CLARK

VOLUME 51, NO. 2 SUMMER 1998

The International Journal of Action Methods

Psychodrama, Skill Training, and Role Playing

Theme Issue: Treating Trauma Survivors

Issue Editors: M. Katherine Hudgins and David A. Kipper

Published in Cooperation With the American Society of Group Psychotherapy and Psychodrama

Founded by J. L. Moreno

The International Journal of
Action Methods
Psychodrama, Skill Training, and Role Playing

Formerly the **Journal of Group Psychotherapy, Psychodrama and Sociometry**

Volume 51, No. 2 ISSN 1096-7680 Summer 1998

Contents

Theme Issue: Treating Trauma Survivors

The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing (ISSN 1096-7680) is published quarterly by Heldref Publications, 1319 Eighteenth Street, NW, Washington, D.C. 20036-1802, (202) 296-6267; fax (202) 296-5149, in conjunction with the American Society of Group Psychotherapy and Psychodrama. Heldref Publications is the educational publishing division of the Helen Dwight Reid Educational Foundation, a nonprofit 501(c)(3) tax-exempt organization, Jeane J. Kirkpatrick, president. Heldref Publications is the operational division of the foundation, which seeks to fulfill an educational and charitable mission through the publication of educational journals and magazines. Any contributions to the foundation are tax deductible and will go to support the publications.

Periodicals postage paid at Washington, DC, and at additional mailing offices. POSTMASTER: Send address changes to **The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing**, Heldref Publications, 1319 Eighteenth Street, NW, Washington, DC 20036-1802.

The annual subscription rate is $73 for institutions and $45 for individuals. Single-copy price is $18.25. Add $12.00 for subscriptions outside the U.S. Allow 6 weeks for shipment of first copy. Foreign subscriptions must be paid in U.S. currency with checks drawn on U.S. banks. Payment can be charged to VISA/MasterCard. Supply account number, expiration date, and signature. For subscription orders and customer service inquiries **only**, call 1-800-365-9753. Claims for missing issues made within 6 months will be serviced free of charge.

The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing is indexed, scanned, or abstracted in *Applied Social Science Index & Abstracts, Child Development Abstracts & Bibliography, Family Resources Database, Health & Psychosocial Instruments, Innovation & Research, Linguistic & Language Behavior Abstracts, Mental Health Abstracts, Psychological Abstracts, Psych-INFO Database, Sociological Abstracts,* and *Social Planning/Policy & Development*

Reprints (orders of 50 copies or more) of articles in this issue are available through Heldref's Reprint Division. Microform editions of the journal are available from University Microfilms, Inc., Serials Acquisition Department, 300 N. Zeeb Rd., Ann Arbor, MI 48106.

HELDREF PUBLICATIONS

Introduction

Action Methods in the Treatment of Trauma Survivors

M. KATHERINE HUDGINS
DAVID A. KIPPER

The seed for this special edition on the treatment of trauma for *The International Journal of Action Methods* was Bessel van der Kolk's keynote address delivered to the American Society of Group Psychotherapy and Psychodrama in New York in 1997. Basing his conclusion on research on the biochemical impact of trauma on the brain, he proposed that experiential treatment is a treatment of choice. The idea of creating the present theme issue developed from discussions with clinicians and researchers who have practiced experiential psychotherapy and were concerned about how best to utilize action methods while maximizing their safety for use with trauma survivors.

Trauma Theory and Self-Organization

Diagnosing persons who present with a history of severe trauma and overwhelming catastrophes as children or adults has not been an easy task. In the past, different classifications were proposed including thought disorders, mood disorders, and personality disorders in an effort to diagnose the nature of damage done to the personality. Until the last 10 years, many trauma survivors were misdiagnosed as having schizophrenia, psychotic depression, agoraphobia, borderline personality disorder (BPD), multiple personality disorder (MPD), or dissociative identity disorders (DID) and labeled untreatable because of the myriad symptoms they displayed. A more accurate diagnosis appeared in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994), in which such people were diagnosed with a complex posttraumatic stress disorder (PTSD). With such a diagnosis, the disorder became more amenable to treatment both medically and psychologically. Recently, Greenberg, Lietaer, and Watson (1998) sug-

gested using "process-diagnosis" that details the interruptions in how a person experiences the world based on traumatic learning from the past and proposed that that perspective provides the most accurate diagnosis and thus facilitates effective therapeutic intervention.

The traumatic stress formulation of psychological problems differs from traditional thinking based on psychoanalytic theory (McFarlane & van der Kolk, 1994). Accordingly, people who have experienced overwhelming childhood or adult catastrophes have resulting developmental delays in many areas of healthy adult functioning. Specifically, when one is exposed to terrifying, life-threatening experience, normal biochemical, physical, perceptual, cognitive, emotional, psychological, behavioral, and spiritual processes are frozen in time, operating at a maintenance and survival level. Traumatic experiences result in deficits in neurotransmitters, disrupted brain pathways, dissociated intense affect, primitive defenses, and uncontrolled reexperiencing behaviors. Primitive, maladaptive defenses, such as denial, dissociation, multiple states of consciousness, projective identification, and identification with the aggressor, are overused, even when the present does not contain life-threatening stress. Emotional experiencing and expression vacillate between psychic numbing and intense explosions of affect. Interpersonal relationships are fraught with projections, transference, and repetition compulsions. These are some of the effects that trauma has on the development of personality structure and self-organization as seen from the traumatic stress model.

For structural change to occur in self-organization, the trauma survivor must have new and positive experiences in order to support new development of the self through positive roles. It is not enough to be able to analyze, and even manage, disrupted self-organization over time. Management leaves the person with a history of trauma still in a survivor-learning state, using the old patterns, albeit in a better way. For true healing to occur, the developmental delays must be brought into conscious awareness so they can be changed with new developmentally relevant experiences that present unique life-giving options. Only then is the person able to function in new and healthier ways in all areas of life. Traumatic experience can create developmental impairment for which experiential methods of psychotherapy are a treatment of choice.

Emergence of Experiential Psychotherapy as a Treatment Approach

Because change-process research has documented its effectiveness, experiential psychotherapy has been increasingly recognized as an important therapeutic approach. Recent reports in change-process psychotherapy research support the conclusion that when done competently, experiential methods can effect profound therapeutic change in general clinical populations (Bergin & Garfield, 1994; Greenberg et al., 1998). Experiential psychotherapy encom-

passes a variety of humanistic approaches that emphasize the promotion of deeper in-session experience as a means of facilitating therapeutic change. In such approaches, people are viewed as experiencing agents who, by symbolizing and reflecting on their experience, construct new meaning and choose courses of action. Research pertaining to the change process during psychotherapy demonstrates that effective treatment involves a change in experiencing the self in the world. This holds true regardless of the theoretical orientation of the practitioner or his or her techniques of intervention.

Of all the currently used psychotherapies, psychodrama and gestalt therapy are the most comprehensive and intensive experiential interventions. Although psychodrama is the seminal action method, other experiential modalities have received more research focus. Currently, psychodrama is experiencing a period of growth and change that calls for new paradigms for action methods procedures that fit the salient characteristics of specific clinical populations (Blatner, 1996; Haworth, 1998; Kipper, 1986). Gestalt therapy, client-centered therapy, and other experiential methods are being tested and are being found effective in treatment of depression, PTSD, and other clinical problems (Greenberg et al., 1998).

At first glance, the use of experiential methods with trauma survivors may appear rather surprising to many readers. Given the great concern psychotherapists always have had about the danger of retraumatizing trauma survivors, a psychodramatic revisit or action exploration of traumatic experiences may seem counterindicated. However, grassroots accolades from 12-step recovery programs and clients' personal reports of success have dovetailed with the recent advances in psychotherapy research, demonstrating the effectiveness of experiential methods across a wide range of psychological difficulties.

It should be emphasized that until now there has been little specific research on the effectiveness of experiential therapy with the symptoms of trauma, either through psychodrama or other experiential modalities. However, the foundation for future research has been properly laid. Recent studies support the effectiveness of treating PTSD with "process experiential" treatment (Elliott, Davis, & Statick, 1998) and of treating sexual abuse with the clinically modified therapeutic spiral model of psychodrama (Hudgins, 1998). It appears that when an experiential intervention draws from sound theoretical foundations and the application is detailed so that it is amenable to standardized training and comparative research, experiential treatment can serve as an effective clinical tool even for disorders considered difficult to treat. In this theme issue, we have included articles by practicing experiential clinicians and researchers that document new experiential models of treating trauma that incorporate protective clinical measures to ascertain that retraumatization does not occur when using action methods.

In the case of trauma patients, experiential methods promote direct access

to the disrupted processes of living and the stored, unprocessed trauma material and its affects, so that they can be changed in the here and now of the therapeutic session. Although it is true that action methods can produce emotionally intensive experiences, the authors of the articles in this theme issue explain and demonstrate how to prevent the client from being emotionally overwhelmed or triggered into uncontrolled regression when working directly with trauma material.

In their article, Greenberg and Paivio present a theoretical understanding of the necessity of using affect in a productive manner when treating trauma. They show how long, dissociated emotions can be accepted and allowed into conscious experiencing and worked through to new meaning in the therapeutic relationships. Hudgins and Drucker demonstrate an effective model for using the *containing double*, a technique to prevent uncontrolled regression when using psychodrama with trauma survivors. The last article is a qualitative research project by Naar and his colleagues, who demonstrate how a time-limited psychodrama provides a safe medium for the maximum exploration of past trauma memories.

REFERENCES

Bergin, A. L., & Garfield, S. L. (Eds.). (1994). *The handbook of psychotherapy and behavior change* (4th ed.). New York: Wiley.

Blatner, A. (1996). *Acting-in* (3rd ed.). New York: Springer.

Elliott, R., Davis, K. L., & Slatick, E. (1998). Process-experiential therapy for post-traumatic stress difficulties. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 249–271). New York: Guilford.

Greenberg, L. S., Lietaer, G., & Watson, J. C. (1998). Experiential therapy: Identity and challenges. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 451–467). New York: Guilford.

Greenberg, L. S., Watson, J. C., & Lietaer, G. (1998). (Eds.). *Handbook of experiential psychotherapy.* New York: Guilford.

Haworth, P. (1998). The historical background of psychodrama. In M. Karp, P. Holmes, & K. B. Tauvon (Eds.), *The handbook of psychodrama* (pp. 15–27). London: Rutledge.

Hudgins, M. K. (1998). Experiential psychodrama with sexual trauma. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 328–348). New York: Guilford.

Kipper, D. A. (1986). *Psychotherapy through clinical role-playing.* New York: Brunner/Mazel.

McFarlane, A. C., & van der Kolk, B. A. (1996). Trauma and its challenge to society. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 214–241). New York: Guilford.

van der Kolk, B. (1997, February). *Keynote address.* Presented at the annual conference of the American Society of Group Psychotherapy and Psychodrama, New York.

Allowing and Accepting Painful Emotional Experiences

LESLIE S. GREENBERG
SANDRA C. PAIVIO

ABSTRACT. In this article, the authors describe a process-diagnostic approach to working with emotion. This involves using different interventions at different times, depending on what emotional process the client is currently engaged in. One such process, the allowing and accepting of pain, is discussed. The phenomenological experience of pain as a state of brokenness and the steps involved in resolving that type of emotional pain are discussed. The steps include overcoming avoidance, reowning, mobilizing an unmet need, having an awareness of maladaptive beliefs, and finally feeling relief and self-affirmation. The authors also demonstrate that emotional change leads to change in meaning.

