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HELDREF PUBLICATIONS

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Psychodrama and Family Therapy—What's in a Name?

ANTONY WILLIAMS

ABSTRACT. Of perennial interest in systemic therapy is the way meanings are created and maintained by social interaction. Psychodramatic role theory has a similar focus. Likewise, family therapy's more recent focus on narrative or story finds strong resonance in psychodrama, where narrative and story form the texture and the text of action methods. Role theory and narrative therapy are used as bases from which to explore ways in which family therapy ideas can influence action-methods practice and, conversely, the part action methods can play in family therapy. "What's in a name?" becomes a theme, as the author investigates ways of doing therapy that are neither psychodrama as such nor family therapy as such. A Batesonian "news of difference" framework is adopted as the principal theory for how people can change.

LIKE MOST PEOPLE in their first 5 years with the method, I was entranced with psychodrama as a brilliant illustrator of the human condition and as a source of profound aesthetic experience. I loved its epic qualities, its richness, its ability to show people value and intentionality in their lives. It made sense of confusing experiences and provided epiphany and poetry in my life. Within a drama, people could become, at least momentarily, the individuals they dreamed of being, transcending their mortality by contacting it more deeply.

At that time, however, I was already seeing families in my practice and was attracted by the intellectual vigor and social responsiveness of the family-therapy tradition. It seemed impossible to reconcile family-therapy theory with psychodrama. That seemed a pity. Originally Moreno himself had not favored an analysis backward toward past trauma but thought that help would come through spontaneity training based on the analysis of the present. Ironically enough, his systemic emphasis on present interactions maintaining the problem has been all but lost, and psychodrama has indeed become oriented toward past trauma (Hare, 1986). This vertical approach became, in its own lifetime, "classical" (Fox, 1987) and dominated the way

in which psychodramatists were trained. No matter what type of presenting problem protagonists brought to the group, the second scene would have them depicting a younger time in their lives, and the third would be set back even further in time, an encounter in early childhood. Needless to say, this format was hard to apply in a family group in which adults and children were together.

Some other difficulties impeded reconciliation. First, psychodrama was a group method, almost universally practiced with a number of relative strangers rather than with the intimate group of a family. It seemed to work best when key people in the protagonist's social atom were absent—an incompatible demand if one is working with families. Second, parents in psychodramas were routinely depicted as villains, enemies of the by-now-adult protagonist's spontaneity–creativity. Third, the possibilities of role theory did not seem to be exploited, and when they were, the distinction between psychodrama and systemic therapy tended to diminish sharply, with psychodrama ceasing to be "individual therapy." Fourth, "causality" within the fantasy of the individual protagonist was often accepted as linear and obvious rather than circular and subtle.

Despite the above reservations, I found no insuperable reason why a family therapy based in action methods and a psychodrama based on systems theory could not be put together (Williams, 1989, 1991, 1994, 1995), especially through the common base of role theory and sociometry. An even deeper link existed, that of spontaneity itself as the solution to many problems of human living. The solution in psychodrama is usually a more spontaneous way of being with other persons, just as it is in family therapy.

In this article, my concern is how one might bring psychodramatic methods into one's work with families and how certain ideas that have their base in family therapy can inform psychodramatic practice with individuals and groups. I make no attempt to "report on the field" in Europe, the United States, or the Pacific Rim, nor do I endeavor to present a "grand synthesis." What follows is idiosyncratic and biased, my personal view—an "underview" of the field, not an overview.

Theoretical Assumptions

What's in a Name?

If the idea of family therapy seems strange to some people, so does that of individual therapy to others. Yet one might construe individual therapy as just one way to intervene in a set of relationships, a way of working with one person in a social atom when for some reason the others cannot turn up. In the following case studies, all clients' names have been changed. Therapists'

names begin with T, mothers' with M, daughters' with D, and sons' with S. Husbands are usually H, and fathers are F.

MARIE'S POISON

Marie has three children, twins aged 18 and a son of 14, all of whom are living at home. Marie herself came from a family of four. Her first memory of her mother was of her making Marie give her favorite toy dog to her brother, because her brother "needed it more." Although not close to her mother, she was, however, very close to her father who died when she was 17. She says that her father was the only person she had ever felt loved her. Shortly after her father's death, she married Frank, because she was "desperate to get out of the house." At the time of her seeing the therapist, this marriage had been over for 5 years. She felt "crazy" during the last years of her marriage, thinking that her husband was having an affair. That was found to be correct, and he left the marriage at age 45 for a woman 27 years his junior.

When she was 9, Marie was digitally abused for one year by a family "friend." When she was 13, her brother took up that practice and blackmailed her with threats if she told.

Her history of self-harming had begun when she was very little, when she would bang her head hard against a wall. At the time of therapy, she had burned her body with an iron, causing huge blisters on her arm. Marie, who has been diagnosed as having a severe borderline personality disorder, sees both a psychiatrist twice a month for medication and support and the family therapist, Tania (reported here).

At the sixth session, Marie gave Tania 100 tablets that she had been saving for her suicide. The seventh session was characterized by long silences. Eventually, Marie told Tania that she had been having erotic thoughts about a woman and that she was worried. Tania "normalized" those thoughts, and Marie seemed very relieved. At the ninth session, she informed Tania that she had decided to kill herself and the three children and that she had already bought the poison. Tania asked why she had not already poisoned herself and them. Marie said that she would not be poisoning the children that night because she was sitting for an exam the next day, and passing it was her only way of proving her worth. However, she could not guarantee the safety of herself or her children in the future.

In empty chair work, Marie acknowledged those parts of herself that sought her destruction and those parts that wanted to get on with life. Although she liked and claimed to profit from the action work, she would sometimes become extremely distressed. Marie had stress-induced epileptic fits when talking or action became more than she could bear. Of course, at that stage Tania backed off. At Tania's request, Marie invited her children to come to sessions. They refused, and she felt devalued and furious. At the time of threats to the children's safety, the therapist persuaded Marie's former partner to come into the house to look after the children and suggested that Marie live elsewhere for some time "until you're in a good space to sort this stuff out." To all this, Marie agreed.

Family therapy can appear as an intellectual monolith, especially as it formidably presented itself to the world in the 1980s when screens, teams, and system-talk were at their height. Family therapy challenged established linear and intrapsychic views with its own systemic orientation. Its epistemology resided in the heady conceptual realms of linguistics, biology, and mathematics, from which it spawned a dazzling array of innovations in ways of working with families.

Family therapy nowadays is certainly no monolith and, in fact, has many brands: structural, strategic, systemic, narrative, feminist, postmodern, solution focused, and so on. The metaphor of the family as a system is gradually being subsumed by a metaphor that construes families as interpretative communities or storying cultures (Paré, 1995). As Crawley (1993) pointed out, however, the surname is *therapy,* and the first name is *family.* First names connect people to those to whom they are close—relatives, friends, colleagues—but surnames are much more basic to identity in society; they signify a kinship group, those to whom one belongs. If one is labeled a *marital therapist* or a *family therapist* or a *narrative therapist* or even a *psychodramatic therapist,* one might have a quibble or two but if one is denied the identity of therapist, then one has reason to be aggrieved. What's in a name, then? Therapy is essentially about persons, and family therapy focuses more overtly on the collective of persons than does individual therapy.

MANDY'S MOTHER

Mandy is a 35-year-old unemployed mother of two teenagers, who acrimoniously separated from her husband 3 years previously. She attends a group for mothers and their daughters with whom they are having difficulty. Using an auxiliary from the group, she portrays a typical interaction with Debbie, her 16-year-old daughter. Tom, the director of the group, then asks her to illustrate a conversation with her own mother when she herself was 16 or so. This she does; her mother is a fiery, irascible woman, capable of rapid and unpredictable changes of mood. No obvious catharsis as such is evident. The director helps Mandy compare herself with her daughter, her daughter with her, herself with her mother, and her mother with her.

That Mandy dates the improvement in her relationship with Debbie to her brief psychodramatic interlude is not the point here. Mandy and Marie's relevance to the present discussion concerns how their therapists operated. Marie's therapist, Tania, is a family therapist who prefers to see whole families when she can. She would describe herself as "a family therapist who has trained in psychodrama and who occasionally uses action methods as adjunctive techniques." Yet Tania cannot see the whole family in therapy, and her direct family work is limited to direct interventions with Marie's former partner. Mandy's therapist, Tom, would describe himself as "a psychodramatic practi-

tioner who has had some exposure to family therapy." Tom almost invariably works in a group setting. The group setting here, however, is for mothers and the daughters with whom they are having difficulty. Is Tania's individual work with Marie or Tom's group work with Mandy Batesonian-based psychodrama, standard action methods, family-focused individual therapy, individual therapy with family support, or even "straight" family therapy?

Vignettes in this article highlight some of the connections between psychodrama and family therapy, and some ways wherein each can inform the other at the practice level are suggested. *Psychodrama* is used interchangeably with *action methods. Action methods,* an umbrella term, refer to processes that dramatize narrative by means of dialogue, objects, and the use of space. They concretely depict events, problems, other people, parts of the self, forces, or thoughts. All psychodramas use action methods, but not all action methods are psychodramas.

Role Theory and Systemic Approaches

One's own sense of oneself as an "I" makes it easy to believe in an inner, irreducible core of human experience. Role theory, however, suggests that one gives up such a structural view in favor of the notion that roles, and thus the self, are continuously being created in interactions. The self-ness of a person is understood recursively as an impermanent construction that changes with context and relationship. A recursive analysis, like a role analysis, is one in which a particular issue is understood in the context of the relationships that have made that issue possible. Recursive thinking is difficult because of the complexity of relationship patterns within systems; it is rich, however, on account of those very factors.

Contemporary systemic therapy attends to the way meanings are created and maintained by social interaction. Meaning is construed as lying between people rather than "in" people. This seems very close to role theory. The notion of roles being created in interaction challenges the assumption that the skin is the most meaningful boundary. Role theory suggests that individuals actively create their experience, even experience that they do not like.

How one makes sense of an experience, including even "who I am," is a collaborative effort between oneself and others. Identity is interactive, a story one tells oneself and gets told. "I" cannot be "me" without "you." Is not this the essence of role analysis? After all, the idea that people change markedly in different contexts is not such a radical one. For example, Hank acts like a pleading, helpless child when he is at home with his partner, but he behaves as a kind, firm, and wise figure when he is working as a psychiatric nurse. Similarly, Wendy makes all the decisions in the house that she shares with Hank, but she is underconfident at work and gets passed over for promotion.

