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Introduction to the Special Issue on Cognitive Behavioral Therapy and Psychodrama

For a long-time, psychodrama has been viewed as a "fringe" therapy, even though clinicians and counselors of various theoretical orientations have eagerly adopted role playing, a pivotal psychodramatic concept, for individual and traditional group psychotherapy. Psychodrama has been traditionally seen as more allied with theater and drama than with psychotherapy. The theater approach is most evident in the use of such terms as *director* and *protagonist* as opposed to the usual psychotherapy terms of *therapist* and *patient* or *client*. The role of the director is to facilitate the protagonist to enact an emotionally troubling episode, recreating the original context with props and auxiliaries, to re-experience any events surrounding the episode. The goal of re-experiencing the troubling episode is to allow the protagonist to vent and discover, with the aid of auxiliaries, new interpretations of the experience or simply to obtain an emotional release. Psychodrama is also, but perhaps less frequently, used for role training, that is, as a means to practice new ways of thinking and behaving.

Since its inception, psychodrama practitioners have been creative in inventing novel ways of producing supportive and thought provoking dramas from which all group members can derive therapeutic benefit. In the past two decades, with the growing influence of cognitive behavioral therapy (CBT), psychodrama practitioners have incorporated or adapted some CBT techniques into psychodrama. We believe that is a constructive change because the flexibility of psychodrama is such that it can accommodate a large number of diversified approaches with good results.

Psychodrama is typically less directive than CBT, despite the use of the director as a role in the drama. In contrast, CBT is often more directive, despite the description of the therapist as a collaborative therapist. Common to both is the emphasis on the "discovery" process through the use of Socratic questioning, the emphasis on the "here and now," role playing, and experimenting with

new ways of thinking and behaving. Thus, to draw sharp distinctions between the two approaches, as if they are truly distinct and separate, is to engage in "all-or-nothing" thinking.

A clear advantage of bringing in CBT techniques into psychodrama is that the combination will facilitate the development of a new perspective—the perspective that psychodrama is primarily psychotherapy. Thus, psychodrama is a form of collaborative psychotherapy, and the role of the director is to engage group members in a collaborative effort to make the therapeutic experience a meaningful, forward-looking, problem-solving process for all group members, and not just for the protagonist.

Recharacterizing psychodrama as a collaborative effort, replacing the long-standing term director with collaborative therapist, and adapting or incorporating various problem-solving CBT techniques might help renew the image of psychodrama as a vital and a dynamic psychotherapy tool. With the intention of promoting the integration of CBT techniques in psychodrama, we have put together this special issue of the *Journal of Group Psychotherapy, Psychodrama, and Sociometry.*

In the first article, Thomas Treadwell, V. K. Kumar, and Joseph Wright describe how CBT techniques can be applied in the three phases—warm up, action, and sharing—of psychodrama. They illustrate their applications with college students and patients diagnosed with mood, substance abuse, anxiety, and personality disorders. They point out that although both CBT and psychodrama models stress the discovery process through Socratic questioning, the use of certain structured CBT techniques (e.g., the Dysfunctional Thought Record) provide additional ways of stimulating the development of self-reflection and problem-solving skills.

In the second article, Julie Jacobs describes a case study describing two adolescent sexual-abuse survivors who were treated in individual and conjoint cognitive therapy sessions, using an altered adaptation of role playing. Male caregivers had sexually abused each girl, and both men committed suicide after the girls disclosed the abuse. Both adolescents benefited from sharing insights in conjoint sessions, with the older girl taking the role of teacher and the younger girl that of learner. Both were able to challenge and change their beliefs about their trauma histories and emerged with different beliefs about themselves, others, and the future, along with new emotional reactions to their pasts.

In the third article, Russell Ramsay discusses some traditional CBT techniques that focus on identifying and modifying patients' distorted cognitions through the use of behavioral activation interventions. Patients often overgeneralize the severity and pervasiveness of their difficulties, and CBT helps them reassess their circumstances and modify their misconceptions. Pervasive mistaken beliefs can engender a sense of hopelessness that results in chronic

avoidance and procrastination. Working with adults diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), Ramsay highlights the use of cognitive case conceptualization and action behavioral interventions to help those patients foster a sense of resilience in the problem-solving process.