IN THIS ARTICLE, WE INTEGRATE traditional experiential theory (Perls, Hefferline, & Goodman, 1959; Rogers, 1959) with current emotion theory and research and explicitly argue for the central role of emotion in functioning and psychotherapeutic change (Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993). The consensus among emotion theorists (e.g., Fridja, 1986; Lazarus, 1991) is that a discrete number of innate emotions are biologically adaptive and enhance functioning. Each of those emotions is associated with a distinct action tendency or physiological readiness to act in a way that promotes survival. The implication for therapy is that full awareness of those emotions enhances adaptive functioning because such awareness accesses the client's associated adaptive information.

Emotional experience is encoded in memory and is part of a complex associative network of feelings, beliefs, learned responses, episodic memory, and motivation. These components are embedded in an emotion structure or scheme (Greenberg & Paivio, 1997). Emotional experience thus involves the processing of physiological, sensorimotor, episodic, and conceptual information and is a rich source of multimodal information. By attending to and acti-

vating core emotional experience in therapy, one accesses the core of associated information about self. Through maladaptive learning, however, components of this information complex can be maladaptive and need to be not only accessed but also modified. In either case, emotion schemes need to be activated in therapy in order to access the associated information and to make maladaptive components available for change.

The efficacy of experiential approaches for different disorders is empirically supported by Greenberg, Watson, and Lietaer (1998). Experiential interventions, with their emphasis on activating emotion, seem particularly well suited for treating trauma-related disturbances (Paivio & Patterson, 1998; Paivio, Tran, & Jellis, 1998).

Disrupted emotional processes are at the core of psychological disturbances stemming from trauma. Traumatic stressors range from a single circumscribed event, such as a natural disaster, to prolonged and repeated exposure to interpersonal violence in early attachment relationships. Trauma entails overwhelmingly painful feelings (e. g., helplessness and terror) associated with the event itself and painful feelings associated with the after-effects of the event. These include impotent rage at betrayal or violation; sadness at loss, including loss of cherished beliefs; alienation; and shame at denigration. Symptoms of posttraumatic stress disorder (PTSD) as stated in *Diagnostic and Statistic Manual of Mental Disorders* (4th ed.; *DSM-IV;* American Psychiatric Association, 1994) include problems with emotion dysregulation and avoidance and numbing of affective experience. There also is a high incidence of comorbidity with other anxiety disorders and depression (Foa, Riggs, & Gershuny, 1995). It makes sense that addressing this complex of affective disturbances can require a complex integration of emotionally focused intervention strategies. Such a comprehensive treatment approach requires a differentiated perspective on the different emotional experiences, states, and processes involved in an appropriate intervention. The following review of the role of emotion in functioning can contribute to such a differentiated understanding.

Process Diagnosis

A four-part process-diagnostic scheme for assessing emotional expression in therapy has been delineated (Greenberg & Paivio, 1997; Greenberg & Safran, 1989). In that scheme, primary emotion is distinguished from secondary and instrumental responses. The term *primary emotion* refers to a person's fundamental, initial response to a stimulus that is not reducible to other cognitive–affective components. Secondary emotional responses, by contrast, are reactions to the more primary feelings or are secondary to thoughts. Secondary emotional responses are the end products of simple sequences, such as expressing anger when feeling afraid, or result from more complex processes,

such as feeling anxious when anticipating the shame of negative evaluation. In the case of responses to trauma, thinking about how one should have behaved differently in the circumstances or that one is somehow responsible for the event can contribute to secondary feelings of guilt, shame, and depression. Instrumental emotions, on the other hand, are experienced and expressed in order to achieve some end, for example, expressing anger to dominate or dismay to impress others with one's moral virtue. The anger characteristic of borderline disturbances, which frequently are associated with exposure to trauma, is intended (usually unconsciously) to prevent dreaded abandonment and, therefore, is considered instrumental.

A final differentiation is important, especially with regard to trauma. Primary emotion can be further subdivided into biologically adaptive and learned maladaptive reactions. Panic attacks and different types of phobias are examples of primary learned responses that are maladaptive. Automatic alarm responses characteristic of PTSD are examples of this type of primary maladaptive responses based on traumatic learning. Conditioned fear responses are activated by stimuli resembling the traumatic situation. They are maladaptive because the danger is not real and are considered primary because they are the person's initial response. They are not secondary to, or generated by, other feelings or thoughts. This has important treatment implications that are discussed later.

Not all emotions, however, are fundamentally adaptive. Thus, in addition to learned maladaptive responses, such as conditioned fear, secondary and instrumental emotions are the cause of much of the bad press that these emotions have rightfully received. Certain emotional responses are not adaptive, nor are they desirable, and they do need to be controlled.

Therapy for the effects of trauma can involve all of the above types of emotion and affective processing difficulties. Thus treatment for the effects of trauma integrates accessing suppressed adaptive emotions, such as sadness and anger, managing secondary rage, changing maladaptive shame and depression, and counterconditioning the automatic alarm reactions. The fundamental treatment principle for all emotional disturbances is that even maladaptive emotion needs to be activated in order to be changed.

However, accessing is complicated because avoidance of feelings and thoughts associated with trauma is frequently the prevalent way of coping with painful experiences. Avoidance interferes with reexperiencing and change. The basic therapeutic challenge, therefore, is to help people overcome avoidance and allow painful experience. In therapy for trauma, this needs to be done in such a way as not to overwhelm or retraumatize the client. Facilitating the process of allowing requires understanding the negative consequences of chronic avoidance of primary emotion and emotional pain.

Avoidance of Emotion

According to Pennebaker (1989), the chronic inhibition of thoughts, feelings, and behavior requires effort; it is a drain on resources; and it places cumulative stress on the organism. Pennebaker presented evidence from various contexts that the chronic inhibition of trauma-related feelings and thoughts results in increased risk of health-related problems. Furthermore, trauma material that is avoided cannot be processed and integrated into current self-systems but continues to exert a negative influence on perceptions and behavior.

If feelings are not to be avoided, are they always to be trusted? This is a complex issue to which the answer is a definite *possibly*. It depends on what feelings are to be trusted and in what way. Trusted blindly to determine action? No. Trusted as primary sources of information about reactions and experience? Absolutely. After all, feeling is a central part of the process of being.

Two subtypes of emotional experience—pain and bad feelings—require special attention. The distinction between the two is important because it promotes differential intervention. Broadly put, emotional pain is adaptive but frequently is avoided, and it is the chronic avoidance of pain that can be maladaptive. A common example of this is the inability to grieve over a major loss. Intervention, therefore, involves overcoming avoidance and accessing the painful experience. On the other hand, bad feelings, such as depression, are themselves maladaptive, and intervention entails accessing and changing the underlying cognitive and affective processes that generate the bad feeling state. Therapy for the effects of trauma involves treating both maladaptive bad feelings and maladaptive avoidance of emotional pain. Most of the literature in the area focuses on changing bad feelings and offers little information on emotional pain. In the following discussion, the focus is on the nature and unique characteristics of emotional pain and implications for treatment, especially in relation to trauma.

Painful Emotional Experience

Emotional pain is a complex, bodily felt experience of damage or trauma to the self. The pain can be experienced in the heart, head, stomach, or other parts of the body. People refer to feeling shattered, broken (thus a broken heart), ripped, or torn apart; having gaping wounds; and feeling empty and hopeless (Bolger, 1996). Subjective reports of pain suggest that the primary emotions of anger, sadness, and shame can be connected with pain, anguish, and overwhelming hurt. When experiencing emotional pain, people feel out of control, overwhelmed, and weak and fear being unable to stop crying. Emo-

tional pain can be extremely frightening, partly because of the sensation of losing control. Pain is aversive, and it is avoided, along with the emotions associated with the painful experience. When pain becomes unbearable, people freeze up and numb themselves. They detach, shut off, disconnect, and dissociate. These responses are frequently observed in trauma-related disturbances. However, allowing pain that previously has been avoided, although initially frightening, often leads to relief and feelings of being alive, connected, and letting go. Experiencing painful emotion has healing properties and leads to change. The treatment challenge, therefore, is to facilitate the client's allowing of adaptive emotional pain.

The adaptive function of emotional pain differs from that of the primary emotions. Primary emotions have an anticipatory function or escape value. They are designed to promote action that prevents undesirable occurrences. Pain, however, possesses survival value by teaching one to avoid things in the future that have been discovered to hurt or be harmful. Pain is protective only after the painful event has occurred. Primary emotions, such as fear and anger, clearly alert us to impending dangers and threats and prepare us to meet them. Pain tells us that something bad has happened and teaches us to avoid it happening again. Rather than use emotional pain as a signal of harm that requires attention and repair, we learn to avoid it, particularly if there is no support for enduring the pain and no experience of benefiting from it. Intense psychological pain is accompanied by a fear of shattering or annihilating the self, and people therefore attempt to escape annihilation by cutting off the associated feelings. Again, the painful feelings that are cut off are primary adaptive emotions, such as anger at the violation and betrayal and sadness at the loss.

Thus, emotional pain provides valuable survival-oriented information. Initially, it is ego-protective but, if chronic, avoidance of painful emotions is not adaptive because it cuts one off from one's primary orientation and response system. Again, in the case of trauma, avoidance is thought to perpetuate the more distressing symptoms of PTSD, such as flashbacks, nightmares, and hyperarousal, and prevents the trauma from being fully processed. The trauma remains an "unfinished business," pressing from completion and integration and intruding on current awareness. For example, children who grow up in abusive environments learn to cope with the pain of the abuse by pushing it away through dissociation. They did not have learning experiences whereby they could internalize the soothing of an attachment figure and, therefore, did not develop self-soothing or emotion regulation skills. Those parts of self that contain the traumatic feelings, memories, and thoughts are blocked from awareness. Through prolonged exposure to interpersonal violence in early development, children learn that it is dangerous to be vulnerable and open about their feelings. They learn not to trust others and avoid seeking comfort from others or relying on others. With limited external supports and internal

regulatory resources, they suppress their own painful feelings of sadness at loss and anger at violation and betrayal and become increasingly unaware of them or alexithymic. Again, they are cut off from their primary orienting and response system.

Under those circumstances, avoidance is the only coping strategy available to protect from being overwhelmed. Thus the rage, pain, and anguish of being abused are disassociated to protect the person from conscious awareness of the painful situation. However, the disavowed experience continues to influence perceptions and behavior at a preconscious level (Bowlby, 1988). The person may feel afraid without knowing why or feel nothing at all. These split-off experiences need to be reexperienced and reowned in therapy and worked through from an adult perspective. The trauma that is frozen in memory can be changed by being reexperienced and forming new and adaptive associations. Treatment needs to facilitate the reprocessing of emotional information, and that can only be accomplished by allowing the painful feelings. The act of confronting trauma memories has been found to reduce the physiological and cognitive work of inhibiting trauma-related thoughts and feelings (Pennebaker, 1986).

Research on exposure treatment for PTSD from rape supports the central role of allowing pain in the process of changing trauma-related disturbance (Jaycox, Foa, & Morral, 1998). Higher client ratings on the Subjective Units of Distress Scale, which measures the degree of psychological distress (pain), during exposure sessions were associated with reduced symptomatology at outcome. Similar findings emerged in emotion-focused therapy for the long-term effects of traumatic child abuse. Paivio, Tran, and Jellis (1998) contended that higher levels of psychological and emotional engagement in imaginal confrontation of abusive and neglectful others, early in therapy, were associated with better outcome. Their research supports the view that allowing the painful experience of trauma is associated with change. However, findings from those studies also suggest that people vary in their willingness and capacity to allow such painful experiences. Therefore, as clinicians, we need to understand the process of overcoming fear and avoidance of a painful experience in order to help clients approach and allow it.