In each of these examples, Hank and Wendy are almost constituted by interaction and context—by what they tell themselves about themselves, by whom they interact with, and by what others say to and about them. Popular expressions, such as "She was a different person when she came back from holiday" or "He's a different man with his children," also express the idea that reality is constructed primarily through context and interaction. Again, role theory, family therapy, and social constructionism seem to be near neighbors, sharing a theory cocktail of personal, social, and cultural ingredients. All assume that even our emotions, although intensely experienced as personal, are part of an interactional process. They are understood by the meanings that other people create, from the culture, and even the physical landscape: the Swedish different from the Spanish, mountain dwellers different from seafarers. One's identity, one's very self-ness, is a multiauthored narrative. Experience is a "text," conjointly authored in community.

Narrative and Story

The word *narrative* opens doors to other useful rooms. Stories or narratives help people order their thoughts and keep them sane by filtering out most experience as irrelevant. People attend only to those parts that they think are useful or that make sense. Stories not only filter but also provide frames for lived experience that would otherwise be unintelligible.

Story involves the idea of time. By means of story, people not only interpret the present but reconstruct the past and predict the future. This notion should suit psychodramatists well, because as Farmer (1995, p. 95) remarked, psychodrama is an instrument for playing with time. A story is not so much a tale as an interpretative device telling people what is happening now, what they used to be like, and how they will become. Again, psychodrama can comfortably share with this theory. Chasin, Roth, and Bograd (1989) wrote in a lead article in *Family Process* of psychodrama's powers within systemic therapy to dramatize ideal futures and reformed pasts. Boundaries of time and place are defined and redefined, allowing events to be arranged and rearranged according to the meanings given to them by the protagonist, director, and group members. Two hours of psychodramatic action can cover a period of 30 years. Meanings can be given historical context. Within the safe holding of a psychodrama, protagonists can see their forgotten pasts, vividly feel the agonizing dilemmas pertaining to those times, recognize in the company of the group and the director how those pasts fit with their present concerns, and express what they had hitherto been unable to utter.

Stories that keep repeating are known as *dominant narratives,* a term commonly used pejoratively, that means persistent narratives that constrain people's actions and options. For example, when Hank says to himself "I am a

worthless person" or when Wendy says to herself "Men are babies," each is offering a description that cuts off certain other descriptions. These negative descriptions may cause them to blanket parts of their lived experience as irrelevant and to select only certain events as belonging to "the truth about me." Narrative structures, therefore, are not about data; rather, they establish what is to count as data (Schafer, 1980). Any events that may contradict Hank's assumed worthlessness or Wendy's ideas about men's infantilism are not even seen. It is as if they did not exist. A compliment is brushed off as "not about me"; a competent action is interpreted as "a flash in the pan." Only those aspects of experience that relate to failure or dependency are selected for attention.

Language and significant images structure life. This is handy because psychodrama works with language and significant images. One might say that the very basis of psychodrama is story or narrative, powerfully told. Psychodramatic enactments provide people with an opportunity to become more active in the authorship of their own lives and provides them with a sense of place in the world and with a feeling of connection to it and to other people. The art of any thêrapy—psychodramatic, family therapy, or whatever—is that of assisting people to change dysfunctional dominant narratives and the unhelpful interactions that spring from them. The narrative basis of psychodrama in itself helps people articulate their story. The following sections contain some suggestions about how they might change that story.

The Perception of Difference. How can one be different if one only knows how to be the same? One would think that something so evanescent and so dependent on context as a "story" would be simple to change. Few therapists, however, would say that changing clients' stories is simple. The psychodramatic family therapy that I practice is based on a simple theory: People can change when they perceive a difference that is relevant to them. In family therapy, this is called "news of difference" or "a difference that makes a difference" or even "information." The theory is based on the work of Bateson (1979), who suggested that people change as a response to information, which always comes in the guise of difference.

> Marie, do you think your mother was more dependent on you, or were you more dependent on your mother?
>
> If you had not been harming yourself, who would you have been harming?

Differences that matter most to people are those between persons (their ideas, thoughts, feelings, attitudes, habits, power, gender, how much each is loved by a third, and so on) or differences within the same person at one time

versus another time or in one environment versus another. Where such differences make a difference, they are called *information.*

> Could you tell me any other steps you have taken so far that do not add up to this view of you as being stupid and crazy?
>
> Marie, what sort of expectations were born in your life when you were born?
>
> Did all those expectations suit you equally well as a person or did some suit you less well?

In the above questions, the therapist encourages Marie to appreciate the history of her struggle against her dominant narrative, that she was "crazy and stupid." The therapist begins to challenge specifications for personhood and the ways that Marie should relate to others. Marie's dominant story, although apparently a seamless garment is, when viewed up close, actually made of patches. The inconsistencies and contradictions, once noticed, allow the entry of a new story that brings out different aspects of Marie's lived experience. The old story, which had seemed to be true, slowly loses its explanatory power and credibility. It is the once-familiar (e.g., "I am an incompetent adult") that now no longer makes sense. Its basis is eroded as new situations, which cannot be accounted for if the old story is to hold up, are brought to mind by the therapist. In constructing a new story with the client, one does not have to resort to jollying along. The new story was potentially ready to be told, but it had not been noteworthy and, therefore, had not been told. Therapists help clients to notice the unnoticed and to tell the untold according to preferred developments.

When there has been a small step in a new direction, a therapist can question both the recent history and the more remote history of the alternative narrative. In Marie's story, she was delaying the suicide–murder until after her high school examinations, which she was taking as an adult. To Marie, the fact of her taking these examinations is not a story of courage and triumph. Indeed, it is not storied, not newsworthy. Far less newsworthy is her delay of the suicide–murder part of her dominant narrative, which says only that she is crazy and stupid. The therapist asks about changes in her belief system about herself and then asks her to give the history of those changes:

> How did you get yourself ready to take this step into further education for yourself?
>
> Just prior to taking this step, did you nearly turn back? If so, how did you stop yourself from doing so?
>
> Looking back from this vantage point, what did you notice yourself thinking or doing that might have contributed to becoming an educated woman?
>
> Could you give me some background on this? What were the circumstances?

> Who was there? What were you thinking? What did you tell yourself that sustained you?

Then the therapist directs her to "show us this in a scene."

These questions and the enactments that follow are designed to increase multiple descriptions of Marie's beliefs and values. She temporarily becomes the observer of her own life, noting especially the unstoried elements. Marie had never thought like this about herself. She has no story with herself being confident enough in her abilities to undertake further study. She begins to favor aspects of her experience that contradict the handed-down versions of herself.

Problem Development

Working with Marie in this way, Tania creates a denser history for Marie's alternative narrative. Very slowly, Marie begins to craft a believable story of herself as a competent adult, a person with educational ambitions, a person whose developmental goals would be interrupted, to say the least, if she killed herself and her children. Although they may take considerable pains to create a history of the alternative narrative, therapists working in this mode spend less time on the search for causes of clients' problems. To do so, in their view, would be to expand the dominant narrative, the very narrative they are attempting to deconstruct. Therapists like Tania are well read in psychological, including psychoanalytic, literature, which they respect. They are indeed interested in "the past" but focus on particular elements of the past that may serve to deconstruct debilitating stories and to begin charting the history of rehabilitating stories. They do not have set theories about why things go wrong for people. As far as they know, some small event or interpretation may have given rise to the problem-saturated narrative that has gathered its own momentum and become "true" by repeated tellings. Perhaps one of the more standard psychological interpretations may be correct, but which one—the Freudian one? the Kleinian one? the Jungian one?

The original conditions of anyone's narrative likely have been lost. Whether the source is known or unknown, however, the dominant narrative continues and grows larger and stronger with time. It is often reinforced by the client's deciding that what he or she "decided to do about the original difficulty was the only right and logical thing to do" (de Shazer, 1985, p. 25). In other words, therapists working in this mode seldom attempt to "get to the bottom of things" in terms of the development of the problem. They focus instead on the development of the solution. They do not believe that they are "scientists," who can see beneath the appearance of things and the surface of the mind.

The Renegotiation of Identity: The Witness

The therapist and Marie have co-created an alternative narrative in the present and together have seen something of its history. When clients begin to create their alternative narratives, they are encouraged to identify and recruit an audience to these preferred developments in their lives. When a therapist starts to chart the course of the alternative narrative, it pays to ask who in the protagonist's early social atom first noticed any signs of difference from the dominant narrative. For example, the reader may recall that Marie's story included her being "loveless" since the death of her father. It comes to light, however, that certain actions she has taken, including raising her family to the best of her ability, contradict that forlorn account. Again, the apparently seamless garment (the dominant narrative), when viewed closely, is shown to be made up of threads and patches. Lovelessness is interwoven with threads of loving self, loving others, and being loved. Those threads are at first too fine for Marie to see. The therapist asks Marie to focus on them, to use a magnifying glass, if necessary.

> Do you remember when this feeling that you were not totally alone in the world after your father's death first occurred?
>
> What was the inner feeling of liking yourself?
>
> Did you approve of approving of yourself or did you think approving of yourself was a betrayal of what you had been taught to think about yourself?
>
> Did you look any different in that time when you first realized that you were not totally loveless? Did it show on your face, or in how you stood, or by the way you walked?
>
> Did you do anything different in those early days when you first caught a glimpse that you may be able to like yourself?

Any of these questions can be put to action in a miniscene. The action can be as simple as asking the person to walk as he or she did then, to hold her head as she held it, to show on his face what he was feeling then.

Then "The Witness" can be introduced. This is a person who actually observed the client feeling differently about himself or herself. It also could be someone who knew that the client had this ability and was convinced that he or she would one day triumph. For Marie, of course, that person would be her father. The witness figures may be significant because they too had challenged accepted ways of living, and like the client, had also entered some uncharted territory of being their own person. A witness can even be someone who did not actually observe the alternative narrative in the client but lived out that alternative narrative—an aunt who did exactly as she pleased, even though everyone thought that she was eccentric.

Was there anyone else in your extended family who had not succumbed to worthlessness and despair and who lived in a spirited fashion?

Would that person have seen something on the outside, or was your feeling about yourself as not giving in to worthlessness something private, tucked away deep inside?

If it were tucked away, what would the witness have said had he or she known it was there? What would you have said back to the witness?

