality. Learning that a student cannot see well changes the approach of the teacher with that student. Likewise, perceiving a student as lazy can perpetuate lazy behavior. The way one perceives, interprets or feels about something can be instrumental in changing the present and future regardless of what has been real in the past.

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*This guideline is a specific application of a general law of processes according to which simpler processes precede and necessarily co-exist with complex ones, while the latter predominate in a more limited spatio-temporal field. "Priority of the simple; supremacy of the complex" (Sabelli, 1983).

The notion of the supremacy of consciousness is the theoretical basis for considering insight therapeutic. Perception cannot be entirely separated from misperception, even if one calls it insight. One's perception of reality is always in part correct and in part incorrect, albeit the proportions of the two components can vary. One may then question whether the protagonist's misconceptions are the result of his uncritical acceptance of his perceptions (appearances) or of the interpretations that he adds to the facts.

2. *Go beyond both initial appearances and premature interpretations by alternately pitting apparent "facts" against "obvious" interpretations.*

This guideline is followed by repeatedly and alternately examining objective facts in search for their meaning and re-examining each subjective interpretation in the light of the objective facts.

As with many abstract terms, "appearance" has two opposite and complementary meanings: what is apparent or self-evident, and what is only apparent but not true or essential. The second meaning, which permeates much philosophy, from Plato to Marx, is reflected in psychoanalytic theory and practice: what the patient experiences and reports is only an appearance that hides deeper meanings and symbolism. These it is the task of the analyst to interpret. Insight therapy thus consists of interpretations which go beyond appearances.

On the other hand, much of the scientific tradition stresses the need to focus on facts rather than on speculative interpretations. Once one has explained his world in some manner, he may assume he has the answer and stop looking for additional meaning, even if his interpretation is only partially correct, incomplete or wrong. Thus, subjective interpretation is one of the ways in which one distorts or loses sight of reality. Since this is a legitimate concern, some therapists see their role as helping patients to see objective reality and avoid interpretation altogether. Following Hobbes's philosophical tradition, they view appearance as revealing rather than disguising reality, considering facts more trustworthy than interpretations. They seek to remain within the reality of appearance (phenomena), rather than rush into the appearance (fiction) of interpretation. This is not only for the sake of objectivity but also because they believe interpreting the patient's report can seem disrespectful and unempathic.

It is our view that both appearances and interpretations are part of reality; they are products of reality, vehicles for consciousness and communication, and originators of interpersonal action. The psychodramatist must not ignore the protagonist's subjective views, yet he must not get caught up in them. Appearance both hides and reveals reality. The walk towards understanding requires two legs: *focusing on facts and separating them carefully from added interpretations, and critically interpreting the facts by attempt-*

ing to fit them into several different frameworks. The psychodrama director thus assists the protagonist to understand reality by carefully attempting to distinguish observed facts from interpretation, a process whose unavoidable failure is instructive.

The role reversal allows the protagonist to become aware of his interpretations and hold them up for re-examination, thereby providing a way to go beyond them. In real life, we perceive ourselves as subjects and perceive others mainly as objects. We often uncritically accept what we believe while we interpret and critically evaluate the ideas of others. Through the role reversal, the protagonist sees himself as an object and experiences others as subject. The incomplete role reversal increases the person's objectivity in viewing himself as he watches and responds to himself, mimicked by auxiliaries, through the eyes of significant others whose role he has adopted. Indirectly, this deepens the protagonist's experience of himself as subject. It can also increase the person's empathy for others when he apprehends them from the inside, subjectively, as he experiences their inner life rather than seeing their outward appearance. Finally, it increases the protagonist's awareness of the meaning *he* ascribes to the behavior of the other. Moreno refers to the protagonist's experiences during psychodrama enactment as "surplus reality" when they are novel and take him beyond anything he has ever experienced in real life. By reversing roles with others, the subject learns:

> Many things about them which life does not provide him. When he can be the persons he hallucinates, not only do they lose their power and magic spell over him but he gains their power for himself. His own self has an opportunity to find and reorganize itself, to put the elements together which may have been kept apart by insidious forces, to integrate them and to attain a sense of power and of relief, a "catharsis of integration." It can well be said that the psychodrama provides the subject with a new and more extensive experience of reality, a "surplus reality." (Moreno, 1978/1953, p. 85)

Because interpretations and evaluations, fair and unfair, impact relationships, the incomplete role reversal is not without its dangers; because the other is not present to validate the protagonist's view, this technique can both reveal and conceal truth. Rather than identify helpful interpretations, it may generate or magnify harmful ones. For these reasons, the psychodramatist must also sort out reality from perception, even if it means going beyond psychodramatic methods, when a possible misperception may harm an existing relation. For example, a female protagonist, while portraying her husband in an incomplete role reversal says, "I'm having an affair with my secretary." This conclusion, if erroneous, sets the stage, in real life, for frequent inquiries into her husband's whereabouts. Her constant mistrust and accusations may push him toward having the very affair she

fears. The protagonist needs to be made aware that her conclusion is an interpretation of facts. Such awareness allows the protagonist to re-examine and go beyond interpretations rather than be bound by them.