Allowing and Accepting Painful Experience

In allowing and accepting emotional pain, the dreaded feeling needs to be approached, rather than avoided. This is similar to the process of approaching bad feelings, except that the change process involves less exploration and unpacking of the underlying cognitive–affective processes. Approaching emotional pain sets in motion a process that leads to further emotional processing. It is feeling the painful feelings, such as those associated with grief, and the

creation of new meaning from that experience that results in completion, relief, and change. Facing pain requires overcoming fear of the self being shattered, at least enough to risk approaching the pain. Taking that risk regarding trauma-related feelings can be safely accomplished only if the experience can be contained. That requires a therapeutic context of regulation and support to protect the client from feeling overwhelmed and accurate labeling of the experience to create a safe distance from it. Emotional processing of painful experience is a type of exposure treatment—an exposure to the pain in order to change elements of the pain-producing structure. In experiential therapy for trauma, the emphasis is on creation of new meaning rather than simple habituation by learning that the pain can be tolerated.

From a phenomenological perspective, in coming to deal with core-dreaded painful aspects of self or with bad feelings, people do learn that they can survive what they previously believed was unendurable. By living through the experience they face their own existential death and are reborn. The critical differences from a typical behavioral approach to exposure are as follows: (a) Facing painful or bad feelings is exposure to previously avoided internal experience rather than to an avoided external stimulus; (b) there is a change in meaning rather than a change in conditioning; and (c) novelty is introduced by accessing new internal affective information and from new interpersonal learning with the therapist, rather than by engaging in new behavior.

The therapeutic relationship and engagement in experiential interventions, such as imaginal confrontation and enactments, are vehicles for accessing this new information. The interventions have behavioral components that provide more complex and multimodal experiences than do imaginal exposure or cognitive restructuring alone. The experiential interventions seem particularly well-suited for addressing the complex disturbances stemming from repeated and prolonged abuse in early attachment relationships.

In sum, solutions to the problems of emotional pain do not lie in understanding the sources of the pain (e.g., the losses suffered), which often are only too evident. Rather, change comes by allowing and accepting the previously avoided painful feelings and by experiencing and expressing the feelings to live them through to completion. The transformation that occurs in allowing painful feelings has been one of the most undocumented processes of psychological healing. The process of resolving pain is a complex one, involving a variety of processes and can result in both relief and enduring change. Although allowing and accepting painful feelings relies on some organismic muscular release and neurochemical recuperative process (experienced as the ability to "go on" after having suffered the pain), it is not just the release of feeling and relief that leads to change. That experience also involves change at a cognitive level.

A model of pain resolution has been developed and is based on intensive

analyses of the therapeutic resolution of painful experience (Bolger, 1996; Greenberg & Safran, 1987; Greenberg & Paivio, 1997). The model, with its components, is shown in Figure 1. According to the model, the therapeutic resolution of painful experience is a stage process. Acknowledging the painful feelings is an early step in the process in which the previously avoided painful feelings first must be approached, allowed, and accepted as part of oneself. The decision to approach, for the first time, that which has been previously avoided involves both intentional and attentional processes. This is a change in internal relations that results in reowning a previously avoided experience with an increased sense of agency in the feeling. Agency (i.e., I chose to allow this, and I am the one who is feeling this) offers a form of containment or control over the feeling. That helps create a safe distance from it and allows the attendant need or affective goal (e.g., to seek comfort) to be mobilized. The accessed need is a healthy internal resource that can help combat or challenge maladaptive processes and cognitions that were preventing or causing the pain. The process of facing pain, accessing needs, and combating dysfunctional beliefs results in a sense of relief and the adoption of a more self-nurturing and self-affirming stance. Thus, the tolerance of the pain plus an internal reorganization result in change.

Having accepted the previously avoided feeling and survived the experience, people no longer rigidly attend to threat cues signaling the emergence of the dreaded feeling; nor do they focus solely on attempting to escape. Rather, now they are more flexible and open to new information. The conditions and opportunity for novelty, for seeing new possibilities and creating new meaning, now exist. By attending to, rather than avoiding, their internal experience, people begin to access previously inaccessible resources and to look for novel ways of coping. It is the shift to accessing organismic needs, and the survival and growth motivation of the essential self, that provides the basis for new coping. Knowing what one wants and needs is a first step in empowering the individual to act on his or her own behalf to get those needs met. The nurturing and support needed to face painful feelings can be obtained internally, in the form of self-soothing and self-affirmation, and interactionally, in the form of asking for support from others or defining personal boundaries.

This process of allowing and accepting pain, therefore, requires that the pain be evoked in the session and lived through, not just talked about. That new experience restructures the pain-producing emotion schemes.

Two sources of new experience are critical in dealing with pain in the here and now: (a) the safe, valued presence of the therapist whose comfort, validation, and soothing presence is internalized (Greenberg, Rice, & Elliott, 1993), and (b) the disembedding of oneself from the pain so that one can view it and how it was created from a distance and then reflect on it. With the help of these two aids—interpersonal support and an internal shift in perspective—

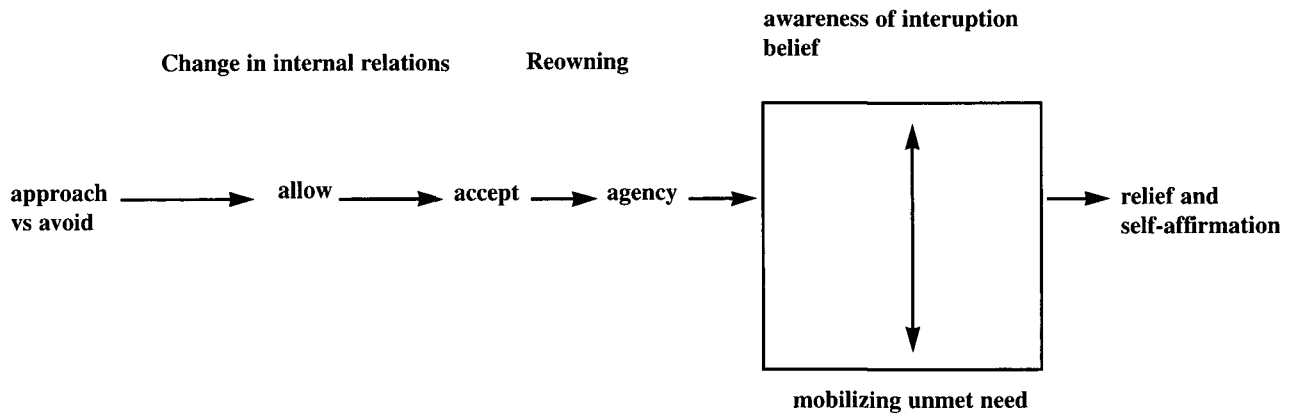


FIGURE 1. Diagram of the Process of Allowing and Accepting a Painful Experience

one is able to access and develop a more self-nurturing and affirming set of functions.

In working with pain, therapists need to promote the previously mentioned steps of resolving pain, using the emotionally focused intervention principles of attending to internal experience, intensifying affective arousal, and symbolizing (articulating, enacting) the meaning of experience. That can be accomplished only in an environmental context of safety and support so that the person is able to take such risks. Ultimately, allowing emotional pain is a deliberate decision (intentionality) to risk doing something different, and therapy must create a context that facilitates and reinforces that decision.

Client Experiences

A further source of data for refining and validating the performance model is clients' recall of their subjective experience of allowing pain. The following data were collected by means of interpersonal process recall (IPR) interviews in which the client reviews, with a researcher, videotaped episodes of the therapy sessions in which they engaged in particular processes. The client, then, is asked to recall his or her internal experience at important moments in the episode. Clients' descriptions of their experience of allowing painful feelings is largely consistent with the observational model, presented in Figure 1. Categories of client experience that support the model are avoidance, allowing, owning, interruptive belief, relief, and self-affirmation. Additional categories that emerged from grounded theory analysis of the client's reports enrich the model with information about the client's subjective internal experience of this change event. The additional categories are control and reason–emotion polarity, struggle to allow, and awareness and questioning of interruption.

Examples of recall data in each of these categories are presented for three clients who engaged in an episode of allowing painful emotion. The clients were in therapy (Paivio & Greenberg, 1995) to resolve painful and traumatic interpersonal issues from the past, namely unfinished business with a significant other.

Avoidance

Client 1: I remember quite often staring at that cloth (on the wall) and my mind would just blank, total blank. Couldn't draw out a thought, couldn't draw out an emotion.

Client 2: I was afraid. It was sort of like going back 25 years and feeling the pain again, only it was stronger (now) because at that time I didn't allow it to happen. I pretended that everything was fine.

Client 3: I'm avoiding, I usually avoid trying to feel it again.

Control and Reason–Emotion Polarity

Client 1: I can see there (in the video) that my head and my emotions are not in sync with each other or something. And my logic sometimes takes over and says "what can you do about it, deal with the pain and get over with it."

Client 2: The restraint has been so powerful it's almost immobilized me, I guess, when I think about it, in dealing with some of this, I feel immobilized.

Client 1: It's like I'm too rational in my approach to things, I can't, the emotions won't come out.

Client 2: This part of myself is saying don't feel, diminish. It's this internalized mother saying, "Your hurt is not important."

Client 3: But I didn't know if my head was ready to let me say it. Like, I was intellectualizing, I guess, my emotions were there, yet my head was saying something different than what was here.

Struggle to Allow

Client 1: So I really had to struggle with bringing the emotions to the surface because it's just been ground down for all these years.

Client 2: Should I talk about it, should I break down? The fear of that, I guess, was very strong, of allowing myself to, because I knew I was going to, and I wasn't sure whether I wanted that to happen.

Client 3: But I feel that I still didn't get it out. It was like I've never allowed myself to do that. And I find it very difficult sitting in the chair talking to myself (in a gestalt two-chair dialogue). Sometimes I can lose myself in it, when I get really emotional, I lose myself in it. But for the most part, I find that difficult.

Client 3: Some resistance, and also of having to build up and convince myself that it was legitimate, okay and valid to feel. One part of me sort of wants to diminish it. So when I was crying, I didn't feel, it just seemed like a natural progression from what we had been doing.

Awareness and Questioning of Interruptive Processes

Client 3: It's like just becoming aware of what I have done all these years. Um, accepting that that's what I did and saying "Okay, that's brought you pain so don't do it anymore."

More Client Reaction

The following two statements are current client reactions to seeing their in-session behavior on videotape during the IPR session, rather than reports on in-session experience. They suggest the usefulness of the IPR method, not

only as a data-gathering technique but also as an awareness-enhancing intervention that could promote client intentions to relinquish interruptive processes in the future.

Client 1: What I'm doing to myself there (in the video), it drains me when I look at that. I say, "Why are you doing that to yourself?"

Client 2: And I'm looking at it now and saying "is that what you do to yourself?" That's really what I was thinking. Is that really how you handle hurt all the time?

Allowing

Client 1: And I was feeling so much in pain that, at some point, I allowed myself to feel it and it kinda took over, you know, the emotion then took over, and I did lose myself in it. But it's not often I can do that.

Client 3: As soon as I was feeling it, it just came flooding back with such force I thought "Gee, there's no reason to resist this." When I cried, it just flooded into me.

Owning

Client 1: I said, "It was me! That was me!" That's what struck me that, don't forget that was me, because my way of coping, all the way along, has been to say this, almost that that wasn't me.

Dysfunctional Belief

Client 1: I'm afraid I'm going to, that I wouldn't stop, that I'd lose it. I'd lose it. If I let myself go there, I would lose it.