Now show such a scene between you and the witness.

Ideally, action work with the witness is suited to groups and can make a useful postpsychodrama intervention. Protagonists can review their life through the witness's eyes and draw conclusions about their intentions for their life, intentions that this witness could have appreciated. The enactment could be an interview-in-role of the other person and his or her views on the protagonist. What did the witness think the protagonist's intentions for life were? Did he or she think the protagonist was having a close shave with worthlessness? Protagonists can be taken to the mirror position, and the action sequence can broaden out into their philosophy of life.

In reviewing these events that took place back then, what do they tell you about what you really believed was important in your life, even though you were tempted to succumb to X (the externalized difficulty)?

Are you becoming aware of any other developments in your life that reflect this belief about what is important to you?

At this point, an action sequence can take place in the future.

Just think about your next steps. Imagine now that what we understand to be important to you is going to feature more strongly in your life. How will this affect your actions? How will it affect your view of yourself if you were to step more fully into this picture of who you are?

Set it up and step into that future now. Who is there?

Through these techniques, clients begin to see their lives as being lived according to the new story, rather than the old one.

Therapeutic Process: Using Action to Create Alternative Narratives

Action methods give people the sense that they are in touch with the profound sources of their being and that they are authentically directing their own lives. They increase people's identification with personal meaning, subjectivity, and authenticity. An extended psychodrama or a modest vignette is equally capable of kicking off the client's alternative narrative and keeping it going until it finds its own momentum.

The function of therapy is not merely emotional relief but the learning of new roles. Action methods can help such learning, illustrating relationships in a way that carries powerful emotional and sensory impact. At the height of action, protagonists are in a state of shock; their accustomed responses to a situation are diminished; new, more primary responses take their place. Action is useful systemically because it dramatizes role and role perceptions. Members observe what each does, how it is perceived, and how the roles are reinforced. The interaction of roles becomes clearer. It becomes evident that someone cannot be helpless unless someone else is prepared to be helpful. Personal meaning becomes more obviously interpersonal.

Verbal interventions based on difference and news of difference can have powerful effects on a family. When the interventions are performed, however, entirely new meanings come to light. Action methods are ahead of the field in their ability to represent difference. By physically moving over a map of meaning (in reality, a carpet in the therapist's office), the swing of the senses induces a swing in the mind. The therapy room itself becomes a matrix of belief. Members take a position in interpersonal space that represents their position in inner space. They compare their opinions and values with the opinions, values, and choices of their intimates. Bodies and consciousness swing together.

Diedre is a 13-year-old girl who is referred to therapy by her mother, Marion, because she is "unhappy." Diedre, apparently, does not want to do anything with friends, spends a lot of time on her own, and is sad about leaving her home state. She is also getting very thin, although she could not yet be classed anorexic. Marion is in a long-term lesbian relationship with Penny, who absolutely refuses to come to therapy. Marion and Diedre are seen together for six sessions. When Marion and Diedre's father broke up 6 years previously, Diedre went to live with her father, a policeman. That was thought to be the more proper course of action because Marion was pronounced "unfit" after she announced her intention of having a sexual partnership with Penny. After Diedre and her father were in a serious car accident, in which the father was killed, Diedre arrived back with mother. She and her mother have a good relationship. Marion is the breadwinner of the family, and Penny stays home.

We will focus on the fourth of the six sessions, the only one involving action methods. Diedre displays little interest in the accident with her father but says that she is mostly unhappy at home and that she does not think that Penny likes her. The therapist notices that although Diedre gives the appearance of sadness, she has become animated when speaking. Diedre describes an incident in the kitchen between herself and Penny. The therapist gets her to set the scene, which Diedre readily does. The focus is on a cask of wine on top of the refrigerator, to which Penny makes frequent excursions. Diedre says something to Penny, and Penny responds in a manner that indicates that she does not like Diedre. During this event, Marion arrives home. The triangle is established.

Diedre is placed in the mirror position, and the therapist and Marion act as Penny and Diedre. Then the therapist acts as Penny, and Marion acts as herself. After

each of these enactments, Diedre is asked what she notices, and whether she has any ideas for how things could be better. The mother models how Diedre might deal with the situation, and so does the therapist. Diedre steps back into the scene and acts the solution she most prefers.

Diedre and Marion were seen only once more after that session because Diedre's improvement had been so rapid. She wrote two letters to the therapist after the final visit, saying how well things were going. The therapist replied to each of the letters, responding to the responses she had made.

Most of the above is standard psychodramatic fare, according to Kipper (1986) for descriptions of role play and Moreno (1965) for mirror and other techniques. The therapist's dealings with Diedre and her mother are not presented here as psychodramatic rocket science. The vignette is included to suggest the modest nature of the action that is appropriate in family contexts and the far-reaching effects that such action can have. Readers may wonder why the therapist did not bring out more of the grieving for the deceased father or the traumatic effect that the accident must have had on Diedre, or whether Diedre's isolation at school was shyness on account of her mother's relationship with another woman. Indeed, the therapist would have followed up on those or any other issues, had there been leverage. Those concerns were simply not evident in the warm-up. Diedre accepted her mother's lesbian relationship as such, but she did claim she was not getting along with Penny. She seemed uninterested in pursuing the events of the accident a year earlier, and, although she had loved her dad, she was not keen on talking about him or "to" him through an empty chair. Her major concern was that she thought Penny did not like her. These reflections led to the notion of solution-focused therapy.

Solution Focus

According to narrative theory, there is no fixed meaning in the past, even in a past of failure; there is no fixed meaning for the future, either. Most narrative therapists tend to adopt a solution focus with their clients. They prefer not to focus on the history of failure but to direct their work toward charting the history of success. Very powerful dramas can be created, based solely on the solution to the drama itself. At the contracting stage of a drama, a solution-focused director might start like this:

What attempts have you made to solve your problem? How did they go? Have you ever tried therapy before? With whom? How did it work out? What helped? What wasn't so helpful?

The director may then ask a form of the miracle question (de Shazer, 1988).

I'd like you to travel three months into the future. Go there now in your mind. The problems you faced in that drama three months ago are not here any more.

> Your life is going well. What's happening? Who's around? How are you interacting with them?

Protagonists may have initial difficulty with those questions, perhaps because they have never really thought about how their lives would be if the problem were resolved. They limit their thinking to what is troubling to them and how intractable their problems seem to be.

Directors can also establish the difference in the amount of problem resolution that clients would consider satisfactory. They first need to know where the clients are now in relation to the problem. Visual or physical analogues, the stock-in-trade of psychodramatists, are once again invaluable. Suppose clients agree that the problem has them "60% in its grip." The therapist can then ask what percentage of resolution the client would consider satisfactory, reminding the client that 100% is rarely achieved in therapy or anywhere else. Sometimes one can bargain about small differences as though one were in a bazaar, haggling over a few percentage points.

The enactment of solutions temporarily interrupts the problem-saturated narrative and is shocking and exciting at the same time. Clinging tenaciously to their story, as most people do, clients find it difficult to imagine alternative ways of being. When people are in difficulty, they think of the future in terms of its problems rather than what they want from it. A fleshed-out description of the desired future also helps the therapist keep on track and keeps the therapeutic work from missing the point.

Many clients, moreover, are caught by the belief that for a problem to be resolved, it is essential to have an explanation for it. Such "explanations," however, are in themselves only stories: the Jung story, the Freudian story, the Kleinian story, the Morenean story. The search for an explanation for why one is experiencing difficulties can limit the fecundity of clients who miss solutions because they look like mere nothings. In a solution-focused framework, it helps to remain curious about the possible connectedness of events that include the problem, rather than needing to know the precise origins of the problem.

Explicit Focus on Difference

In a framework for therapy, Bateson suggests that people are able to change when they recognize difference. Therapeutic effort, therefore, is directed at bringing relevant differences to clients' minds. Much of psychodrama accomplishes that automatically, of course, but it may be more uncommon to produce difference deliberately, as part of a therapeutic strategy.

Working within a Batesonian framework, therapists look for distinctions and differences that might trigger spontaneity. For example, Sarah, a 16-year-old in the family, is seeing a therapist because she is anorexic.

> Sarah, do you think your mother sees anorexia (indicates the chair) more as a gesture of your power or more as a sick compulsion?

(A mild action spin can be given to this and similar questions about other family members' opinions on the matter by representing "anorexia nervosa" by a chair or a cushion. Two anchors in the room can also be set up, one representing Sarah's power, and one representing "a sick compulsion." Sarah can then be asked to place her mother somewhere along the continuum.)

> Is Sarah more eager to please her dad now, or was she more eager 2 years ago when she was eating normally?

(If one wishes, a similar continuum of now–2 years ago, with "pleasing dad" as the criterion, can be established.)

> Who most believes that anorexia nervosa will continue to run Sarah's life? Who in the family least believes that? Do you think anorexia nervosa is stronger than Sarah's strength?

Such questions can help to clarify the family's stories about the problem and how it affects other people. The family identifies their domain, and members define themselves as they are but along the dimensions supplied by the therapist. This combination of contributions assists them to discover possibilities that have not occurred to them before.

Not every member needs necessarily to take an active part in these processes of distinction. Seeing and hearing the responses that the others give, the observers can obtain information from their own private responses to the questions and note the differences between their private responses and those of other members.

Scaling

Scaling is highly suited to action methods. Psychodramatists are able not only to ask about differences but also to have them enacted. They can make space represent time or intensity or division of opinion. They can illuminate simple differences by means of space or distance.

> How bad is your depression today? Walk this line that represents where you are now . . . where were you 2 weeks ago? Show the amount you have been most hassled by your children compared with the amount you are now hassled by them.

Differences can take more complex and circular forms (Williams, 1988). Brad, an at-risk adolescent, can physically arrange the other members of his family on a continuum, the criterion for which is how upset they would be if he committed suicide. The reactions of other family members to the possibility of the suicide can be shown by positioning them in specific spots.

> Stand at this side if you believe that his attempts to kill himself are because he is angry at someone, and stand to that side if you believe it is because he is depressed. Stand over here if you think it is something else that makes Brad attempt to kill himself.

The therapist introduces new connections in thought and action by placing together previously unconnected bits of information. When one uses action sociometry with a family, the family "walks the talk." That expression has become a cliché in management literature, but there it is a metaphor. In action methods, clients actually do walk the talk by literally putting themselves on the line.