Thus far, we have proposed that the incomplete role reversal can enable a protagonist to: (1) discover objective reality—the first step in modifying it for the better; (2) create additional alternative perceptions that explain the "facts" in a useful way; and (3) discover and correct harmful misperceptions. However, this technique is not without danger as it can also magnify or generate harmful misperceptions.

The Incomplete Role Reversal as a Tool for Discovering Objective Reality

Since material reality exists and operates whether it is perceived correctly or not, there are times when it is most helpful to aid the protagonist in gaining insight. If the situation can be corrected or improved, the protagonist, by seeing things as they really are, acquires knowledge and choice to change what he can.

Case 1:

Mr. Anderson had been diagnosed two months previously with inoperable, terminal lung cancer. He also had symptoms of depression and, although he said he had decided to have chemotherapy, he was "just unable to go" each time the day of his appointment arrived. He requested to be a protagonist in a psychodrama to explore his reluctance to go for the treatment which might prolong his life. Early in the drama he soliloquized, "I know I don't really have cancer. God just wouldn't let this happen to me." In the role of his wife, however, he said, "Arnold Anderson, you have cancer and you're dying and you'll die more quickly if you don't have chemotherapy." The denial, cut through by the protagonist himself, allowed him to explore the real question at hand, "Is chemotherapy worth the price it will require?" Mr. Anderson began chemotherapy the following week and today, two years later, he is still alive and working part time. He and his family have been able to talk about his impending death and have been able to make realistic plans for their limited future together.

This case exemplifies clearly the priority of the objective (Mr. Anderson's illness), the supremacy of the subjective (Mr. Anderson's decision regarding treatment). It was necessary for Mr. Anderson to recognize he had a terminal illness before he could make the choice to submit to chemotherapy.

Case 2:

Mr. Redford, during a psychodrama, portrayed his wife as irritable and grandiose. She had recently lost her job as a librarian because she became abusive with her boss when he vetoed her plan to revise the library's entire

catalog. She was now spending a lot of money redecorating the house for the second time in two years. We suspected Mrs. Redford had a manic depressive illness, and suggested this to Mr. Redford who brought his wife for an interview. A bipolar affective disorder was diagnosed, drug treatment instituted and psychodrama was used as psychotherapy. A session took place the day before Mrs. Redford's interview for a new job in another university library and she requested an opportunity to rehearse it in the psychodrama group. She chose someone to take the part of the prospective employer. Mrs. Redford was asked to reverse the roles with the interviewer. In his role, it became evident that she fantasized that the interviewer would be able to tell, just by looking at her, that she was a psychiatric patient. An auxiliary was brought in to play the role of the interviewer. As the applicant, Mrs. Redford could barely be heard when answering his questions, did not make eye contact, and fiddled with her ring.

She was then asked to reverse roles again with the interviewer. The auxiliary, now playing Mrs. Redford, imitated her presentation as closely as possible, allowing her to experience the impact of her own behavior on the interview. Still in role of the interviewer, she decided not to hire such a nervous and inhibited young lady. Warmed up to the role of prospective employer, Mrs. Redford was able to say what qualities would be assets. Several other group members volunteered to try different approaches. Mrs. Redford seemed to enjoy being the interviewer. The nervous, meek qualities presented when she was on the other end of things were no long evident.

After everyone who wanted a chance to try interviewing finished, Mrs. Redford became herself again. With the experience she had gained from playing her role as the interviewer, Mrs. Redford seemed like a different person. The knowledge about how she had come across, and the modeling of other styles and responses helped her modify her self-defeating behavior.

At the next session Mrs. Redford joyfully announced she had the job. To succeed, she had needed to know not only how she acted and what employers expect, but she also needed to realize that her symptoms could be managed with medication. This helped provide her with self-confidence to try again. The events of losing the job and redecorating the house were not the cause of Mr. and Mrs. Redford's problem, but rather a manifestation of an ongoing process which could be modified. It should also be noted that the reality of Mrs. Redford's illness was first suspected because of her husband's portrayal of her symptoms in his own drama.