Client 2: My belief that I couldn't show my vulnerable side you know. Once I did do that I realized that the world doesn't change, that it's very permissible for me to do that. And how the other person takes it is not my concern. It's how I feel about it myself that's of importance.

Relief

Client 1: I was so completely and totally drained, but I felt like a burden had lifted, like I was carrying something here (points to chest) and it lightened, that feeling.

Client 2: Yes, because I can remember when it was over that it was a sense of sort of relief about having said how I felt about that situation, about him.

Client 3: Felt immense relief and release. I don't have to keep this emotion down and away, just let it be, not suppress it.

Self-Affirmation

Client 2: I don't know, memories were opened up, and I felt that it was okay to cry and that these feelings of mine were legitimate.

Summary Statements

Client 1: What shifted was I allowed myself to really feel the pain of what I went through when my husband just simply walked away. I never really dealt with that pain before, I don't think I've ever dealt with it like that. I don't think I felt it so strongly as I did. It was almost like a revelation that, was I in that much pain that I would feel that deeply and feel that hurt. And I felt a sense of relief. That was a good feeling. That was probably the biggest change.

Client 3: I just feel like I've been walking around all this time with stuff buried, and it's so great to release it, acknowledge it, and come to terms with it. This has been invaluable, I have felt so optimistic.

Conclusion

One key aspect that operates in working with emotion in therapy is the allowing of the previously inhibited painful experience. That phenomenon is particularly salient to therapeutic work with trauma survivors because that work relies on reexperiencing of trauma material as a mechanism of change. The experience of allowing emotional pain appears to facilitate change through three necessary processes: a change in internal relations, a reowning of experience, and an increased sense of agency. The change in internal relations involves a move from avoidance and negative evaluation of the painful experience to an accepting stance. Painful, bad, and hopeless feelings are products of internal relations. The person's new acts of intentionally approaching, attending to, and accepting or positively evaluating one's pain lead to its transformation.

Reowning is the process of identifying with feelings and associated thoughts, memories, needs, and action tendencies that have been disowned or disavowed. Disowned experience, although not integrated into the dominant self-organization, continues to influence behavior. People tend to deal with the unacceptable by depersonalizing their feelings and not experiencing them as their own, thus weakening their self-organization. Therapy can be understood, not so much as a process of bringing previously unconscious material into consciousness, but more as a process of reclaiming disowned experience and creating new meaning from it. Gestalt therapists (Perls et al., 1951), for example, use deliberate awareness interventions to promote experiences of "It is me who is thinking, feeling, needing, wanting, or doing this." People can

distinguish between the conceptual processing of information at an intellectual level, and the experiential linking of that information to the self (Greenberg, et al., 1993). It is the latter that is important in therapeutic change.

Finally, an increased sense of agency results from the two processes. With reowning comes an increased sense of self in relation to a domain of experience. Hope develops as one senses that "It is I who is feeling this, it is I who is an agent in this feeling" and then "it is I who can do something about this." Although a sense of agency may not yet provide a concrete plan of action, there is a feeling of mastery, self-control, and confidence that action is possible and that change can occur.

REFERENCES

Bolger, L. (1996). *The subjective experience of transformation through pain in adult children of alcoholics.* Unpublished doctoral dissertation, York University.

Bowlby, J. (1988). *A secure base.* New York: Basic Books.

Clarke, K. M. (1990). Creation of meaning: An emotional processing task in psychotherapy. *Psychotherapy: Theory, Research and Practice, 26,* 139–148.

Elliott, R., Suter, P., & Manford, J. (1995, June). *A process-experiential approach to posttraumatic stress disorder.* Paper presented at the Annual Meeting of Psychotherapy Research, Vancouver, British Columbia.

Foa, E., & Kozak, M. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20–35.

Foa, E. B., Riggs, D. S., & Gershuny, B. S. (1995). Arousal, numbing, and intrusion: Symptom structure of PTSD following assault. *American Journal of Psychiatry, 152,* 116–120.

Frijda, N. (1986). *The emotions.* New York: Cambridge University Press.

Greenberg, L., Rice, L., & Elliott, R. (1993). *Facilitating emotional change.* New York: Guilford Press.

Greenberg, L., Watson, J., & Lietaer, G. (1998). *Handbook of experiential therapy.* New York: Guilford Press.

Greenberg, L. S., & Foerster, F. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology, 64,* 439–446.

Greenberg, L. S., & Paivio, S. C. (1997). *Working with emotions in psychotherapy.* New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist, 44,* 19–29.

Jaycox, L. H., Foa, E. B., & Morral, A. R. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of Consulting and Clinical Psychology, 66,* 185–192.

Johnson, S. (1997). *The practice of emotioally focused couples therapy: Creating connection.* New York: Brunner/Mazel.

Lazarus, R. (1991). *Emotion and adaptation.* New York: Oxford University Press.

McMain, S. (1996, April). *Emotionally focused treatment of opiate dependence.* Symposium presented at the Society for the Exploration of Psychotherapy Integration, Toronto, Canada.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving "unfinished business": Efficacy of

experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology, 63,* 419–425.

Paivio, S. C., & Patterson, L. A. (1998). *Efficacy of Emotion Focused Therapy for adult survivors of child abuse.* Manuscript under review.

Paivio, S. C., Tran, N., & Jellis, J. B. (1998). *Early engagement in imaginal confrontation as a predictor of outcome in therapy for child abuse issues.* Manuscript under review.

Pennebaker, J. W. (1989). Confession, inhibition and disease. In L. Berkovitz (Ed.), *Advances in experimental social psychology* (Vol. 22, pp. 211–244). New York: Academic Press.

Perls, F., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy.* New York: Julian Press.

Rice, L., & Greenberg, L. (1984). *Patterns of change.* New York: Guilford Press.

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: The study of a science* (Vol. 3, pp. 184–256). New York: McGraw Hill.

Traux, C. B., & Mitchell, K. M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (1st ed., pp. 299–344). New York: Wiley.

Watson, J., & Rennie, D. (1994). A qualitative analysis of clients' reports of their subjective experience while exploring problematic reactions in therapy. *Journal of Counseling Psychology, 41,* 500–509.

LESLIE S. GREENBERG is a professor at York University in Canada. SANDRA C. PAIVIO is a professor at the University of Windsor. The corresponding author is Leslie Greenberg, who can be reached at the Department of Psychology, York University, 4700 Keele St., Toronto, Ontario, Canada M3J1P3.

National Institute of Mental Health

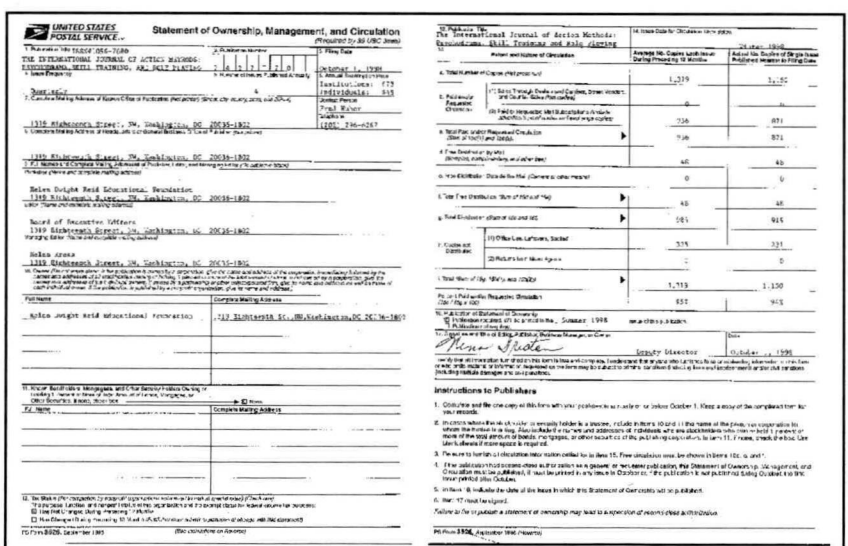
Public Service Announcement Campaign on Anxiety Disorders

The National Institute of Mental Health (NIMH) has developed dramatic television and radio public service announcements (PSAs) on anxiety disorders for you to use as part of your community education efforts. These PSAs portray the severely disabling fears associated with obsessive-compulsive disorder, panic disorder and post-traumatic stress disorder, and send the hopeful message that people living with these frightening mental illnesses can be successfully treated.

The PSAs were developed as part of NIMH's Anxiety Disorders Education Program, and include a 30-second television PSA in English and 30-and 60-second radio PSAs (in both English and Spanish).

A technical assistance kit accompanies the PSAs and provides easy-to-use tips and tools for promoting the PSAs to local media, as well as to members of your community. For example, it discusses ways you can use PSAs to coordinate group viewings and follow-up discussions about mental health topics.

To order these materials, write to the National Institute of Mental Health, Anxiety Disorders Education Program, Room 7C-02, MSC8030, 5600 Fishers Lane, Bethesda, MD 20892; or fax to (301) 443-4279. Please specify which materials you would like to receive and include the corresponding order number. Materials include the: PSA Technical Assistance Kit (OM-00-4180), 30-second Television PSA in VHS format (OM-00-4174), Radio PSAs on CD with English packaging (OM-00-4178), and Radio PSAs on CD with Spanish packaging (OM-00-4179). Limited quantities are available at no cost and will be distributed on a first request received basis.



UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation

(Required by 39 USC 3685)

1. Publication Title: THE INTERNATIONAL JOURNAL OF ACTICS METHODS: EXPERIMENTAL WETI TRAINING, AN: SELF PLACING
2. Publication Number: 0 1 2 3 - 2 0
3. Filing Date: October 1, 1994
4. Issue Frequency: Quarterly
5. Number of Issues Published Annually: 4
6. Annual Subscription Price: Institutional: $75 Individual: $35

7. Complete Mailing Address of Known Office of Publication (Not printer): 1316 Eighteenth Street, NW, Washington, DC 20036-1802 (202) 296-6267

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer): 1319 Eighteenth Street, NW, Washington, DC 20036-1802

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)

Publisher (Name and complete mailing address): Helen Dwight Reid Educational Foundation 1319 Eighteenth Street, NW, Washington, DC 20036-1802

Editor (Name and complete mailing address): Board of Executive Editors 1319 Eighteenth Street, NW, Washington, DC 20036-1802

Managing Editor (Name and complete mailing address): Helen Arons 1319 Eighteenth Street, NW, Washington, DC 20036-1802

10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)

Full Name	Complete Mailing Address
Helen Dwight Reid Educational Foundation	1319 Eighteenth St., NW, Washington, DC 20036-1802

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities. If none, check box → ☒ None

Full Name	Complete Mailing Address

12. The Purpose, Function, and Nonprofit Status of this Organization and the Exempt Status for Federal Income Tax Purposes:
☒ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)

PS Form 3526, September 1995 (See instructions on reverse)

13. Publication Title: The International Journal of Action Methods: Psychodrama, Skills Training, and Self-Placing	14. Issue Date for Circulation Data Below: October 1995
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)	1,319	1,150
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales (Not Mailed)	0	0
(2) Paid or Requested Mail Subscriptions (Include Advertiser's Proof Copies/Exchange Copies)	736	871
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))	736	871
d. Free Distribution by Mail (Samples, complimentary, and other free)	48	48
e. Free Distribution Outside the Mail (Carriers or other means)	0	0
f. Total Free Distribution (Sum of 15d and 15e)	48	48
g. Total Distribution (Sum of 15c and 15f)	784	919
h. Copies not Distributed (1) Office Use, Leftovers, Spoiled	535	231
(2) Returns from News Agents	0	0
i. Total (Sum of 15g, h(1), and h(2))	1,319	1,150
j. Percent Paid and/or Requested Circulation (15c / 15g x 100)	93%	95%

16. Publication of Statement of Ownership
☒ If the publication is a general publication, publication of this statement is required. Will be printed in the November 1995 issue of this publication.
☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Executive Director — Date: October 1, 1995

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. If the publication had Second-Class authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, in the first issue printed after October.
5. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form 3526, September 1995 (Reverse)

The Containing Double as Part of the Therapeutic Spiral Model for Treating Trauma Survivors

M. KATHERINE HUDGINS
KAREN DRUCKER

ABSTRACT. In this article, the authors describe the containing double, one intervention from a clinically driven model of psychodramatic therapy called the *Therapeutic Spiral Model.* That model is used to treat trauma survivors through an integration of classical psychodrama, self-psychology, and object-relations theory. Developed by the authors during 20 years of clinical psychodramatic practice with patients diagnosed with posttraumatic stress disorder, borderline personality disorder, and dissociative identity disorders, the model has the potential for uncontrolled regression and retraumatization. The containing double was developed specifically to prevent uncontrolled regression when therapists use experiential methods with trauma survivors. The article includes clinical examples and suggestions for future research.