Emphasis on Interacting Narratives

Systemic therapy, like psychodrama and sociometry, focuses on relationships, the systems and space between people, rather than on the meaning those relationships have for people.

> Dad, do you think Susan would fall apart if Sarah gained weight?
>
> Susan, what do you think would happen to your parents' relationship if anorexia no longer had hold of Sarah?
>
> If anorexia nervosa no longer dominated Sarah's thinking, do you think Mary (Mother) would become preoccupied with another problem? If so, what do you think it might be?

Answers to the foregoing questions record relationships and provide temporary maps of emotional meanings in perpetual motion. When father, mother, Susan, and Sarah are provided with the opportunity to recognize their actual and possible connections, they can change. The release of information is of a circular nature that matches the circular nature of causality in a group of people. A third person is asked about the relationship of two or more other people around a particular event; in this case, Susan is asked about the effects Sarah's conquest of anorexia would have on the parents' relationship. For the most part, family members answer verbally, but they can also answer by physically moving across the room and taking up particular positions—circularity in action. The release of information into the family makes solutions or proposals for betterment unnecessary. The solutions become obvious, activated when there is room to move.

The core of the dramatic method is irreducibly social; as it unfolds, it creates a community to share in the performance of the various lives. The acted-out story brings people into intense social contact, even though that contact may sometimes be raw. Nevertheless, in all their frailty and glory, members strive to be present to each other, finding heart in the heart of darkness.

Social Atom

Social atoms are maps of social relationships as they stand at the moment, readouts of the flow of feeling to and fro. Depiction of individual social atoms emphasizing the family members actually present is an often-practiced use of action methods in family therapy. Carvalho and Brito (1995) advocated the form of a family photograph in which the family sculpturally positions itself as if for a snapshot, after which one member emerges from the sculpture to view it from the outside. The resulting balance or imbalance in the sculpture is commented on by both the therapist and the family members.

Physical methods, however, are underexploited in mainstream family therapy. With the exception of the late Virginia Satir in the United States and Bert Hellinger in Germany, few high-profile family therapists seem to be aware of the possibility of using space to translate systems theory into physical form. Yet as action methods practitioners know, allowing spatial metaphors to stand for human relationships is highly effective as an intervention. Blatner (1995) observed that Satir's family sculpting is nearly identical to action sociometry.

Guldner (1982) has recommended action methods in family therapy, especially if the identified patient is an adolescent. He claimed that adolescents are "less comfortable with verbal communication than they are with activity" (1990, p. 143). He asked each family member to sculpt how he or she saw the difficulties in the family and then to sculpt how each would like the family to be if it could be changed to meet individual and family needs. Guldner has also used an action genogram. First, a standard genogram, which is a family map extending back at least to the grandparents, is recorded on a large flip chart. Then the processing of relationships and triangles is portrayed in action, with the use of empty chairs to represent extended generations or other significant members who are not present. Issues introduced at subsequent sessions are role played or put in the form of psychodramas. Farmer (1995) provided an exposition of the complexities of psychodrama, family therapy, and systems theory within a psychiatric setting. Remer (1986, 1990) has published articles on the direct use of psychodrama with families and on the application of psychodrama in teaching marital and family therapy.

Family therapists' interest lies in the world of difference or distinction. Such an interest leads inevitably to curiosity about change over time. Therapists might ask the family to construct presentations, depicting its social atom at the moment, for last year, and for the period "before these problems began." The members can use chairs or cushions to represent other persons that are important now but were not significant 2 years ago. Thus they have concretized one description and then followed it up with a second, forming a double description—us now and us then. Family members can comment on the two portrayals and the differences between them. They can step into any role

from either period and speak from one time to another. They can address issues, such as what people are new, which ones have changed places, what is the shape of each atom, and why they are different.

If there were a single event, such as a marriage, a betrayal, an illness, a birth, or a death that was pivotal in the changed shape of the social atom, that event could then be acted out in a vignette. The family can be asked to project to a year in the future, imagining that the members have made the changes that they have come into therapy to make. They then set up a family sculpture or social atom in the way it will have rearranged itself when the members have made those changes.

In the following case report, the therapist herself made changes in the form of the social atom that the protagonist had set up.

> Forty-five-year-old Peter has never married and never had children. He complains of his state and tells the director, Trish, and the group that he wants to work on why he could never choose a mate and why he never had children. Peter describes himself as being the youngest of four children. Trish asks Peter to set out himself and his family of origin. She does not specify a time in Peter's life for him to do this, and he does not ask her. He seems to know exactly what he has to do.
>
> Using members of the group as auxiliaries, Peter arranges his alcoholic father, his mother, his two brothers, and his sister. He also chooses an auxiliary to represent himself and places that person in the family sculpture. While he is selecting group members to depict various people in his family, he tells the director that he has just remembered that his mother had a favorite brother, also called Peter, who died shortly after she married. He then remembers being told that his mother had a first child, who died soon after childbirth. That boy may also have been called Peter—he is not sure. The director instructs Peter to choose auxiliaries for the uncle and the dead elder brother and to place them in the sculpture. He does so. He is asked to choose an auxiliary to represent himself, place that person somewhere in the sculpture, and to sit down in the audience and watch.
>
> Trish then briefly interviews each member of the family but instead of focusing on biography, concentrates exclusively on the feelings that are coming to the person as they stand in that spot. Neither dialogue, role reversal, maximization nor interaction among auxiliaries is encouraged; only the director and the nominated auxiliary do the talking. The atmosphere is quiet but very intense. Trish herself moves various family members, paying special attention to strengthening and separating the parental subsystem from that of the children. She installs the deceased firstborn as the eldest child and places the deceased uncle next to Peter's mother. After any shift in position, she repeatedly asks the auxiliaries how they feel in their new spots. They are encouraged to report only the most primitive data—that they feel cold or that they do not know what they are doing or that they feel sad, isolated or in contact, or joyous. When most members are happy with where they are standing, Trish asks Peter to take his own place in the sculpture and talk about his experience in that position.

This highly interventionist work, modeled on that of Hellinger (1996), appears to combine structural family therapy (e.g., Minuchin, 1974), transgenerational family therapy (e.g., Boszormenyi-Nagy, 1973), psychodrama, and other therapeutic and philosophical elements. Part of the approach suggests that matters on the parental level should be kept separate from matters on the child level. In Peter's case, the mother's grief over the loss of her brother and firstborn son is hers, although it affects Peter all his life.

> From her position in the new family formation, one that has been sculpted by the director, the mother speaks. This is the first piece of dialogue. The mother is coached to tell Peter that she will look after her own grief about her brother and her son and that he is free, no longer charged with caring for her in her loss. Peter weeps.
>
> The following week he informs the group that he now feels that he is free to choose a mate and that he will not disappoint his mother (who is now dead) if he claims someone. He feels he no longer has to "make up to someone for something."

Following up on Change

Family work using action methods tends to take the form of modest vignettes rather than full psychodramas. Perhaps that is because the effects of systemic work come from the gradual expansion of relevant difference (differences that make a difference) in follow-up. After initial change occurs from a psychodramatic intervention, the gap has to be regularly widened by responding to responses until the change is well in place. Conversely, a failure to check-out on change usually equals no change.

Responding to Responses

Responding to responses (White, 1986) is a way of expanding differences that make a difference and therefore, in a Batesonian framework, change. In the second session, the therapist begins inquiries about the changes, whether positive or negative, that have taken place since the last meeting. In assuming that there has been change after a session, a therapist is on safe ground, even though the inquiry may initially be met with a denial of any difference. Changes will have occurred but may not have been noticed. An unnoticed change has less chance of survival than a noticed change. It does not matter whether the change has come directly from the session or not; something will be different in a week or a fortnight. It is on that difference that the therapist capitalizes. The differences sought are preferably in behavior, but differences in thinking or feeling suffice. The starting place is irrelevant; anything can be used for leverage. A change in feeling may have led to one small change in the person's outer life, and that can be used as a shoehorn for further changes.

Peter, what's different now?. . . Have there been occasions in the last few weeks when you were nearly overwhelmed by those difficulties you demonstrated in your sculpture but you somehow managed to undermine them?

What was the time you most felt like quitting and going back to trying to make up to your mother for the loss of her brother and first son? What did you do on that occasion? Who were you with? Did you say anything? Was there a time when you thought you had at last got a handle on this thing?

The therapist values but does not simply ask about feeling states that have changed. The bonus is getting Peter to notice different things he is doing and to ask what new feelings or thoughts accompany the new ways of acting. Feelings, thoughts, actions . . . any way will do. Responding to responses is as much part of the subject matter of the therapy as conducting the drama. Psychodrama is a powerful method that makes it quite easy to get an initial change. The secret is to get the change to endure.

Level of Intervention

Differences in Time—A Walk Down Memory Lane

By compressing time, many events or sets of relationships can be brought sharply against each other so that the difference between them can be noted. The memory-lane technique is useful for occasions when the therapist hypothesizes that the family's difficulty is, at the base, an overreaction to an ordinary developmental phase. It is a visual and acted analogue for the passing of time and the changes that have occurred in a given period. To illustrate the technique, I re-present the Riccardi (not the real name) family (Williams, 1989).

The Riccardi family came to therapy on the advice of their general practitioner. Mrs. Riccardi was presenting as depressed and having apparently psychosomatic headaches that were becoming more frequent and more severe. Mr. Riccardi worked in a government department as a clerical assistant. Their eldest daughter, Daphne, aged 11, and their son, Simon, were doing quite well at school, but their youngest child, Diana, aged 6, was highly anxious and reported as refusing to play or interact with other children.

In the first two sessions, Mrs. Riccardi's despair became a major theme. She was disappointed with her marriage and with her life and was very worried about Diana's fear and nervousness. After some questioning about the early years of the marriage, the therapist decided that a kind of moving history that could mark the differences between those days and these might be useful.

In the next session, the therapist tells the Riccardis that he wants to try an experiment with them to see if they can make a sort of a film together, depicting their lives. They agree that that would be an interesting thing to do and indicate a line on the floor to represent their history from when they met until the present. The therapist sets up three chairs at certain spots along the line to represent the birth of the three children.

The therapist interviews Mr. and Mrs. Riccardi in role at the beginning of the line. He asks them when they met, who noticed whom, what they were wearing on the day they first meet, what their first impressions of each other were, and so on. He leads up to the time when they were engaged, asking them to take one step forward down the room for every step that is significant in their relationship. Whenever they take a step, he interviews them in role once more, assuming that they are in a different role each time. He always interviews in the present. There are a few steps between engagement and wedding day, and he interviews each time, spending more time on the wedding day itself. The couple is now thoroughly warmed up to each other and the relationship.