An Example of Psychodramatic Enactment Obscuring Truth

In this case what was objectively real had harmful consequences that could be modified or corrected once they were known. The psychodramatic

method was not sufficient to illuminate some of these realities. This case is included to alert the therapist to the fact that psychodramatic enactment can be misleading.

Case 3:

Mr. Jones was admitted to our adult psychiatric unit with acute anxiety and depression. His main symptom was overwhelming fatigue which prevented him from doing his best at the pharmacy where he had been employed for 14 years. He was unable to work overtime, had trouble concentrating when filling prescriptions and had developed a fear of killing a customer by giving him the wrong medication. He refused to fill prescriptions without another pharmacist available to check his work and had been put on probation because he seemed unable to manage his time. Things at home were not much better. He was no longer spending time tutoring his hyperactive son or helping with the family chores. His wife was losing patience with him, and there were frequent fights with threats of divorce. While playing the role of his wife he screamed at himself, "You're a lazy bum just like your father. He never amounted to anything and neither will you. If I have to support us, you're leaving." His own response was, "Don't leave me. I don't know what's wrong with me. I'm not myself. I can't help it. DON'T LEAVE ME!" We did several other psychodramas, exploring his relationship with his sister, sons and parents, and also his fear of killing a customer. We helped him practice talking with his boss when explaining his hospitalization.

Mr. Jones's routine admission x-ray and lab work results indicated a small spot near his lung and a mild anemia. Further tests revealed Stage 1 Hodgkins disease. This illness was the source of his overwhelming fatigue that in turn had led to self-doubt, anxiety and depression. Mr. Jones recovered his strength and was able to return to work following surgery and a short course of chemotherapy. His family conflicts diminished as he was again able to spend time with his son, and his job was no longer in danger. The material produced in the role reversal was an accurate perception of his wife's thoughts and feelings. His own helplessness in dealing with his family's disappointment in him was wrenching to watch. Psychodrama allowed him to act out his truth, but was not an essential part of his treatment. It could have, in fact, by highlighting a likeness to his father, done a great deal of harm by masking the illness underlying his behavior.

The Incomplete Role Reversal as a Tool for Creating Positive Perceptions

The following examples illustrate how changing a protagonist's perceptions about reality may be helpful, even though the reality itself cannot be

altered. This process of "reframing" is defined as "changing the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or better, thereby changing its entire meaning" (Watzlawick, Weakland & Fisch, 1974, p. 95). Reframing exemplifies the supremacy of the subjective in bringing about change.

Case 4:

The protagonist, a young man, had recently been diagnosed as having multiple sclerosis, a progressive and debilitating neurological disease with no known cure. He was aware of the diagnosis and prognosis. The psychodramatist's task was to help him express his feelings about having been singled out to bear this disease, and to explore his furious sense of "why me?" The role reversal allowed the protagonist to make sense out of what really made no sense, by having him answer his own whys from the role of his "God." Often this allows a protagonist to comfort himself, to feel understood and not alone in what he must handle. Many psychotherapists consider it necessary to avoid dealing with a patient's religion. Psychodramatists, on the other hand, can handle religious issues with sufficient respect and insight to make the role reversal with God one of the deepest forms of therapy (Nolte, Smallwood & Weistart, 1975). Because this role reversal can *only* be an incomplete one, and there is no way whatever to check the perceptions, it is, in the last instance, the reflection of the protagonist's ideals and perceptions of the world and of his/her parents. Psychoanalysts promote the transference by offering a blank screen to patients' projections. Similar projections are magnified in the infinitude of God, allowing the protagonist to explore his truth, and perhaps substitute or add more helpful perceptions to those that already exist. For a truly religious person, helping him to relate better to God, to make a better picture of his God, constitutes the analysis and working through of the person's most profound transference. For example, the protagonist may say in the role of God, "You did many bad things to your brother when you were growing up and that's why I am punishing you." The psychodramatist will want to challenge this statement strongly, "Come on, 'God,' be straight with your questions; many other people have been just as mean to their brothers and have not gotten multiple sclerosis. Why did you choose *this* person for *this* possible affliction?" Questions of this kind eventually bring out responses such as, "I afflicted him with multiple sclerosis because I knew he was strong enough to bear it." Such a statement backhandedly highlights the protagonist's inner strength which can be further identified and utilized in a positive way, or underscores irrational beliefs, which can be dealt with more easily when known.