GREENBERG, ELLIOTT, AND LIETAER (1994) summarized the change-process research in experiential therapy. Research on principles of change, therapist and client variables, and well-delineated interventions has shown that experiential psychotherapy is equally as effective as psychodynamic, cognitive–behavioral, and behavior therapies in individual practice. Research programs have demonstrated the success of experiential therapy with depression, panic, and other behavioral problems.

When experiential interventions are anchored in theoretical foundations and their application is according to specific instructions, those powerful clinical tools are effective in producing therapeutic change (Garfield & Bergin, 1994). Although there has been little specific research on experiential therapy with the symptoms of trauma, several studies have shown the benefits of psychodrama with posttraumatic stress disorder (PTSD), eating disorders, and multiple personality and dissociative identity disorders. Nevertheless, the researchers also

offer caution (Altman, 1992, 1993; Burge, 1996; Hudgins, 1989; Raaz, Carlson-Sabelli, & Sabelli, 1993; Reynolds, 1996, Widlake, 1997).

In the following section, we present the theoretical foundations of the therapeutic spiral model (Hudgins, 1998) before we present a derived intervention module, the containing double (Hudgins, Drucker, & Metcalf, 1998). The intervention increases narrative labeling of unprocessed trauma material in order to prevent uncontrolled regression during experiential therapy with trauma survivors.

Experiential Therapy With Trauma

In 1997, at the annual meeting of the American Society of Group Psychotherapy and Psychodrama in New York City, Bessel van der Kolk said "experiential psychotherapy can be a treatment of choice for patients working on a history of trauma." Earlier, Turner, McFarlane, and van der Kolk (1996) had stated:

> The focus of treatment is on helping the individual to process and come to terms with the horrifying, overwhelming *experience* of trauma. The importance of capturing the experience in its *full range of representations* goes beyond the person's simply remembering and reporting the verbal schemata. Treatment must address the somatosensory, emotional, biological, cognitive dimensions of experience. (p. 546, emphasis added)

Many articles on sexual abuse have noted the predominance of perceptual disturbances, information processing difficulties, intrusive reexperiencing, primitive defenses, and emotional flooding as a normal part of the symptom picture (Ellenson, 1986; Gelinas, 1983; Young, 1992).

All experiential therapies treat actual disruptions in sensation, perception, narrative labeling, emotional processing and expression, and behavior that are often the aftermath of trauma. As van der Kolk (1996) wrote:

> Prone to action, and deficient in words, these patients can often express their internal states more articulately in physical movements or in pictures than in words. Utilizing drawings and *psychodrama* may help them develop a language that is essential for effective communication and for the symbolic transformation that can occur in psychotherapy. (p. 195, emphasis added)

Experiential therapy provides hope for those patients for whom verbal therapy has long been shown to provide only symptom management, not structural change.

PTSD and Psychodrama

Recently, classical psychodrama and its adaptations have received a resurgence of practical interest in a variety of fields—advocacy, education,

psychotherapy, community change, human rights, business, and organizational development (Blatner, 1997; Holmes, 1991; Holmes, Karp, & Watson, 1994; Karp, Holmes, & Tauvon, 1998; Kellerman, 1992; Kipper, 1992). Although research in psychodrama has been meager (Wilkins, 1997), studies support its treatment effectiveness in general, and specifically with symptoms of war trauma and sexual abuse (Bannister, 1991; Baumgartner, 1986; Karp, 1991).

The psychodramatic double (Moreno & Moreno, 1969) is one of the original techniques that has been explored and evaluated. Hudgins and Kiesler (1987) used the classical doubling intervention module in individual therapy. Kipper (1986, 1992) provided a 5-step manual for using the classical double. The present study on the containing double draws on that material as a starting point for validation of the intervention module with trauma survivors.

The Therapeutic Spiral Model

The Therapeutic Spiral Model provides (a) a construct for organizing self-structures into energy, experiencing, and meaning; (b) a process of psychodramatic psychotherapy to treat trauma that includes types of "reexperiencing dramas," principles of "conscious-reexperiencing with developmental repair," and use of an action trauma team; and (c) a series of operationalized clinical intervention modules. Prior antecedents to the Therapeutic Spiral Model can be found in earlier attempts to structure psychodramatic treatment with clients who have experienced trauma (Altman, 1992; Dayton, 1997; Raaz, Carlson-Sabelli, & Sabelli, 1993). This model is anchored in classical psychodrama through spontaneity–creativity theory (Moreno, 1953) and role theory (Holmes, 1992; Moreno, 1961), and the construct of "surplus reality" (Moreno & Blomkvist, in press).

The very nature of severe trauma tests the limits of personal spontaneity and the creative resources of the individual, family, group, or culture for survival. All levels of experience are affected by trauma and frozen in time: biochemical, neurological, perceptual, physical, mental, emotional, psychological, relational, and spiritual. Restoring a belief in one's own spontaneity and creativity provides an antidote for the sense of helplessness and horror that accompanies all trauma experiences.

Role theory contributes clarity when working with trauma survivors as it relates the function of the role within the individual's personality to its behavioral enactment. The use of role terms, rather than names or complex psychological labels such as "parts of self," "subpersonalities," and "personalities," immediately normalizes the adaptive states the self develops to organize the experience of severe trauma. It is much easier to change "the me on the ceil-

ing" when it is seen as a role whose function is protection than to think of integrating a part of self, such as "Julie, my 3-year-old personality."

Role theory is the basis for the trauma survivor's intrapsychic role atom (Toscani & Hudgins, 1996), which guides the clinical practice of psychodramatic interventions in the therapeutic spiral model. The intrapsychic role atom describes the concretization of prescriptive roles of restoration, containment, and observation as necessary before one can focus on trauma material directly. Trauma-based roles (defenses, victim, perpetrator), internalized from the experience of trauma, are then structured for the safe enactment and conscious reexperiencing of core trauma material. Transformative roles describe the evolution of healing that occurs for the individual or group. The three-child model of experiential treatment (Sheridan, 1990) was the first template of the present role atom. The containing double (Hudgins, 1993) intervention was the first "prescribed" role developed and qualitatively tested in clinical practice with trauma survivors.

Psychodramatic techniques seek to make the client's internal reality overt and "larger than life" so that experiential awareness is broadened. As Moreno (1965) stated:

> There is, in psychodrama, a mode of experiencing that goes beyond reality, which provides the subject with a new and more exhaustive experience, a surplus reality. (p. 212)

For the trauma survivor, that level of experiential awareness is not surplus reality but is, in fact, a normal part of his or her everyday living. Sensory and perceptual disturbances, emotional processing difficulties, primitive defenses, and behavioral reenactments are all part of the trauma survivor's awareness, and psychodrama provides an opportunity for expression of those symptoms in a nonpathological manner.

The Containing Double Intervention Module

As the name suggests, the containing double can be visualized as a flexible, psychological holding space that puts boundaries on the protagonist's experiences, whether sensorimotor or symbolic representations, when boundaries are needed to prevent uncontrolled regression with trauma material. The role of the containing double is described to all protagonists–clients as

> an inner voice that speaks in first person—a role inside of you that knows your strengths no matter what level of distress you experience—a part of you that knows all your body sensations, feelings, thoughts, whatever you are experiencing. This role, the containing double, can put words to whatever you are experiencing and let people here know what is going on for you. If your containing double is wrong, please make sure to say what is right for you. (Hudgins, Drucker, & Metcalf, 1998, p.10)

This role, like the good-enough mother role, is unconditional in its support and stability. It contains unprocessed trauma material by building a space with flexible psychological boundaries so that thoughts, feelings, and actions can be narratively labeled and expressed in awareness.

The number, frequency, and length of each containing double sequence varies. Each sequence, however, has been standardized to include (Hudgins, Drucker, & Metcalf, 1998):

1. A reflective statement that reports what the protagonist–client is experiencing in order to establish empathic bonding and interpersonal support. For example, when a protagonist was starting to dissociate, the containing double said, "Oh, I can feel myself floating to the ceiling and I'm scared." And the protagonist nodded agreement.
2. A containing statement that frames, as manageable (by the protagonist, the team, and the group) the content, the affect, or the adaptive process that was reflected, without negating the reflection. The statement promotes narrative labeling of the somatic, emotional, and adaptive processes that are being experienced.

To continue: The containing double said, "Yes, I am scared, and I can take a breath and remember I can go as slowly as I need to in my feelings today. I have the choice."

3. A statement that anchors the protagonist–client's perceptual attention in the present moment, the here and now through sensorimotor, interpersonal, and time references. The intervention module finishes with the containing double stating, "And as I breathe, I feel my feet on the floor and look around and see the other group members here with me as I am telling my story."

If a protagonist is showing intense terror that is triggering uncontrolled regression, the containing double could state: I feel really terrified now, as if I am starting to become little again [reflection of affect and defense of regression]. But I know I can reach out to my supports here in the drama and stay in my adult self to make sense of what is happening [containment through focus on interpersonal support and ability to make narrative meaning out of the experience]. I know I am in my psychodrama group, and I can feel my containing double's hand on my shoulder right now [interpersonal, sensorimotor, and time references].

Clinical Procedure

The director–therapist may (a) take the containing double role for moments at a time, (b) assign a trained action team auxiliary to the role, or (c) ask the protagonist to select a group member to be the containing double. The person who assumes the role of the containing double stands or sits near the protag-

onist and moves and speaks as if she or he were the client's inner voice that can provide self-support in the present moment.

The containing double can be learned through role reversal with the protagonist at the beginning of the session. After the initial role reversal for role training, the containing double stays with the protagonist in all roles. When the protagonist role reverses to other roles, especially victim or perpetrator roles, the containing double follows the protagonist to provide the intrapsychic strength to take on even those roles most difficult for trauma survivors.

The experience of being the containing double can also be a therapeutic role assignment for a group member in need of increasing his or her own experience of containment and self-support. If the auxiliary loses the role, role reversal is then used to correct the role. A timely role reversal with the containing double can also augment the protagonist's sense of self-support or stability when that is needed during trauma work.

The containing double can be introduced during all stages of an individual session or protagonist psychodrama to promote stabilization of the patient's ability to hold unprocessed material in conscious awareness in order to promote narrative labeling. Suggestions for the use of the containing double intervention module for different therapeutic purposes follow.