The Riccardis step further, representing the first year of the marriage, and jump then to their third year, the year when they conceive their first child. The process is repeated until they have passed all three chairs and have all three children. They are interviewed about what it is like to be a family, what the differences are in their life, finances, time, and freedom.

People without psychodramatic training can pick up the technique quite well. It is a simple process, comprising a series of interviews in role. Once the walk has been completed in the forward direction, with all the anchors in place, it is easy to walk backward in time or to proceed to the middle and walk forward again or to visit any spot of special significance. One can have the clients at the end of the lane look back at themselves at a much younger stage, comment on that stage, or even talk to themselves. One can also have a vignette at any spot on the lane, although it is important not to be distracted from completing the journey. It seems preferable not to do therapy as such on the way; the journey is the journey, and telling it and walking it seem to be a deeply satisfying experience for clients. The two ends of the lane act as bookends, embracing the history in between. Seeing it there in one piece brings peace.

The lane technique can be extended from the present into the future, and the family or person can be invited to walk a little further to see what happens. It can have three branches in the future, representing the family if the problem stays the same, the family if the problem gets worse, and the family if the problem gets better. An interview-in-role needs to take place at each of those places.

Mrs. Riccardi revealed that she was most worried about her son, Simon, because he was changeable in his moods and aggressive at school. She confided to the therapist that her own father had been diagnosed as manic depressive and that he used to drive around the suburbs with a shotgun under the front seat. She was afraid that Simon would turn out like her father. The therapist encouraged her to encounter her son on his 21st birthday and coached her in role reversal. As Simon, she told Mrs. Riccardi that Simon was fine and that the mother worried too much.

This simple psychodramatic encounter had a very strong effect on Mrs. Riccardi, and she gave up worrying about Simon.

Externalization

Externalization in narrative therapy has some similarities to psychodrama's concretization, except that the externalized object remains relatively constant, whereas in psychodrama, it is more a part of production that is to be visited *en passant.* Through "relative influence questioning," the therapist invites people to derive two different descriptions of their problem. The first is a description of the influence of the problem in their lives, and the second is a description of the life over the problem. Even if it seems apparent that the problem has saturated one's life, one can usually find areas to which the problem has not spread. Clients have to account in some way for the contradictions involved in being problem soaked. Probing the relative influence of something—alcohol usage, for example—over someone versus the influence someone has over something is a typical process of strategic work and has been refined by family therapists such as Penn (1982) and White (1986, 1988, 1989).

The process can be shocking, especially for people who have been brought up on the language of "owning" or "taking responsibility." The procedure of locating responsibility in the interpersonal system is not intended to make people more feckless, immature, and irresponsible. Externalization of a problem is done entirely in the service of creating new descriptions that allow fresh thinking about the problem.

In a simple form of relative influence externalization, the therapist asks the person working on the problem what "starves" and what "feeds" the problem. That language gives the problem a life of its own, external to the person. A process for externalization may take the following form:

- warming the person up to the problem
- isolating the problem and choosing an auxiliary to portray it
- asking the client whether at the moment the problem is in control or whether he or she is in control; asking whether the problem has established a trend in recent times and if so, the length of the trend
- if appropriate, enacting a scene about when the problem first became apparent or enacting a scene in the present and commenting on the difference between the two scenes
- asking the client to name the behaviors and factors that starve the problem and to choose auxiliaries for each
- having the client mention the behaviors or factors in his or her life that feed the problem and select auxiliaries for each
- having the whole system interact, with the client role reversing into each part
- following up in successive sesions to determine which side is winning

Persistent mapping of relative influences can create new descriptions that take clients into entirely new territory. On one side, the problem's power is mapped, and on the other, the person's power, even if it is small, is mapped (White, 1989). Therapists assist their clients in identifying the problem's sphere of influence and facilitate a full problem-saturated description of life in the social atom. The no-stone-unturned inquiry goes much further into the influence the problem has on the person's life than the person has ever done. When the relative influence questioning is conducted in a family, the influence of the problem is not limited to the individual but is shared by him or her and the various persons and relationships in the family. Once a description of the problem's sphere of influence has been derived, a second enactment and description can take place, showing the influence of the client on the life of the problem. Ordinarily, clients have difficulty with the second type of description and need encouragement.

Nevertheless, construing one's problem (alcoholism, bedwetting, or marital difficulties) as outside oneself seems to give one a handle on it. The very charting of the influence of "it" versus "you" makes the "it" more manageable. Externalization breaks the problem's mesmeric hold on the person. People are freer in their perception of events surrounding the problem and the way it developed a stranglehold on their relationships. On the old map, the problem's sphere of influence seemed to cover the globe. When the map is redrawn, little bits of the person's own colors start to spill over, with tiny revolutions and independence movements having some success. The person's life is no longer so colonized by the problem.

Special Issues and Conclusion

Difficulties of Working With the Whole Family Present

Few family therapists these days consider family therapy to be the only way of working. It is now more accepted that therapists can make use of family therapy ideas without necessarily having to convene family meetings in line with earlier clinical models. Therapists are aware that family therapy stresses context and that the family is only one of the contexts of people in trouble. The family needs to be seen in all its contexts, including the pressures brought about by poverty, gender, race, employment, and social deprivation.

To ask "What's in a name?" is not to imply that there is no difference between therapeutic modalities or no preferred system of working with different populations. Family consultations that involve the interaction of children and adults are distinctly different from individual therapy with adults and from groupwork with a set of clients who are relative strangers to each other. Families attending therapy are usually concerned with coping with particular

problems in their lives. The family might anticipate attending only one session, after which the members expect their problems to be solved or much alleviated. Reimers (cited in Jackson, 1992) found that in Britain about half the people attending his child guidance clinic did not appreciate the fact that therapy involved talking.

The production techniques and therapeutic requirements for a whole family attending therapy present a markedly different set of challenges to a director than those for conducting a conventional family-of-origin drama in a group of strangers. The family is the group. Moreover, it is a group whose members are unlikely to sit passively watching or to be obedient auxiliaries of a member's drama. That is particularly evident when the heat of the drama is directed toward them or when the protagonist's interpretation of reality differs markedly from the others. An extended psychodrama with an individual protagonist and with the rest of the family as auxiliaries is rarely indicated. The production difficulties are too great, and more significant, such a drama may be therapeutically risky. In a family session, the systemic meanings are more relevant than individual meanings. Extended therapy with one person could foster the notion that one member is to blame or that if one member got better, the rest of the family would no longer have any problems. Unfortunately, the family may have already been thinking that way for some time, and that belief may be contributing to the difficulty. When the whole system is present, each member of the system is a protagonist. Individual psychodramatic interventions need to be brief and to relate rapidly back to the whole family. Modest action methods, such as some that have been suggested here, are more appropriate than lengthy psychodramatic interventions.

For therapeutic impact, one does not need the power and rhythms of a classical psychodrama. The family's presence in itself guarantees as much intensity as one could wish. Interactions take on a significance commensurate with the importance of the members to each other. Even the slightest well-timed action method stays alight long after the session is over.

Disappointing Humility of the Narrative Position

The naive position of the narrative psychodramatist can be a disappointment to a therapist. Adopting a narrative approach suggests that one does not have access to a body of knowledge that explains clients on a different and superior level to their own experience. Narrative therapists abandon the idea that their story about the family is more reflective of the underlying truth about the family than the family's own story about itself.

When one first becomes involved with psychodrama, one may be tempted to think that the really big drama, the definitive drama, the ultimately salvific drama is hidden, yet fully formed, and waits to be found and eased into the

world by the right midwife-director. The psychodramatic tradition itself struggles with "the real" and "the role." It plays with the idea that there is a real self and yet maintains that a self is a set of roles in constant interaction. It plays with psychodramas themselves as texts about reality and yet also admits that these texts are the coconstructions of the protagonist, the group, and the director. (That is surely why protagonists prefer one director over another. With a favored director, they do a different drama, even a different type of drama, than the one they perform with a less-favored director.) A director does not merely facilitate a drama; he or she cocreates it. The drama is not "inside," fully formed, waiting for its liberating sculptor to "find" it. The director is no sculptor, no midwife, but a parent, adding his or her genes to those of the protagonist in the birth of a narrative.

What, then, is in a name? The illustrations I present in this article have not been taken from straight psychodramas, nor have they focused on straight family therapy. Rather, I have explored the fringes—techniques used by family therapists with an action bent and by psychodramatists influenced by family-therapy ideas.

Tom, the reader might recall, fits the latter category. His work with Mandy paid off. Mandy and her daughter Debbie's relationship significantly improved after the group, and soon afterward, Mandy's son, with whom she also had difficulty, went to live with his father. Mandy got paid employment, and Debbie is now at a university. Peter, who also worked in a group setting with his director Trish, did not achieve equal success: His attachment is still weak and he still has no children. Trish was not a psychodramatist, but she did use action methods. She would not describe herself as a family therapist, although she worked consistently on family-of-origin constellations. The lesbian lover of Diedre's mother refused to attend therapy sessions, so Diedre's therapist not only did not work with the whole system but also only used action methods in one of the six sessions. Nevertheless, Diedre prospered.

Tania liked to work with whole families and to use action methods when she could, but Marie's children had refused to come to therapy, saying that it was their mother, not they, who was crazy. Because of Marie's stress-induced epileptic fits, Tania used action methods sparingly. Being able to do neither traditional family therapy nor extensive action methods, Tania nevertheless persised, forming a consistent relationship with Marie, who kept coming to therapy.

Marie has stopped burning herself, declaring that she preferred to be "self-soothing" rather than "self-harming" and that she no longer had to tell so many lies about scars that had sometimes daily appeared on her body. She passed her school exams and evicted her eldest son, Stefan, and his drug-taking friends. Stefan, who had been violent toward Marie, now lives with his father. Marie's boundaries with her children have strengthened, and she is no

longer prepared to be abused by them. She is competently sorting out family disputes, one of the more spectacular of which was disarming her 17-year-old daughter, Denise, of a carving knife when she was attacking her little sister.