Reversing roles with significant friends and family can enable the protagonist to interact more appropriately with those around him. By exploring the thoughts and feelings he has about himself, his disease, and its significance to others, he can begin to be more open about these feelings. He can validate the material he produces in the role reversal with the real people in his life, and thus provide more meaningful communication. The objective is to allow full expression of feelings about what has happened and reframe it in such a way as to create a more meaningful life. Realizing the growth that arises out of the pain may enable the protagonist to make further sense out of his affliction.

Case 5:

The protagonist was mourning the death of her mother. She had not been there when her mother died and wished she had been. The psychodramatist did not know anything about the protagonist's mother or details of her death. Here the important thing was that the protagonist's reality, known and unpleasant, was now a reality only in the protagonist's memory. Mom could be "brought to life again" on the psychodramatic stage and the daughter, although she could not change what had happened, could expand her memory of it. She created an additional "surplus reality" by saying psychodramatically what she wished she had said earlier, and she experienced in fantasy her mother's reaction and response to it. Thus she could finish the unfinished business of her response to her mother's death, letting go of the past and moving on toward building new relationships in the future.

In this case, the psychodramatist's knowledge of the event and opinion about the validity of the protagonist's perceptions in the role reversal were secondary to the protagonist's experience. The purpose of the role reversal was not to determine the daughter's perceptions of her mother and her death for future validation, but to provide the protagonist with dramatic completion of something which could never be completed in life. The perception of reality as it might have been provided additional memories for the protagonist. Also, it brought to the protagonist an awareness that her mother lives on through the memories everyone carries of her—a more comforting reality than the mere awareness that she died before the protagonist could say good-bye.

In the two cases above it is not necessary to sort reality from perception, because the reality cannot be changed. However, positive perceptions can be generated via the incomplete role reversal: ones that become a part of subjective reality and are instrumental in creating a healthier, happier self. Enactment of how one wishes something could have been provides a subjective experience, albeit in fantasy. This begets an objective reality in which the protagonist can actually act and interact differently than he could

before the dramatization. Thus, the supremacy of the subjective can facilitate change even though past objective reality is unalterable.

The Incomplete Role Reversal as Generator of Harmful Misperceptions

Since expectations often operate as self-fulfilling prophecies, surplus reality, including material generated in the incomplete role reversal, is a two-edged sword. On one hand it can help free the protagonist from negative past expectations and perhaps provide more useful ones to stage the future. On the other, it has the potential to generate or reinforce negative misperceptions. Although not unique to psychodrama, the latter is one of the most serious pitfalls of the incomplete role reversal. The psychodramatist who is aware of this potential problem can take measures to avoid it, or help the protagonist check out negative information before acting as if it were as true as it felt in the psychodrama. The following example illustrates this concern.

Case 6:

The Alm family had been in therapy for a year and a half when Karen, the oldest daughter, developed severe symptoms of depression for which she was hospitalized. During the intensive inpatient therapy, memories of an early traumatic relationship surfaced. Karen, in her psychodrama, was enraged that her uncle had molested her several times when she was young. During the heat of her anger she screamed, "Mother warned us about you, you bastard!" and then audibly gasped, as awareness of what that meant dawned on her. She confronted mother next. "Why did you let it go on so long? Why didn't you tell me sooner?" In mother's role she answered, "I didn't want to see my sister (Bill's wife) hurt. I thought you could take it . . . that you would understand. I told you not to let him touch you." In her own role again she screamed, "You hurt me. . . . You let him take advantage of your own daughters. You sacrificed me for your sister on a bloody altar . . . and now your hands carry *my* blood . . . and it won't come off. . . . You thought I wouldn't remember. . . . Well, I do. . . . You thought I'd understand. . . . Well, I don't. . . . I hate what you let happen to me. . . . May God forgive you. I can't forgive you. I hurt too much" (Alm, 1982, pp. 6–11). Her anger, fueled by the psychodramatic enactment, only made her relationship with her mother worse. Something had to be done.

Guideline Two suggests that Karen's subjective interpretation needed to be re-examined in the light of objective facts. New facts could be discovered to corroborate or refute Karen's interpretation. Giving priority to objective reality, we chose to encourage Karen to talk with her mother about the incident as part of the ongoing family therapy.