Increasing ego development. The containing double can be interjected into the self-structure by creating a positive role that provides ego support and development. Both the experience of being in the role of the containing double and being the person who is supported by the containing double are positive ego states that are internalized through enactment.

The containing double might say, "I know that I can stay present to what goes on here today [reflection and time anchor]. I can open my eyes, breathe deeply [sensorimotor anchor] and see what is possible for me be different in this scene with my father when I was little [containment]. I can stay aware of being an adult while I also try out what I wish I could have done then [containment]."

Preventing uncontrolled regression. When a protagonist is working on trauma material, it is often important to offer a containing double at the beginning of the drama, even if the protagonist does not spontaneously request one. The enactment of this prescriptive role alone can be reparative as the protagonist no longer has the experience of being overwhelmed or alone during the recollection and sharing of trauma. With the physical empathy and support for cognitive awareness, the protagonist can use the containing double to prevent being overwhelmed by sensorimotor representations and the intense affect associated with working through unprocessed trauma memories.

For example, the containing double could say to the protagonist, "I am really, really scared right now and feel as if I'm gonna scream [reflection]. And I can also take a deep breath [use of sensorimotor cues] . . . and . . . feel my strength . . . and my ability to see what is real [containment and narrative labeling] and what I am working on today [here and now]."

Decreasing dissociation. If the protagonist or a group member is dissociating, a containing double can be assigned to decrease dissociation and increase active experiencing of safety and conscious awareness in the here and now. To decrease dissociation, the containing double can focus on stable sensorimotor experiences in the here and now, while attempting to provide narrative labeling of what is happening with the unprocessed trauma material from the past. When the protagonist knows she or he is dissociating, there is a choice to let go of this primitive defense and use the self and group support available in the moment.

The protagonist may say, "I am really having a hard time paying attention right now [reflection]. I keep going out into space and then pulling myself back to what I am witnessing [reflection]. But I'm finding I can stay with my thoughts and feelings just a little longer [containment and narrative labeling] each time I go away and come back. My feelings are OK a little at a time [containment] right now with my therapist and the group [here and now and interpersonal anchors]."

Interrupting behavioral reexperiencing. If the protagonist or group member is overly warmed-up to affect or traumatic triggers, experiential work may set off flashbacks, body memories, and other re-experiencing of unprocessed trauma material. In such a case, the use of the containing double can provide the support and stability to interrupt the flashback pattern or involuntary abreaction and stabilize the regression.

The containing double might say, "I feel as if it is happening all over again [reflection]. It feels as if his hands are on my body [reflection]. And yet I know this is a flashback and I can stop it with practice [containment and narrative labeling]. I can breathe [sensorimotor focus] and take it slow right now, and notice I am here in the group [interpersonal anchor]. I can create a new role of how to handle these flashbacks differently in the present [time focus]."

Conversely, a containing double is useful to support and encourage the safe expression of a voluntary, controlled catharsis of intense dissociated emotions and conscious reexperiencing of core trauma in its original state. Perhaps, the most important of all, the use of a containing double guarantees informed consent and narrative labeling when the client is expressing primary affect. For example: "I know it is hard to express my anger [reflection], but I can just let it out a little right now [containment and time focus anchor]. I have a right to

be angry and this is a safe place to express it by saying some angry words now [space and time anchor]."

A Clinical Example

To protect confidentiality, the clinical example is a representative composite of many protagonists with stories of severe trauma. In the following example, the protagonist (Susan) has picked a group member (Jean) to be her containing double as the drama begins. The action sequence to establish the initial enactment of the role of the containing double follows.

Director (to protagonist): OK, reverse roles with Jean and become your own containing double. Become that inner part of yourself that always supports you. No matter how scared you are, how worried you get, how self-critical you might become, this containing double never lets you down. Move in a supportive way, speak in the first person and give yourself unconditional care. [The protagonist plays this role initially for several reasons: first, to show the group member the role; and second, to begin the internalization of this role. The use of the body and movement increases the active experiencing of this role].

Director (to protagonist in containing double role): Good, now that you're warmed up as the containing double, I want you to stay somewhere near Susan (Jean is holding the protagonist role). Say what Susan needs to hear to do her work today. Remember to speak in first person. First, note what is going on [reflection]. Then tell yourself that you can handle whatever it is that is happening [containment]. Then remind yourself where you are, who is here with you [here and now reference].

Protagonist (as containing double): I'm not sure what to do. I'm kinda scared now [reflection] . . . but I can take a deep breath and feel the part of me that wants to do this work today [sensorimotor anchor and containment]. I'm not alone today [containment and interpersonal anchor].

Director (to containing double): Good, reverse roles. Jean, come stand beside Susan and become her containing double. Now your job is to provide support to Susan just like she showed you in the containing double role. (The director instructs the person playing the containing double to stand near the protagonist and repeat a few containing statements in the first person to establish an empathic link with the protagonist and to test out the accuracy of the statements. The director also checks for an approximation of the standardized structure of reflection, containment, and here and now anchor.)

Director (to protagonist): If your containing double is right, repeat what she says in your own words. If she is wrong, then correct the statement and say what is true for you, what you need for support. For instance, your con-

taining double just said, "I am scared and I can still do this work." Was that right? If so, you repeat it out loud; if not, correct it.

Protagonist: Yeah, that's right. I'm scared, but I came here to tell my story today, and I still want to do that.

This sequence establishes the role of the containing double and the link between the group member and the protagonist.

The containing double has proved to be a fine and exquisite therapeutic tool, one of the most useful interventions in preventing uncontrolled regression and retraumatization when action methods are used with trauma survivors. As soon as the protagonist has internalized the experience of this intrapsychic support, she or he is able to work consciously on the distorted perceptions, intense affect, and dissociated memories that are a part of the normal recovery process for survivors of severe trauma. The role of the containing double truly allows the patient to establish a physical and psychological holding space for unprocessed material, so that the material can be transformed from sensorimotor representations to an integrated, symbolic, personal narrative.

Discussion

The containing double intervention module has unlimited use for trauma survivors because it promotes safety, self-support, and cognitive–emotional balance when they are experiencing unprocessed material. It can be used in individual psychotherapy in which the therapist takes on the role for a brief 5- to 10-min period of enactment to support containment, safe expression of affect, or the ability to tolerate the exploration and labeling of core trauma material.

After the role has been established by the individual therapist, the containing double can be externally represented by an object, such as a solid stone, a creative arts project, or an image, that is, a visualization of a good-enough mother and thus, always available to the client as the image is internalized. Moreover, this "safety" object can become a physical and developmental transitional object that the trauma survivor takes home in between sessions to further increase active experiencing of containment.

In psychodrama groups working on severe trauma, the containing double becomes an integral part of the treatment process and is used in creative ways through role plays, creative arts projects, dance and movement exercises. After a while, the containing double role becomes so internalized that it can be represented by an empty chair, which is then available to any group member who needs to increase his or her sense of containment during a session.

The containing double can be learned quickly through didactic instruction, skill demonstration, and supervised practice. The intervention module has

been successfully used in education, advocacy, and human rights, as well as psychotherapy. It is hoped that future research can empirically validate the effectiveness of the containing double with clients diagnosed with PTSD. Research focused on adolescent sex offenders can evaluate the usefulness of this technique with both offenders and victims, in light of finding the place of healing.

REFERENCES

Altman, K. A. (1992). Psychodramatic treatment of multiple personality disorder and dissociative disorders. *Dissociation, 5*, 104–108.

Altman, K. A. (1993). Psychodrama in the treatment of post-abuse syndromes. *Treating Abuse Today, 2*, 27–31.

Bannister, A. (1991). Learning to live again: Psychodramatic techniques with sexually abused young people. In P. Holmes and M. Karp (Eds.), *Psychodrama: Inspiration and technique* (pp. 77–94). London: Tavistock/Routledge.

Baumgartner, D. D. (1986). Sociodrama and the Vietnam combat veteran: A therapeutic release for a wartime experience. *Journal of Group Psychotherapy, Psychodrama, and Sociometry, 39*, 31–39.

Blatner, A. D. (1997). Psychodrama: State of the art. *The Arts in Psychotherapy, 24*, 23–30.

Burge, M. (1996). The Vietnam veteran and the family—both victims of post traumatic stress: A psychodramatic perspective. *The Journal of the Australian and New Zealand Psychodrama Association, 5*, 25–36.

Dayton, T. (1997). *Heartwounds: Unresolved grief and trauma.* Deerfield Beach, FL: Health Communications.

Ellenson, G. S. (1986). Disturbances of perception in adult female incest survivors. *The Journal of Contemporary Social Work, 3*, 149–159.

Garfield, S. L., & Bergin, A. E. (1994). Introduction and historical overview. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change,* (4th ed., pp. 3-18). New York: Wiley.

Gelinas, D. J. (1983). The persisting negative effects of incest. *Psychiatry, 46*, 312–333.

Greenberg, L. S., Elliott, R. K., & Lietaer, G. (1994). Research on experiential psychotherapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 509–542). New York: Wiley.

Holmes, P. (1991). Classical psychodrama. In P. Holmes & M. Karp (Eds.), *Psychodrama: Inspiration and technique* (pp. 7–14). London: Tavistock/Routledge.

Holmes, P. (1992). *The inner world outside: Object relations theory and psychodrama.* London: Tavistock/Routledge.

Holmes, P., Karp, M., & Watson, M. (Eds.). (1994). *Psychodrama since Moreno: Innovations in theory and practice.* London: Routledge.

Hudgins, M. K. (1989). Treating anorexia nervosa with psychodrama and gestalt therapy. In L. Hornyak & E. Baker (Eds.), *Experiential therapies with eating disorders* (pp. 234–251). New York: Guilford Press.

Hudgins, M. K. (1993). *The containing double* (Monograph). Charlottesville, VA: The Center for Experiential Learning.

Hudgins, M. K. (1998). Experiential psychodrama with sexual trauma. In L. Greenberg, J. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 328–348). New York: Guilford Press.

Hudgins, M. K., Drucker, K., & Metcalf, K. (1998). *Instructional manual for the intervention module of the containing double* (Monograph). Charlottesville, VA: The Center for Experiential Learning. (Unpublished paper).

Hudgins, M. K., & Kiesler, D. J. (1987). Individual experiential psychotherapy: An analogue validation of the intervention module of psychodramatic doubling. *Psychotherapy, 24*, 245–255.

Karp, M. (1991). Psychodrama and piccalilli: Residential treatment of a sexually abused adult. In P. Holmes and M. Karp (Eds.), *Psychodrama: Inspiration and technique* (pp. 95–114). London: Tavistock/Routledge.

Karp, M., Holmes, P., & Tauvon, K. B. (Eds.). (1998). *The handbook of psychodrama*. London: Routledge.

Kellerman, P. F. (1992). *Focus on psychodrama: The therapeutic aspects of psychodrama*. London: Jessica Kingsley.

Kipper, D. A. (1986). *Psychotherapy through clinical role playing*. New York: Brunner/Mazel.

Kipper, D. A. (1992). Psychodrama: Group psychotherapy through role playing. *International Journal of Group Psychotherapy, 42*, 495–521.

Moreno, J. L. (1953). *Who Shall Survive?* Beacon, New York: Beacon House.

Moreno, J. L. (1961). The role concept, a bridge between psychiatry and sociology. *American Journal of Psychiatry, 118*, 518–523.

Moreno, J. L. (1965). Therapeutic vehicles and the concept of surplus reality. *Group Psychotherapy, 18,* 211–216.

Moreno, J. L. (1977). *Psychodrama* (Vol 1). Beacon, NY: Beacon House (Original work published 1946).