Tania had been working extensively with Marie's feelings of failure and sense of complete lovelessness. Shortly before the writing of this article, Denise told Marie that she loved her. When Tania asked, "How did you react to that?" Marie replied, "She didn't want anything from me, so I knew she meant it."

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Role of Catharsis in Group Psychotherapy

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ABSTRACT. The authors reviewed the literature in counseling theory and research concerning the use of catharsis and the integration of catharsis in group psychotherapy. From their review, they provided answers to 3 questions: (a) Is catharsis effective in producing therapeutic change? (b) How does catharsis cause change to occur? and (c) What counselor interventions activate emotional arousal and enhance expression? The authors contended that the use of catharsis is not limited to any particular theoretical orientation and is used in both brief and long-term group psychotherapy, and they outlined specific considerations for group psychotherapists when using catharsis.

THE CONCEPT OF CATHARSIS was first considered by Aristotle to describe the release of negative emotions among theater audiences (Davis, 1988; Fuhriman, Drescher, Hanson, Henrie, & Rybicki, 1986). He believed that one function of a tragedy was to arouse strong emotional responses in the audience and then to purge those emotions through catharsis. Pythagorea, a Greek philosopher, believed that catharsis resulted in a restoration of harmony through the discharge of feelings (Walsh, 1981). Many years later Charles Darwin presented a different point of view, stating that the free expression of emotions intensifies feeling (Biaggio, 1987).

The debate about the role of catharsis, or emotionally arousing and expressive methods, has continued in the context of therapeutic change and has been described as one of the longest running debates in the social sciences (Scheff & Bushnell, 1984). This controversy needs to be reconsidered in light of recent research and changes in thinking about the affective components of counseling (Frank & Frank, 1991; Young, 1992). The first psychotherapeutic position on the subject was advanced by Freud (1895/1956). He introduced the use of catharsis as the cardinal method in the following statement from "The Psychotherapy of Hysteria."

> The patient only gets free from the hysterical symptom by reproducing the pathogenic impressions that caused it and by giving utterance to them with the expression of affect and thus the therapeutic task consists solely in inducing him to do so. (p. 283)

Since then, many theoretical viewpoints have developed. Some, such as cognitive therapy (Deffenbacher & Stark, 1992; Lazarus, 1991; Prochaska & Norcross, 1994), do not rely on catharsis as a foundational methodology and are more concerned with reducing undesirable emotions such as fear, anger, and depression rather than with encouraging their expression. Others, including gestalt therapy and psychodrama, consider catharsis as fundamental to producing positive therapy outcomes (Kellerman, 1984; Kottler, 1994). The battle continues to be between those who believe emotional expression is a curative force (Stratton, 1990) and those who believe that emotions should largely be restrained (Lewis & Bucher, 1992). Evidence in the literature supports both positions (Padover, 1992; Young, 1992). Rather than take sides in this controversy, we believe that a resolution is more likely to be discovered in an integration of these apparently dichotomous perspectives. Our goals are to provide a review of the literature on the role of catharsis in group psychotherapy and to propose some general principles that group counselors and psychotherapists can rely on to guide them in the use of affective techniques.

The term *catharsis* has been interchanged with abreaction, emotional insight, corrective emotional experience, unblocking blocked emotion, and experiencing. The word stems from the psychodynamic approach. Although it tends to evoke the psychodynamic paradigm, it has become a catch-all term (Scheff, 1979). It does not differentiate two separate counseling activities: emotional arousal of the client and the encouragement of emotional expression by the client. *Arousing techniques* are those that frustrate, shock, anger, or produce some other state of emotional arousal for the purpose of helping the client make a change. *Expressive techniques* are those that help clients experience fully and convey present emotions or those associated with past events. A variety of methods exist to achieve arousal and expression. Those methods have arisen from psychoanalysis and emotional flooding therapies as well as from other more conventional therapies. Before discussing specific methods, we would like to pose and attempt to answer two basic questions about catharsis that are pertinent to the practice of group counseling and psychotherapy: (a) Is catharsis effective in producing therapeutic change? and (b) How does catharsis cause change to occur?

Is Catharsis Effective?

Nichols and Zax (1977) reviewed early studies evaluating emotional arousal as a method for achieving therapy goals. One study showed no effect

(Keet, 1948), but six later studies endorsed it (Dittes, 1957; Goldman-Eisler, 1956; Haggard & Murray, 1952; Levison, Zax, & Cowen, 1961; Martin, Lundy, & Lewin, 1960; Ruesch & Prestwood, 1949). Mixed results were reported in three other studies (Gordon, 1957; Grossman, 1952; Wiener, 1955). In brief, Nichols and Zax found that the evidence supported the effectiveness of emotional arousal as a treatment method but pointed out weak methodology in some studies. They concluded that further research was needed to identify the actual mechanisms of change.

The perceived efficacy of catharsis by clients and therapists has received mixed reviews. Several researchers (e.g., Burlingame & Fuhriman, 1990; Marcovitz & Smith, 1983) found catharsis to be among the highest valued factors in brief group therapy. Hoge and McLoughlin (1991) found varied results when they identified and ranked the therapeutic factors that most significantly affected acute treatment settings in five previous studies. Their findings showed that clients in the five different studies ranked catharsis eighth, third, first, second, and ninth, respectively. In other studies, therapists working with short-term groups, including incest survivors (Wheeler, O'Malley, Waldo, Murphey, & Blank, 1992), adult offenders in prison (MacDevitt & Sanislow, 1987; Zimpher, 1992), men's structured groups (Hertzel, Barton, & Davenport, 1994), faculty encounter conflict groups (Herrick, Kvale, & Goodykoontz, 1991), and children of chemically dependent families (Rhode & Stockton, 1993), consistently ranked catharsis in the top four of valued therapeutic factors. In a 2-year group with elementary school girls, Shechtman, Vurembrand, and Malajak (1993) found that the expression of feelings was a dominant therapeutic factor. In another study in which catharsis was instituted in groups as a means to counter the effects of negative criticism, findings showed greater psychological distress after a strong emotional expression of feelings (Baron, 1990). Even so, generally catharsis seems to be highly valued by clients and therapists (Butler & Fuhriman, 1983; Fuhriman et al., 1986).

Bohart (1977) and Bohart and Haskell (1978) compared the effectiveness of cathartic treatments. In the first study, four groups of participants were compared. One group of participants intellectually analyzed an anger-producing incident from their pasts. Each member of the second group expressed anger verbally to an imagined person. A third group role played the incident, and a fourth group, which was used as a control, was simply asked to recall the details of the anger-producing incident. The role-play participants reported the greatest reduction of anger and hostility and were the least willing to punish an observed participant in another room. In the second study, the researchers found that cathartic "pillow pounding" was less effective in reducing anger than nondirective counseling and role playing. They concluded that a cognitive component, such as insight, was needed for the emotionally arous-

ing technique to be effective. Bohart (1977) had indicated that cognitive analysis alone was not the most powerful condition in the equation. That eventually led Bohart (1980) to conclude that both expression and cognitive change are required for reduction of anger and hostility.

Another body of research was summarized in an article by Pierce, Nichols, and Dubrin (1983). In that study, they reported that women used emotional expression or "discharge" more than men. They also found no significant difference between hysterical individuals and obsessive individuals in the degree of change caused by emotional expression, although the former spent more on average time discharging than the latter. In an earlier study, Nichols (1974) had compared "feeling-expressive" and dynamic therapy conditions and concluded that catharsis leads to improvement because in the feeling-expressive therapy, the high dischargers improved at a significantly greater rate than the low dischargers did. That change was measured on the basis of behavioral goals. Participants in the dynamic therapy condition showed more improvement on Hathaway and McKinley's (1943) Minnesota Multiphasic Personality Inventory (MMPI) than those in the feeling-expressive therapy did.

In a second study, the same research group (Nichols & Bierenbaum, 1978) found that emotionally expressive therapy was effective with people who have personality disorders, those who have trouble with intimacy, and people who are depressed. The researchers concluded that an individual who has difficulty expressing feelings because of rigid defenses will benefit more from expressive therapies than someone who is already expressive or overexpressive.

In a study designed to judge the effects of two therapeutic techniques on anger reduction, Conoley, Conoley, McConnell, and Kimzey (1983) placed 61 participants in three treatment groups. One group received individual therapy involving the gestalt technique of "the empty chair"; the purpose of that technique was to examine an anger-producing incident from the client's past. A second group was treated in the same manner, with the action-behavior-consequence (ABC) cognitive restructuring technique of rational emotive therapy (RET). The control group received reflective listening. On the dependent measures of systolic blood pressure and a feeling questionnaire, experimental participants showed reduced blood pressure and feelings of anger, compared with those of the control group. Neither the empty chair nor the RET technique was shown to be superior.

In summary, cathartic techniques have generally been shown to be effective treatment methods, although earlier studies used flawed methods. Clients report "cathartic events" as being extremely significant. Two studies indicate that emotional arousal should be accompanied by a cognitive change to achieve maximum therapeutic effectiveness. Researchers found some indication that individuals who are underexpressive benefit most from high expressive therapies.

Why Does Catharsis Lead to Therapeutic Change?

Emotional Expression

The psychoanalytic explanation of catharsis-facilitating therapeutic change is that emotional expression (i.e., abreaction) is actually a re-experiencing of a past memory with the freeing of emotions attached to it. In addition, repressed or dissociated aspects of the remembered events may accompany the emotional expression. This early Freudian definition encouraged thinking that used a hydraulic metaphor for emotions. Emotions came to be thought of as pools of stored energy that sought release and, once released, dissipated like water running down the drain. Although Freud changed his thinking over time, many therapies were spawned from this early psychoanalytic conceptualization, each with its unique position on the role of emotional arousal–expression.

Support for the ventilation–draining conceptualization is mainly theoretical. One group of these theories may be called *emotional flooding therapies* (Olsen, 1976). These distinct therapeutic modalities are based on the belief that emotional problems can best be treated by the release of blocked emotions (Prochaska, 1984). The progenitor of this general approach was Wilhelm Reich (1945, 1971), who founded vegetotherapy. Reich believed in the early Freudian ideas, but he also hypothesized that the body was involved in repression. Anger, for example, might be held down through bodily rigidity (body armor) by the unconscious tightening of the jaw muscles. Prochaska (1984) criticized Reich's view as having become fixated at an early stage of psychoanalysis (id psychology) with a disregard for the importance of the ego and its defenses. Offshoots of Reich's work include primal therapy (Janov, 1970), reevaluation counseling (Bronstein, 1986; Jackins, 1962), and bioenergetics (Lowen, 1967, 1989), as well as implosive therapy (Stampfl & Levis, 1967) and the new age therapy, rebirthing (Orr & Ray, 1977; Regloss, 1986).