The additional hypothesis as to why mother waited so long to give her warning could be introduced within the drama, allowing Karen to re-examine her initial and perhaps premature interpretation and come up with an explanation less likely to hurt her relationship with her mother. This solution exemplifies Guideline Two. At one point Karen became confused by her inability to forgive her mother and said, "How can I say that to her? I love her, I respect her." A double might respond, "Maybe she didn't know Uncle Bill was dangerous until she warned us; that would explain things also." Doing this within the drama provided an alternative interpretation, highlighting the necessity for future exploration. It did not eliminate the necessity for Karen to talk with her mother about the incident, but it may have made it easier.

During a talk with mother in the family therapy session, Karen portrayed her turmoil as she realized that her mother had no idea whatsoever that she had been molested; and that her mother had indeed given the warning as soon as she was told by her own mother that Uncle Bill might be dangerous. The fact that Karen was unable to discuss Uncle Bill with her parents, even after being warned by her mother, was not an isolated event; she failed to discuss many other important things with them also. Finding out that it is possible to talk with mother about difficult and painful matter opened the communication process, allowing Karen to reveal some other secrets about herself.

In Conclusion

The incomplete role reversal is a powerful and useful tool that can be utilized more fully as its problems and possibilities are understood. Two guidelines are offered to help the psychodramatist utilize this tool to its capacity: Give priority to objective reality, supremacy to subjective reality, and Go beyond both initial appearances and premature interpretations by alternately pitting apparent "facts" with "obvious" interpretations.

Information generated by the protagonist in the role reversal is subjective in nature and prone to distortion, due both to incomplete knowledge of what really happened and to misperceptions of how others viewed the same event. When material generated during the incomplete role reversal is likely to increase rifts in significant relationships, it is important to provide a safe means of confirming or discrediting such perceptions. Just as the incomplete role reversal can generate harmful misconceptions, it can also facilitate discovery of objective reality enabling the protagonist to see things as they really are.

The psychodramatist utilizes psychodramatic enactment to discover truth, but there are truths it cannot illuminate. If necessary, the therapist

must go beyond the psychodramatic method to a diagnostic interview, a family assessment or a medical referral. The enlightened psychodramatist is careful not to obscure a real process with harmful consequences which could be corrected if brought to light. The skilled psychodramatist, also aware of the supremacy of the subjective, utilizes the incomplete role reversal to reframe reality in a helpful way or to revive some positive memories, even when past objective reality cannot be changed.

The incomplete role reversal is a two-edged sword. It can obscure or illuminate truth, create both helpful and harmful perceptions and interpretations, and, in either case, change behavior. Its catalytic action in altering objective reality by altering the perception of it is both its weakness and its strength. It behooves the psychodramatist to wield this sword prudently.

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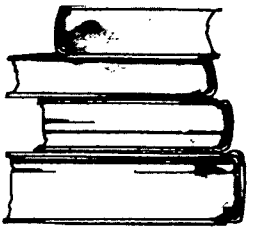
Address: Linnea Carlson-Sabelli
Hector C. Sabelli
Rush-Presbyterian-St. Luke's Medical Center
1753 West Congress Parkway
Chicago, Illinois 60612

Linnea Carlson-Sabelli is Assistant Professor, Psychiatric Nursing and Psychodrama Practitioner with inpatient units at Rush-Presbyterian-St. Luke's Medical Center, while Hector Sabelli is Attending Psychiatrist at the Center and Director of the Psychobiology Laboratory.



Book Review

D. W. Johnson and F. P. Johnson *Joining Together: Group Therapy and Group Skills*, 2nd edition. Englewood Cliffs, New Jersey: Prentice-Hall, 1982, $18.95.

In *Joining Together*, the brothers Johnson present a cornucopia of concepts, guidelines, and activities concerning small group functioning. Chapters are devoted to the basic group processes of leadership, decision making, goals, communication, controversy and creativity, conflict, power, cohesion and norms, and problem solving. For each, the authors present pertinent social psychological concepts, ideas for strengthening that aspect of group functioning, and relevant group activities. The concepts, guidelines and activities are skillfully combined to complement each other. Thus, the structured activities are carefully designed to elucidate not overwhelm the conceptual material. There is a good mix of substance and involvement that can be both intellectually grounded and interpersonally engaging.