Moreno, Z. T., & Blomkvist, L. D. (in press). *Healing through the use of surplus reality*. London: Aronson.

Moreno, J. L., & Moreno, Z. T. (1969). *Psychodrama: Vol. 3. Action therapy and principles of practice*. Beacon, NY: Beacon House.

Raaz, N., Carlson-Sabelli, L., & Sabelli, H. C. (1993). Psychodrama in the treatment of multiple personality disorder: A process-theory perspective. In E. Kluft (Ed.), *Expressive and functional therapies in the treatment of multiple personality disorder.* Springfield, IL: Charles C Thomas.

Reynolds, T. (1996). Dissociative identity disorder and the psychodramatist. *The Journal of the Australian and New Zealand Psychodrama Association, 5,* 43–62.

Sheridan, M. S. (in press). The three-child model of recovery. In M. K. Hudgins (Ed.), *The therapeutic spiral model: An experiential practice approach to heal sexual trauma.* New York: Guilford Press.

Tosacani, M. F., & Hudgins, M. K. (1996). *The trauma survivor's intrapsychic role atom* (Monograph). Charlottesville, VA: The Center for Experiential Learning.

Turner, S. W., McFarlane, A. C., & van der Kolk, B. A. (1996). The therapeutic environment and new explorations in the treatment of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 537–558). New York: Guilford Press,

van der Kolk, B. (1996). The body keeps score: Approaches to the psychobiology of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 214-241). New York: Guilford Press.

van der Kolk, B. (1997, February). Keynote address. Presented at the annual conference of the American Society of Group Psychotherapy and Psychodrama, New York.

Widlake, B. (1997). Barbara's bubbles: The psychodrama of a young adult recovering from an eating disorder. *The British Journal of Psychodrama and Sociodrama, 12*, 23–34.

Wilkins, P. (1997). Psychodrama and research. *The British Journal of Psychodrama and Sociodrama, 12*, 44–61.

Young, L. (1992). Sexual abuse and the problem of embodiment. *Child Abuse and Neglect, 16*, 89–100.

M. KATHERINE HUDGINS is the president of and primary trainer at the Center for Experiential Learning in Charlottesville, Virginia. KAREN DRUCKER is a certified phychodramatist and a doctoral candidate at the American Professional School of Psychology. The corresponding author is M. Katherine Hudgins, 1460 Stoney Creek Drive, Charlottesville, VA 22902, e-mail: ExpCenter@aol.com.

Short-term Psychodrama With Victims of Sexual Abuse

RAY NAAR
CHRISTINE DOREIAN-MICHAEL
ROBIN SANTHOUSE

ABSTRACT. In this article, the authors describe various methods of dealing with victims of sexual abuse. They show how an approach method, using psychodrama as a treatment modality, can minimize potential risks to the patients and how positive results can be achieved in short-term groups. The article includes theoretical background and 2 vignettes.

STRATEGIES FOR THE TREATMENT OF posttraumatic stress disorders (PTSDs) range from an emphasis on the patient–therapist relationship (Auerhahn, Lamb, & Peskin, 1993; Olio & Cornell, 1993) and story-telling (Gold-Steinberg & Buttenheim, 1993) to analytic groups (Gartner, 1997) and groups relying on an ego–object relations approach (Wells & Glickauf-Huges, 1995). Although most clinicians favor a group modality (Haaken & Schlaps, 1991), some have advocated an individual approach (Jackson, 1994) and others a couples approach (Buttenheim & Levendosky, 1994). All these strategies for the treatment of PTSD patients fall into two general categories—approach and avoidance (Dye & Roth, 1991).

Approach methods of treatment deliberately concentrate on the traumatic experience through talking and thinking about it or reliving it in fantasy. The assumption underlying such methods is that, in order to cope with the disorder (PTSD), the individual must reexperience the emotions associated with the traumatic event and reintegrate them within his or her self-concept and awareness.

Avoidance methods steer the individual away from the traumatic experience through a number of techniques specifically designed to achieve that purpose, such as thought-stopping. The underlying assumption is that coping

becomes easier if the victim learns to distance himself or herself from the experience.

According to Dye and Roth (1991), there are inherent drawbacks in each of the two categories. Approach methods may achieve the opposite effect. Reliving the traumatic event may lead to such flooding of anxiety that, instead of integrating the experience, the individual may reexperience the trauma in all its initial intensity; instead of being cured, the victim is retraumatized. Faulty or incomplete integration of the traumatic experience may result in obsessive worrying and interfere with the victim's ability to function. Caution in the use of approach methods is cited by Blizard and Bluhm (1994), who advocated a go slow approach in dismantling dissociative defenses, and by Gold-Steinberg and Buttenheim (1993), who believed that telling one's story of abuse must be preceded by careful preparation.

Avoidance strategies present a different set of problems. Having dealt only with the symptoms, the individual may not learn to avoid or face other traumatic experiences that may occur in his or her life. Furthermore, repressed memories of a traumatic event may, at times, intrude into the individual's awareness and create dysfunctional behavior and emotional poverty. Olio and Cornell (1995) concluded that avoidance approaches reinforce the mechanism of denial with resulting self-doubts.

In a further discussion of treatment modalities for victims of sexual abuse, Dye and Roth (1991) stated that, without exception, group therapies adopt approach strategies. They also concluded that short-term groups cannot achieve the same benefits as long-term groups in helping the victims positively reintegrate the traumatic experience.

In this article, we focus on the approach strategy and show how such a treatment can be used in a way that minimizes the dangers described above. Furthermore, we describe how that can be accomplished in short-term groups and how such short-term groups can achieve great depth of reexperience and reintegration.

Rationale

The main tenet of the approach strategy described here is to help the individual confront and reintegrate the initial trauma a second time from a position of power and strength that the individual was not aware he or she possessed. This is accomplished by using the concept of *surplus reality*, introduced by Moreno (1965). As explained by Marineau (1990), surplus reality is a more complete and rewarding expression of the individual's reality, as it is expanded through his or her creativity and imagination. It is not a distortion of reality but a reality made fuller.

During a psychodrama in a group run by the first author, a 26-year-old man

was confronting an abusive father with little success. During an *a parte* scene, the therapist directed him to see himself, in fantasy, as a child; he saw himself as a frightened, lonely 6-year-old. He was then asked if the strong adult that he was now could talk to the 6-year-old. In the ensuing dialogue, he realized how he missed the spontaneity, the openness to life of his child self, but he also became aware of his strength and his ability to protect the child in him against all dangers (Naar, 1977). He then went back to his father and was able to confront him with appropriate assertiveness and anger.

In reflecting on what happened, it occurred to the therapist that what enabled the young man to confront his father was his acquired awareness of the strength that made it possible for him to protect a lonely, frightened little boy. He used that new knowledge to protect himself when confronting his father. That knowledge was acquired through the medium of his creativity and imagination when he entered into a dialogue with the little boy.

That same concept could be used to empower and treat victims of other kinds of abuse. In the following case reports, the approach concept was applied to two groups of women who had been sexually abused. Psychodrama was the therapeutic medium chosen.

Participants

Each group was composed of six women, ranging in age from 23 to 55 years, who had been sexually molested in different ways at one time or another in their life. Half the women came from the first author's private practice and the rest from the outpatient Eating Disorders Clinic at Western Psychiatric Institute and Clinic. Diagnoses varied and were not a factor in being accepted for participation. None were diagnosed with schizophrenia or organicity, however, and all were of average or above-average intelligence. An additional criterion for participation was that each member of the group be in therapy or have the available support of, or access to, a therapist outside of the group.

Method

The treatment consisted of 20 hr of group therapy spread out over 9 weeks. The first session was a get-acquainted and introductory session. The purpose of the introductions was to provide a model of openness and affective interaction. (The first author began the introductions.) He stated his name and expressed his trepidation at being the only male in a group of women who had suffered at the hands of men and his gratitude for the trust they were investing in him by their participating in the group. He very briefly alluded to the fact that he had survived a German concentration camp and was no stranger to suffering and pain. He was followed by the coleader, who introduced her-

self in the same vein, and, in turn, by the six participants who described the nature of their sexual trauma, their fears, and their hopes for the outcome of the brief group therapy treatment.

It had been made very clear to the participants that at no time should they feel compelled to share more than they were absolutely comfortable in sharing. At no time was any pressure exercised on any of the participants. We encountered very little resistance, and any reluctance to becoming involved that was displayed by one or two members quickly waned. The example of disclosure provided by the leaders and the first members who volunteered opened the floodgates of sharing and participation.

Interestingly enough, once or twice, when a statement was made that an event in a person's life was too painful even to think about, instead of insisting, the group members became fiercely protective of that person's privacy and expressed their understanding of and respect for that member's need for privacy. Without exception, however, all members eventually self-disclosed and participated. The first session ended on a very high note. It was as if invisible barriers had come down and an unexpected bond of friendship had been established between six very lonely women. In fact, the two leaders wondered whether the bond would be maintained over the life of the group. Indeed, not only was it maintained, but some friendships were forged and were long lasting.

The next sessions were devoted to individual psychodramas involving the abuse. Each of the women took one session. Those meetings were extraordinarily intense and, even though we had contracted for 2-hr sessions, it was a rare session that lasted less than 3 hr.

The way in which the concept of surplus reality was at the core of each psychodrama becomes evident later in the vignette. The drama itself was followed by a long period of sharing, and the support and love that those women—so hard on themselves—were able to give to each other was a marvelous sight to behold.

The Vignettes

Janet, a 45-year-old teacher, was raped by a man with whom she had gone out once and who forced himself into her apartment. Janet was so traumatized by the occurrence that she became a recluse, moved to another apartment, and bought a German shepherd dog, who became her sole and constant companion. When asked to confront her assailant, she laughed bitterly, stating, "You must be crazy. He is 6 feet 3 inches, weighs 225 pounds, wears a gun, and has a black belt in some kind of martial arts. I am 5 feet 4 and weigh all of 113 pounds. What do you think?"

The therapists, stumped for a minute, decided to use a variation of the judgment technique (Sacks, 1965). Three of the women in the group became mem-

bers of a jury, another became the prosecuting district attorney, and another, the defense attorney. The coleader played the part of the rapist, and the first author became the presiding judge. All the anger, bitterness, and hate that Janet could not direct at her abuser was now directed at his defense attorney. The jury found the man guilty and sentenced him to twenty lashes to be administered by the victim. With pillows, we built a dummy of the perpetrator and, with a coat hanger, Janet carried out the sentence. After it was over, she was laughing and crying at the same time. During the sharing phase, she said, "That felt wonderful. For the first time in ten years, I am not afraid. I feel downright powerful."

The second vignette was more dramatic but illustrates the same principle: Empower the protagonist. In the second vignette, the technique was different.

Debbie was a 40-year-old nurse who had been molested by her father over a 1-year period when she was 7 years old. He would enter her bedroom after she had gone to bed, insert his hand under her nightgown, and fondle her. During that period of time, the father was severely alcoholic. When Debbie turned 8, he joined Alcoholics Anonymous (AA) and never touched her again. In all other respects, he was an acceptable father, that is, a good provider who helped the children with their homework, took them away on vacation, and never abused them verbally. The molestation was never mentioned, and Debbie never felt close to her father. Even though he was in his seventies when the group sessions took place, she still felt uneasy in his presence and found it very difficult to talk to him. We endeavored to stage a scene in which Debbie was requested to talk to her father. That was to no avail. This highly articulate and competent nurse was completely tongue-tied. The following interaction then transpired.