The emotional flooding therapies mentioned above have checkered reputations in the therapeutic community, partially because of the personality and fortunes of Wilhelm Reich and also because several of the techniques have been considered high risk and immoral (Havet, 1989). Many more accepted therapeutic systems, however, advocate the use of arousing and expressive techniques for ventilating or purging emotions. They include gestalt therapy (Perls, 1977; Prochaska & Norcross, 1994), psychodrama (Blatner, 1989; Moreno, 1958), and group approaches such as the encounter and marathon.

Insight

Insight and the gaining of greater self-knowledge have traditionally been seen as primary curative factors in psychodynamic and humanistic psy-

chotherapies (Young, 1992). In 1971, Sidney Jourard's book, *The Transparent Self*, became popular with counselors and the general public. Jourard elevated the notion of self-disclosure, including expression of one's emotions, to a sine qua non for mental health.

Significant research relative to emotional expression is found in the work of Pennebaker (1990). Pennebaker became interested in the topic of confession when he talked with polygraph technicians who told him of the high rate of confession by criminals when they are given lie detector tests. The technicians indicated that following confessions, participants often thanked the polygraph operator and some operators received Christmas cards from those they had helped to convict.

Pennebaker began his formal research by studying students in a college counseling center and allowing them to write about traumatic experiences in their lives. Very often, those were events that they had not previously discussed with anyone. In general, the participants (a group of 50 students) would write about one or two major topics for 20 min a day on 4 consecutive days. Half of the students wrote about their deepest "thoughts and feelings" concerning a traumatic event they had experienced. The other half wrote about superficial topics. The major result of the first study was that students who wrote about their deepest thoughts and feelings experienced less illness as measured by visits to the student health service than those who wrote about superficial topics. The participants were aware that their journals would be read by the experimenter. Later medical studies showed that compared with superficial writers, the deep writers showed heightened immune function for up to 6 weeks and fewer visits to the student health service.

In a similar later study, Segal and Murray (1994) asked college students with unresolved traumatic experiences to write essays about trivial or traumatic topics. Initially, the students reported negative moods following the writing but had overall heightened immune functions. When psychotherapy was added, negative moods following the writing disappeared and a cognitive restructuring took place. Kraus (1997) substantiated the importance of a combination of reconceptualization and catharsis in helping group members to recontextualize strong feelings and initiate new goals. Siegel (1995) successfully introduced catharsis and the subsequent development of new coping strategies into law enforcement debriefing sessions, whereas Everly (1995) structured cathartic experiences in a model of debriefing from trauma by systematically reconstructing the incident.

Although these are dramatic findings, other aspects of the research are more relevant to psychotherapy. First, the participants did not feel that positive changes were simply the result of the release of pent-up emotions. Participants gave no indication that they felt better following the writing experience. In their follow-up responses to the study, the participants did feel that the

experience had been very helpful, but 80% of them explained that the benefits came from greater self-understanding rather than from getting negative emotions "off their chests." Clients made these statements (Pennebaker, 1990): "It helped me think about what I felt during those times"; "I never realized how it affected me before"; "I had to think and resolve past experiences. . . . One result of the experiment is peace of mind, and a method to relieve emotional experiences. To have to write emotions and feelings helped me to understand how I felt and why" (pp. 48–49).

Greenberg and Safran (1988) have written extensively on the mechanisms of change factors associated with emotional expression and their relationship to insight. Of these, three seem pertinent to this discussion. The first is acknowledgment of primary affective responses. Expression of strong emotions helps the client recognize the existence of deeply felt but unconscious emotions. Such experiences are difficult to refute or defend against because they are felt in the present and are not merely a verbal rehashing of past events.

Another factor leading to insight because of emotional expression is that one takes responsibility for the affective experience. Greenberg and Safran hypothesized that when one expresses an emotion, one begins to "own" it. Therefore, as the emotion is personalized, "I" becomes the one who can do something about resolving it. A shift from an external locus to an internal locus of control takes place.

Greenberg and Safran also identified the expression of emotion within the therapeutic relationship as one of the reasons why catharsis leads to a change of perception or insight. In some ways, that notion is similar to the concept of confession. Expressing emotions alone is not the same as acknowledging them to someone else. As Yalom (1975) concluded, "Catharsis is part of an interpersonal process; no one ever claimed enduring benefit from ventilating feelings in an empty closet" (p. 84).

Arousal and Attitude Change

Jerome Frank (1981, 1991) is responsible for a shift in thinking about the causes of change in counseling. Frank identified six curative factors or mega-techniques shared by various theories that are behind the healing power of many methods: (a) enhancing efficacy and self-mastery, (b) increasing the strength of the counselor–client relationship, (c) providing new learning experiences, (d) providing opportunities to practice new behavior, (e) increasing motivation and expectations of help, and (f) arousing emotions. These common factors are supposed to account partly for researchers' inability to have failed to find any one theoretical approach to be superior to the others and their conclusion that psychotherapy generally is effective (cf. Ginter, 1988;

Miller & Berman, 1983; Norcross & Goldfried, 1992; Smith, Glass, & Miller, 1980). Frank's research has placed emotionally arousing methods at the center of therapeutic change, rather than as a radical and isolated technique.

Frank and his associates conducted a number of experiments with counseling clients to gauge the effectiveness of emotional arousal (see Frank, 1991, for a discussion of these experiments). Using ether or adrenaline to heighten emotions, the researchers demonstrated that pharmacologically produced emotional arousal led to attitude change more readily than conditions of low emotional arousal did, even when a placebo was used. The participants were more suggestible to attitude change if they were artificially stimulated, even if they were unaware that they were receiving a stimulant. An interesting finding was that the timing of the counselor's suggestion seemed to be important. Attitude change was less likely when the suggestion was made during the peak of emotional arousal and more likely as arousal subsided.

Arousal and Dissonance

Another answer to the question whether catharsis leads to change rests on Festinger's (1957) theory of cognitive dissonance. That theory states that people are motivated to keep their cognitions—such as values, beliefs, and attitudes—consistent. Kiesler and Pallak (1976) reviewed dissonance studies and equated dissonance and arousal. Researchers have found physiological evidence that cognitive dissonance is associated with various physiological measures of arousal (Cooper, Zanna, & Taves, 1978; Croyle & Cooper, 1983; Pittman, 1975; Zanna & Cooper, 1974). McCarron and Appel (1971) concluded that confrontations by counselors bring about emotional arousal more often than reflections or probes and that the most discrepant confrontations cause the most arousal.

Levy (1963) examined the relationship of cognitive dissonance to the process of counseling, positing that clients accepted interpretations as a way of reducing arousal caused by the counseling process. *Interpretations* are defined as counseling interventions that provide a discrepant point of view and offer an opportunity to envision the situation differently. *Confrontations,* by contrast, are interventions that point out inconsistencies in the client's beliefs, behaviors, words, or nonverbal messages (Young, 1992). *Reflections* are defined as supportive restatements of a client's emotional messages. Levy contended that interpretations first cause dissonance with the client's current attitudes, values, or beliefs. The subsequent arousal motivates its own reduction. Attitude change occurs because clients are driven to reduce the arousal caused by the counselor's discrepant messages. Interpretations offer clients a way of reducing arousal by adopting a different conceptualization of the problem.

Building on earlier findings (see Claiborn, 1982), Olsen and Claiborn (1990) manipulated arousal (the independent variable) by offering clients one of two different messages during a counseling interview. The first was a confrontation followed by an interpretation (high-arousal condition), and the second was a reflection followed by the interpretation (low-arousal condition). The interpretation was the same in both conditions. They had three hypotheses: (a) that participants in the high-arousal condition would show a decrease after interpretation and low-arousal participants would show an increase, (b) that those in the high-arousal condition would show greater attitude change related to the interpretations and that their affective response and perception of the counselor would be more positive for the low-arousal condition participants, and (c) that participants in the two treatment conditions would show greater attitude change and accept interpretations better than control participants, whose physiological readings were taken but who did not participate in a counseling interview.

Olsen and Caliborn found that confrontations produced more arousal (as measured by galvanic skin response) than reflections did. In the low-arousal conditions, however, reflections did not increase arousal, as was predicted. High-arousal participants did accept interpretations better than controls. The authors concluded that the study lent support to early research that arousal facilitates attitude change (the acceptance of a new interpretation).

Emotions as Unfinished Actions

One concept of emotions suggests that they are connected to action; they have a directional component (Greenberg & Safran, 1988; Lazarus, 1991; Plutchik, 1980). The frustration–aggression hypothesis is a good example of that notion, which experimentally conceptualizes aggression (presumably the result of anger) as the consequence of being unable to attain one's goals. Among recent writers, Nichols and Efran (1985) have done the most to elucidate the concept of emotions as action tendencies. They contended that emotions are partially blocked actions. An action is often not completed because of external circumstances or internal taboos. They gave the example that avoidance behavior becomes the emotion of fear only when escape is blocked. Fans in the sports stadium become emotional because they are restrained from playing. Many experiences of danger are not experienced as frightening until later, posttrauma, when fleeing is not appropriate.

This notion of emotions as blocked actions fits with the gestalt concept of unfinished business being a primary source of psychological distress. It is also consistent with ideas such as "act hunger" in psychodrama and with the psychodynamic dictum that "one must return to the sources of trauma." The psychodynamic conception promotes the idea that it is a painful memory that

causes one's continuing disturbance. For others, including Fritz Perls, it is the incomplete action or unfinished business rather than the memory:

> The gestalt wants to be completed. If the gestalt is not completed, we are left with unfinished situations, and these unfinished situations press and press and press and want to be completed. Let's say you had a fight; you really got angry at that guy, and you want to take revenge. This need for revenge will nag and nag and nag until you have become even with him. So there are thousands and thousands of unfinished gestalts. (Perls, 1977, p. 119)

What Cathartic Interventions Activate Emotional Arousal and Enhance Expression?

Several methods for catharsis can be grouped together as stimulus techniques. Group psychotherapists supply clients with media, such as music, films, or books, that relate to their personal problems. The ability of the client to identify with the protagonist of the story enhances the emotional arousal and subsequent expression. Prescribing the task of watching the movie *The Great Santini* to a client from a military family would be an example of a stimulus technique.