The content is drawn from the mainstream of social psychological group theory, research, and application from the last fifty years. The contributions of Kurt Lewis on leadership and decision making, Sherif on intergroup conflict, Bales on distributed leadership, Deutsch on competition and collaboration, Gibb on defensive communication, and many others are clearly presented. Similarly, the list of structured activities includes many of the best known, most widely used exercises and their variations: the hollow-square activity for examining leader-follower relations, the consensus decision-making tasks that involve ranking survival items (descendants of the "Lost on the Moon" exercise), the broken square puzzle for exploring competition and collaboration, the one way-two way communication exercise to study communication patterns, and many others. Simply put, this book is the answer to the two questions: How have social psychologists thought about groups? How can those ideas be experienced and put to constructive use?

However, *Joining Together* has limitations as well as its numerous strengths. Chief among these is the authors' tendency in writing to stay at a conceptual level without offering either illustrative examples or integrative

theory. More examples would help bring the concepts to life for the reader who might not have an immediate opportunity to participate in an appropriate group exercise. More effort to articulate the similarities, differences, and relations among the many concepts presented would help them be more clearly understood and remembered. Currently, too much is introduced but not developed; especially those ideas and guidelines presented in list form, like the suggestions for the constructive management of conflicts of interest. Consequently, concepts sometimes seem blurred or redundant and guidelines lack richness that would help in trying to apply them. Interestingly, the presentation of group goals which draws heavily on the authors' work includes both the focal constructs (competition and cooperation) and examples from research, as does the discussion of decision making. In sections like these, the constructs provide conceptual integration and the examples offer a context to use in understanding the concepts.

Another limitation that says more about the field of the social psychology of small groups than about the Johnson and Johnson book is the strong emphasis on concepts and research from before 1974 (a year before the publication of the first edition). It is unfortunate that some more current contributions have not been included, such as Bednar on group development, Smith on group outcomes, and Davis on group decision making. However, the heyday of small group research was in the 1950s and 1960s. Also, the Johnsons have greatly expanded the reference list from the first edition and have included many of the major figures and their work from 1930s to the early 1970s.

Compared to other books concerning groups, *Joining Together* is relatively unique in effectively linking concepts, guidelines, and activities. It is not a compilation of group activities like the *Annual Handbook for Group Facilitators* published by University Associates (cf. Jones and Pfeiffer, 1980). Nor is their overview limited to small group concepts and research as presented in traditional social psychology texts (e.g., Shaw, 1976). In fact, the only other book with which I am familiar that intelligently melds those disparate domains of concepts, activities, and guidelines is *The Second Handbook of Organization Development in Schools* by Schmuck, Runkel, Arends, and Arends (1977). Yalom's (1975) classic text on group psychotherapy has a more clinical focus, includes a more illustrative narrative, and lacks group activities. I think of Johnson and Johnson as a complementary book to Yalom. Yalom's text introduces the clinical psychological dimensions of groups and the Johnson and Johnson text introduces the social psychological ones.

Joining Together is sufficiently broad in scope to be useful to several audiences. It provides an introduction to key ideas and activities that is useful for advanced undergraduates who want to learn about groups. Several

students in my group consultation course commented in particular on the structuring of the chapters. They liked the inclusion of key concepts and many quiz items to focus their attention and check their understanding. Clinicians will find a useful perspective that is more group-oriented and less pathologically-focused than most clinical books on groups and families. Becoming more aware of "normal" group dynamics can help define a baseline to which patient groups can be compared. Those involved in staff training, administrative meetings, or family interactions may find this book stimulating interest in improving the working of those groups. The many specific suggestions that Johnson and Johnson offer for enhancing group effectiveness seem particularly apropos for work group meetings. In the hands of a skillful group facilitator, the structured activities could engender valuable experiences and insights for groups of students, patients, staff, or family members.

In sum, I think the Johnsons have made a valuable contribution by uniting so much of what is best in group concepts and group activities in one volume. Although some improvements are suggested, the book is an important resource for those who would understand intellectually and experientially the contributions of social psychology to the field of small groups.

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Christopher B. Keys

The reviewer is a clinical-community psychologist at the University of Illinois at Chicago. He can be contacted at: Psychology Department, University of Illinois at Chicago, P.O. Box 4348, Chicago, Illinois 60680.

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Information for Authors

The *Journal of Group Psychotherapy, Psychodrama and Sociometry* publishes manuscripts that deal with the application of group psychotherapy, psychodrama, sociometry, role playing, life skills training, and other action methods to the fields of psychotherapy, counseling, and education. Preference will be given to articles dealing with experimental research and empirical studies. The journal will continue to publish reviews of the literature, case reports, and action techniques. Theoretical articles will be published if they have practical application. Theme issues will be published from time to time.

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