Therapist: Debbie, this is so hard for you. Instead of talking to your father, why don't you become a story teller. Tell us what happened.
Debbie: OK, I'll try. I was 7 years old.
Therapist (interrupting): Can you speak in the present tense?
Debbie: I am 7 years old, and it's time for me to go to bed.
Therapist: What time is it?
Debbie: It's 9 o'clock, and I get ready to go to bed.
Therapist: Describe your room, Debbie.
Debbie: My bed is in this corner (she points). There is a window there, chest of toys, a pink bedspread, I remember. I think there are pictures on the walls.
Therapist: Pick someone to be little Debbie.
Debbie: Donna.
Therapist: And someone to be your dad.
Debbie: Janet.
Therapist: OK, Donna, you are 7-year-old Debbie, and Janet, you are her father. As Debbie shares with us her painful experience, you will act it out.
Donna and *Janet*: We'll try.

Therapist: I know it is so hard and hurts so much, but please try.
Debbie: (In a voice choked with emotion) I get into bed and pull my blanket over me. (Donna lays on the floor with her head on a pillow and covers herself with a group member's overcoat.)
Therapist: Are the lights on?
Debbie: Just a night light.
(Therapist dims the rheostat light.)
Therapist: What's happening, Debbie?
Debbie: I can hear him come up the stairs. I am scared. Oh God. I am so scared.
(Janet shuffles her feet to imitate the sounds of an approaching person.)
Debbie: He enters the room and sits on my bed.
(Janet sits on the floor next to Donna.)
Debbie: Please don't, please; he puts his hand under the blanket.
(Janet pretends to insert her hand under the overcoat covering Donna.)
Debbie: Don't, don't, please don't.
Therapist: Will you let him do that, Debbie, she is just a child?
Debbie: (screaming) No, no!!
Therapist: (in a very loud voice) Help her, Debbie, help her.
Debbie: (screams) No, no, leave her alone, you bastard. Leave her alone!
(She runs to Janet, pulls her up and propels her outside of the room. She then returns to the room, slides on the floor, cradles Donna's head and cries, first with convulsive sobs, then more quietly.)
Debbie: (crying, to Donna) Oh! My poor baby, my poor baby, what have they done to you? There was no one to help. But I am here now. You'll see. I'll never, never let anyone hurt you. Never.

By that time, everyone in the group was crying with Debbie. Her father (Janet) then reentered the room, and Debbie confronted him without anger but with assertiveness and firmness. She told him the pain he had caused her, the horror of her experience, the ways in which it had influenced her life; toward the end, she could even recognize that, for the past 30 years, he had been a good father. She finished by telling him that, although she could not ever forget, she would try to forgive.

Many months later, Debbie told the first author that, after her psychodrama, she felt much more at ease with her father. She said, "I don't believe that I'll ever be close to him, but at least we can be in the same room without my wanting to run away."

Discussion

When those groups were conducted, research was not a primary motivation, and no efforts were made to assess formally before and after changes. The participants' comments, however, were telling:

"For the first time ever I don't feel guilty. I don't feel that I have to be ashamed of myself."

"I thought that I was all alone and nobody wanted me. It is so wonderful to be loved. You are beautiful people."

"I feel so much stronger. I'll never let anyone hurt me again."

It should be added that half of the women remained in individual therapy after the group ended. It took approximately three to four additional sessions to process the happenings of the group. After that, the abuse surfaced occasionally in the sessions, but it was no longer the focus of therapy. The other half remained in treatment at the Eating Disorders Clinic, Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania.

REFERENCES

Auerhahn, N. C., Lamb, D., & Peskin, H. (1993). Psychotherapy with holocaust survivors. *Psychotherapy, 30,* 434–442.

Blizard, R. A., & Bluhm, A. M. (1994). Attachment to the abuser: Integrating object-relations and trauma theories in treatment of abuse survivors. *Psychotherapy, 31,* 383–390.

Buttenheim, M., & Levendosky, A. (1994). Couples treatment for incest survivors. *Psychotherapy, 31,* 407–414.

Dye, E., & Roth, S. (1991). Therapy with Vietnam veterans and incest survivors. *Psychotherapy, 28,* 103–120.

Gartner, R. B. (1997). An analytic group for sexually abused men. *International Journal of Group Psychotherapy, 47,* 373–383.

Gold-Steinberg, S., & Buttenheim, M. C. (1993). "Telling one's story" in an incest survivors group. *International Journal of Group Psychotherapy, 43,* 173–189.

Haaken, J., & Schlaps, A. (1991). Incest resolution therapy. *Psychotherapy, 28,* 39–47.

Jackson, M. (1994). Psychotherapy for chronic psychiatric patients who are survivors of child sexual abuse. *Psychotherapy, 31,* 391–397.

Marineau, R. (1990). *J. L. Moreno: Sa vie et son oeuvre* [His life and his work]. Montréal, Canada: Editions Saint-Martin.

Moreno, J. L. (1965). Therapeutic vehicles and the concept of surplus reality. *Group Psychotherapy, 18,* 211–216.

Naar, R. (1977). A psychodramatic intervention within a T.A. framework in individual and group psychotherapy. *Group Psychotherapy, Psychodrama and Sociometry, 30,* 127–134.

Olio, K. A., & Cornell, W. F. (1993). The therapeutic relationship as the foundation for treatment with adult survivors of sexual abuse. *Psychotherapy, 30,* 512–523.

Sacks, J. (1965). The judgment technique in psychodrama. *Group Psychotherapy, 18,* 69–73.

Wells, M., & Glickhauf-Hughes, C. (1995). An ego/object relations approach to treating childhood sexual abuse survivors. *Psychotherapy, 32,* 416–429.

RAY NAAR is in private practice and a faculty member in the Clinical Psychology Department at the University of Pittsburgh. CHRISTINE DOREIAN-MICHAEL is a psychologist who is in private practice in Murrysville, Pennsylvania. ROBIN SANT-

HOUSE is a clinical social worker in the Division of Behavioral Medicine at the University of Pittsburgh Medical Center. The corresponding author for this article, Ray Naar, can be reached at the Medical Center East, Suite 540, 211 Whitfield Street, Pittsburgh, PA 15206.

BOOK REVIEW

Group Counseling (3rd ed.), by E. E. Jacobs, R. L. Masson, R. L. Harvill. Pacific Grove, CA: Brooks/Cole Publishing, 1998.

This well-written and well-organized group counseling manual strongly bespeaks its academic nascence. Each of the carefully developed 17 chapters could be used, and quite possibly has already seen application, as a classroom lecture in a course on group counseling. The stated object is to enhance the ability of the reader to lead all kinds of groups, training sessions, and meetings. To implement that end, the authors expended effort on the learning of skills, techniques, and the art of leading.

Common sense solutions to problems are offered. For example, if a group leader dislikes certain group members, assigning a coleader to help or structure activities may divert the participants from whatever the difficulty was. Although the credentials of the authors point to considerable sophistication, they wisely stop at that level. The opportunity for growth on the part of the leader to enable transcending whatever personality characteristics were making for the difficulty in relationship was not touched. There are probably several valid reasons for limiting the focus. The idea that a student group leader might have some personality flaws flies in the face of a sense of superiority, which only time and maturation changes. Self-examination might well lead to the feeling that Noel Coward expressed when in the early stages of his own therapy, he exclaimed, "This is the most expensive sort of insult there is." Class enrollment and readership would certainly be affected if this were not very carefully handled. Practicums and participation in therapeutic groups would be most helpful to the leader-in-training.

Meticulous attention is paid the myriad problems that do arise within every group that is oriented to change and growth. One of the invaluable features of this book is the helpful presentation of those problems and an effective solution to each. The structure and organization is such that they invite the potential leader to try group counseling, knowing that when the inevitable problems arise, help is just a few pages away.

I personally found *Group Counseling* very worthwhile. It was engaging and down-to-earth in style. I hope the authors write a sequel with emphasis on the integration and characteristics of the leader. Toward that end, there is much that cognitive behavioral management and psychodramatic role training can offer to a pragmatic and impatient society that wants results and wants them fast.

HOWARD M. NEWBURGER
Rye, New York

Notice to Readers

James M. Sacks, PhD, now serves as the book review editor of this journal. He is responsible for choosing the books to be reviewed, assigning them to readers, and assessing the reviews before they appear in the journal.

INFORMATION FOR AUTHORS

The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing contains manuscripts on the theory and application of action methods in the fields of psychotherapy, counseling, social and personal skill development, education, management, and organizational development. The journal welcomes manuscripts bridging research and practice appropriate to educational and clinical simulations, behavior rehearsal, skill training, and role playing within group settings. The focus is on action interventions, psychodrama, and sociometry. The journal publishes theme issues, main articles, and brief reports on small research studies, case studies, and empirically tested new action techniques.

Manuscripts should be submitted to the Managing Editor, *The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing,* Heldref Publications, 1319 Eighteenth Street, NW, Washington, DC 20036-1802.

All manuscripts should be prepared in conformity with the style and format described in the *Publication Manual of the American Psychological Association,* 4th edition (1994). Manuscripts must include an abstract of no more than 120 words, be double-spaced throughout, and ordinarily not exceed 25 pages. Special attention should be directed to *references.* Only articles and books cited in the text of the manuscript are to be listed in the references. Authors should avoid using abbreviations, symbols, and footnotes. It is the responsibility of the author to ascertain that the activities described in the manuscripts are consistent with the generally accepted standards of ethical practice. Manuscripts that do not conform to the *Publication Manual*'s standard (margin, sexist language, references, format, etc.) will be returned unreviewed to authors.

Authors should submit 4 copies of the manuscript to expedite the reviewing process. Each copy must include all tables and reproductions of all figures, graphs, and charts. Glossies of the original figures must *not* accompany the manuscript. Those need to be supplied only after the manuscript is accepted for publication. Manuscripts are accepted for review with the understanding that the same work has not been and will not be published—nor is presently submitted—elsewhere, and that all persons listed as authors have given their approval for the submission of the paper. It is also understood that any person cited as a source of personal communication has approved such citation. Articles and any other material published in *The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing* represent the opinion of the author(s) and should not be construed to reflect the opinion of the editors or the publisher.

Authors submitting a manuscript do so with the understanding that if accepted for publication, copyright for the article, including the right to reproduce the article in all forms and media, shall be assigned exclusively to the publisher. The publisher shall not refuse any reasonable request by the author for permission to reproduce his or her contribution to the journal.

Accepted manuscripts may be edited for style and readability. Ordinarily, proofs are **not** sent to authors. Each author receives two complimentary copies of the issue in which the article is published.

For further information, please call (202) 296-6267, ext. 213, or fax: (202) 296-5149.

The International Journal of Action Methods

Psychodrama, Skill Training, and Role Playing

FOUNDED IN 1942

For more information, call or write:

ASGPP
301 N. Harrison, #508
Princeton, NJ 08540
(609) 452-1339

The American Society of Group Psychotherapy & Psychodrama is dedicated to the development of the fields of group psychotherapy, psychodrama, sociodrama, and sociometry, their spread and fruitful application.

Aims: to establish standards for specialists in group psychotherapy, psychodrama, sociometry, and allied methods; to increase knowledge about them; and to aid and support the exploration of new areas of endeavor in research, practice, teaching, and training.

The pioneering membership organization in group psychotherapy, the American Society of Group Psychotherapy and Psychodrama, founded by J. L. Moreno, MD, in April 1942, has been the source and inspiration of the later developments in this field. It sponsored and made possible the organization of the International Association on Group Psychotherapy. It also made possible a number of international congresses of group psychotherapy. Membership includes subscription to *The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing,* founded in 1947 by J. L. Moreno as the first journal devoted to group psychotherapy in all its forms.