Another set of methods for inducing catharsis in counseling is primarily physical. In psychodrama, a client's conflicts are physically acted out, and the client may be physically pulled in several directions by auxiliaries to the drama. In bioenergetics, individuals are taught breathing techniques and bodily postures that bring on shaking, burning, and stimulation to the body. Direct pressure by the counselor's hands on parts of the client's body has been used in neo-Reichian and other forms of therapy. A client whose "tears are blocked" may be touched on the eyes by the counselor, to facilitate unblocking of that bodily area. Rolfing, Astin Patterning, postural integration, and other forms of body manipulation are therapeutic methods similar to massage. Clients are encouraged to focus attention on the area being treated and to perform breathing exercises. At such sessions, clients frequently cry or experience anger or sadness. The aim of these "mechanical" therapies is to stimulate the emotional arousal and expression that leads to the purging of traumatic events. Recovery of lost memories has also been reported.

A third set of techniques is associated with the use of the creative arts in counseling (Gladding, 1992). Through a variety of methods, clients are invited through artistic media to express themselves and to experience and release emotions. The arts as emotional catalysts differ from stimulus methods in that clients are not passive but active creators. Techniques in this area include the creative use of dance and movement, music performance, expressive writing of poetry, journaling, painting, drawing, sculpting, collage making, sand tray work, and drama with puppets and dolls.

Some of the most intensely emotional methods are those elicited in psychodrama. Psychodrama was conceived by Moreno (1946) as a method of expression similar to dance and visual art and is the recreation of an individual's joys and sorrows on a therapy stage. Typically, in a group, the protagonist is asked to recreate a scene from the past. Moreno believed that life happens too fast or too slow, too much or too little. Therefore, psychodrama brings an event back at the proper speed so that an individual can fully experience it. Through dramatic creation of the scene, the client experiences what Moreno described as *surplus reality* (Blatner, 1989). Rather than remembering (overdistanced) or reliving (underdistanced), the client is taught to return as both a participant and an observer. Psychodrama motivates this return as both participant and observer by moving the client to a strong emotional experience—including both arousal and maximum expression or catharsis—and then by stimulating the client to process the experience cognitively. In addition to the client, audience members have strong emotional reactions that must be processed later.

Confrontation is a fundamental counseling skill for creating emotional arousal. Confrontation has been raised to a high art in rational emotive and gestalt therapies and was probably used destructively at times in Synanon and other highly confrontive groups (Young, 1992). In general, confrontation is achieved by the counselor pointing out discrepancies. Discrepancies can exist in three major realms: the cognitive–perceptual, affective, and behavioral (Hammond, Hepworth, & Smith, 1977). A discrepancy in the cognitive–perceptual area would include such things as confronting a client's refusal to take responsibility for actions (seeing self as victim vs. the cognition that change is possible and requires personal effort). Affectively, clients can be confronted on inconsistencies between verbal and nonverbal messages. Behaviorally, typical confrontations might help clients face inconsistencies in such areas as lifestyle and values. As indicated in the section on cognitive dissonance, emotional arousal is a consequence of the client's awareness of inconsistencies.

Hypnosis is another method for bringing about cathartic experience. Much of the work on hypnosis currently being done is used to bring clients back in time to the origin of trauma. Interest in early sexual trauma has led many practitioners to return to the use of the psychodynamic paradigm. The argument still states that the only way to rid oneself of a traumatic event is by expressing and reliving the trauma. As a result, hypnosis has become more popular as a tool to recover lost memories. Steele and Colrain (1990) contended that because a client was often traumatized at an early age, he or she experienced only a flood of emotions and bodily sensations. Through hypnotic regression and revivification, the client can react with words rather than "being paralyzed" by the trauma (Peebles, 1989). Some researchers have suggested that many therapists working with clients who have experienced incest

rely too much on emotional arousal and emotional expression and that the use of those techniques needs to be carefully monitored (Haaken & Schlaps, 1991; Roland, 1993).

Group Psychotherapy and Catharsis

Group therapy is often associated with emotional arousal and has consistently been found effective as a means of enhancing emotional expression in clients who have difficulty sharing their feelings (Flowers & Booraem, 1991). Yalom (1975) was among the first to examine the importance of emotional experiences, specifically in group therapy. He reported on a study that involved 20 participants' answers to a Q-sort about curative factors in group psychotherapy. The identified curative factors included such things as interpersonal learning, universality, and existential factors. Interpersonal input (learning about one's impression on others) was ranked by clients as the most significant curative factor with catharsis as the second highest ranked area. On the basis of both research and clinical experience, Yalom has maintained that catharsis is vital to the group therapeutic process and a prime ingredient in the building of group cohesiveness.

Yalom's view was based partially on evidence from a number of previous studies. The first of those (Berzon, Pious, & Parson, 1963) identified ventilating emotions as one of nine curative factors identified by judges from client reports. Dickoff and Lakin (1963) also used judges to categorize clients' statements and found that catharsis was one of the three major categories. In their well-known encounter group study, Lieberman, Yalom, and Miles (1973) also identified catharsis as a frequently reported curative factor by clients. In addition, the authors found that those who reported high emotional arousal were slightly more likely to report negative outcomes for psychotherapy, unless those experiences were also accompanied with a new learning about the event.

Early studies about group psychotherapy and catharsis were used as a basis for theory and research in later work. Kellerman (1984) argued that to regain psychological balance, the emotional pressure must be released by expressing emotional residue. He asserted that the quality and quantity of cathartic expression varied for each individual. Rugel and Meyer (1984) found in a study of Tavistock groups that catharsis was more valued by involved group participants and those who were more action oriented and extroverted.

Different stages in group therapy have been associated with more effective usage of therapeutic factors (Bonney, Randall, & Cleveland, 1986). Yalom (1975) found that during the later stages of group development, catharsis increased as universality and hope diminished in importance. That contradicts earlier findings that catharsis was helpful in the early stages of the group but had no significant impact 6 months later (Cabral, Best, & Paton, 1975).

Summary and Implications for Practice

Although earlier studies showed mixed results and, in some cases, weak methods, we view the research literature as supporting the effectiveness of catharsis for producing attitudinal and behavioral change. Emotional discharge or ventilation, insight, attitude change, creation of cognitive dissonance, and completion of unfinished actions are all psychological mechanisms for which there is some support in explaining the efficacy of catharsis. Beyond the general conclusions listed below are some suggestions drawn from the review of literature that group psychotherapists may wish to consider when using emotionally arousing and expressive techniques.

Combine Cognitive and Behavioral Methods With Emotional Arousal–Expression

Most writers agree that producing arousal and maximizing expression is not sufficient for therapeutic change (Corey & Corey, 1992). This point was noted by some of the earliest proponents of cathartic techniques (Moreno, 1940). A contemporary psychodramatist, Blatner (1985) reiterated this position, stating that clients should first re-experience (heighten awareness), then abreact (maximize expression), and finally learn how to integrate these feelings through learning new skills and cognitions (a new role). The research of Pennebaker (1990), Kraus (1997), and Bohart (1980) confirmed that clients report that the release of emotions is not as significant as the new insights and new learning experiences that result from emotional expression and confession.

Expect Clients to Move Away From Emotional Arousal

Dissonance theory as well as psychodynamic concepts such as resistance and defense suggest that clients are motivated to reduce emotional arousal. They do this in a wide variety of ways that require careful monitoring on the part of a group psychotherapist (Ginter & Bonney, 1993; Young, 1992). Without being aware, a counselor may collude in the lowering of arousal by allowing therapeutic conversation to drift away from painful issues. It is the group psychotherapist's responsibility to remain vigilant toward the clients' movement away from deeply moving experiences, to point out discrepancies, and to help clients develop new frameworks that are more constructive (see Ginter & Bonney, 1993).

Some Clients Benefit More Than Others From Catharsis

Individuals who have difficulty expressing emotions may actually be helped more from emotional arousal–expression than those who are already

expressive or overexpressive. One implication of this finding, especially considering the growing interest in men's issues, is that men who tend to have more difficulty in expressing emotions may derive benefit from those methods (see Kelly & Hall, 1992). Other individual and cultural differences may also define the effectiveness of cathartic techniques.

Emotional Arousal May Be an Indicator of Unfinished Actions

The gestalt therapists and other clinicians cited in this article have suggested that a primary source of emotional arousal is blocked or incomplete actions. One implication of this is that resolution of emotional experience often includes some action on the part of the client that is directly tied to "unfinished business." Thus, the counselor's task is to help the client not simply to ventilate emotions but to resolve those feelings by changing the situation that has given rise to them. To accomplish that, the client must translate those feelings and thoughts into a constructive plan of action that "completes business." The context of group psychotherapy is particularly powerful for addressing this because it allows for interpersonal feedback, confrontation, and interaction.

Emotional Arousal–Expression Is a Powerful Tool That May Be Misused

Catharsis is a hazardous method in mental health counseling and is probably responsible for the negative outcomes noted in early encounter groups (see Lieberman, Yalom, & Miles, 1973). Furthermore, inappropriate catharsis is considered a major ethical issue in group counseling (Corey & Corey, 1992). Some authors (e.g., Peebles, 1989) have suggested that with posttraumatic stress disorder, the abreaction and revivification caused by emotionally arousing techniques can retraumatize clients. Evoking memories of traumatic events as a stimulus may promote further repression and dissociation or even trigger psychotic decompensation, self-mutilation, or suicide attempts.

Blatner (1985) suggested an approach that offers parameters for the use of catharsis. He stated that in psychodrama the group therapist never sets out to achieve a catharsis. Instead, the client's expression is facilitated, and if strong emotions come out, a resolution of the incomplete action is attempted. Such an attitude is consistent with a model that promotes the client's agenda over that of the group therapist and is congruent with the position that we advocate.

The counseling literature points to the power of catharsis to help and conceivably to harm a client. The guidelines we have reviewed suggest that the group psychotherapist who is operating in accordance with these findings selects emotionally arousing and expressive methods for the clients who are

most likely to benefit from them. Group therapists help clients face their deepest feelings while encouraging them to translate insights into positive action within the group setting.

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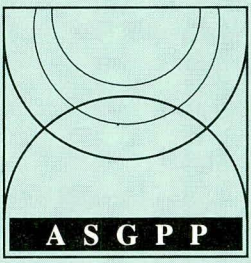

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