In the last article, David Kipper introduces the cognitive double technique, which combines elements of cognitive restructuring, a core CBT technique, with the double, a classic psychodrama technique. To distinguish between the two doubles, the latter is referred to as the *classical double*. The cognitive double follows a set of six prescribed steps: awareness, validation, identifying the irrational thoughts in context, confronting automatic thoughts in action, articulating erroneous belief(s) or schemas, and creating a new rational belief to replace the former irrational conviction. The function of the cognitive double is to provide supportive, positive perceptions, identify mental distortions, and to aid in the process of reframing those patterns of thinking. In contrast, the classical double makes available to the protagonists an ongoing, internal, emotional monologue. Kipper also describes an auxiliary technique, the automatic thoughts ticker, that can be used in conjunction with the cognitive double and is an action version of automatic thought record technique.

Editors of the Special Issue on CBT and Psychodrama
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This bracelet was a gift Amber Apodaca
received from the center where she helped teens with
drug and alcohol problems. She was wearing it
when an underage drunk driver took her life.

Friends Don't Let Friends Drive Drunk.

Enriching Psychodrama Through the Use of Cognitive Behavioral Therapy Techniques

THOMAS W. TREADWELL
V. K. KUMAR
JOSEPH H. WRIGHT

ABSTRACT. In this article, the authors combine psychodrama and cognitive behavioral therapy techniques in applied group settings. They illustrate the application of some cognitive behavioral therapy (CBT) techniques that they found helpful in the 3 phases of psychodrama with college students and patients diagnosed with mood, substance abuse, anxiety, and personality disorders. Although both CBT and psychodrama models stress the discovery process through Socratic questioning, the use of certain structured CBT techniques (e.g., the Dysfunctional Thought Record) provides additional ways of stimulating the development of self-reflection and problem-solving skills.

Key words: CBT and psychodrama, CBT techniques, cognitive behavior therapy and psychodrama, psychodrama and CBT

ALTHOUGH TRADITIONAL PSYCHODRAMA is conceptualized in terms of three main techniques—warm up, action, and sharing—there is no dearth of techniques that may be applied in those three phases (see Treadwell, Stein, & Kumar, 1988, 1990). The versatility of psychodrama stems from the variety of techniques that have been borrowed or adapted from various individual and group psychotherapy modalities. With the increasing popularity of cognitive behavioral therapy (CBT) techniques, especially those developed by Beck and his colleagues (see Beck J, 1995, Beck, A. T., Rush, Shaw, & Emery, 1979) in the treatment of anxiety and depression in individual psychotherapy, there is an increasing interest in applying techniques unique to the cognitive behavioral model to group modalities, including psychodrama. Practitioners of traditional psychodrama, however, appear to be slow to borrow or adapt techniques from cognitive therapy.

In this article, we illustrate the application of a few basic CBT techniques that we found helpful in the three phases of psychodrama with college students and groups of patients diagnosed with mood, substance abuse, anxiety, and personality disorders. The CBT techniques discussed in this article are sufficiently flexible for application during any of the three phases of psychodrama. We believe that the techniques can enrich traditional psychodrama not only by emphasizing the cathartic aspects of psychotherapy but also by incorporating the more goal-focused, problem-solving aspects of CBT. Therapists often criticize the CBT model for being overly structured and intellectually oriented (Young & Klosko, 1994; Jacobson, Dobson, Truax, Addis, Koerner, et al., 1996; Woolfolk, 2000.), but they view psychodrama, which is spontaneous, as unstructured and unfocused, encouraging participants' emotional responsiveness (Blatner, 1988).

Both the CBT and psychodrama models stress the discovery process through Socratic questioning. We found that the use of certain structured CBT techniques (e.g., the Dysfunctional Thought Record, Downward Arrow Technique) within the context of psychodrama provide additional ways of stimulating the development of self-reflection and problem-solving and mood-regulation skills. The blending of the two models yields a complementary eclectic approach to multiple problem-solving strategies.

Some General Guidelines for Running a CBT Enhanced Psychodrama

In applying the various CBT techniques within the context of psychodrama, it is important to devote the first one or two sessions (at least 3 hr each) to educating the participants about the CBT model and the psychodrama model to create a safe and secure environment in which individuals can share their concerns freely with group members over the next several weeks. The initial didactic sessions convey the notion that the group format is, foremost, a problem-solving approach for working through various interpersonal, occupational, educational, psychological, and health-related conflicts. Group members receive instruction about the nature of the structured activities so that they have realistic expectations about how the group will be run. At the outset, the therapist introduces the group members to the significance of completing the Beck Depression Inventory-II, the Beck Anxiety Inventory, and the Beck Hopelessness Scale on a weekly basis. The group members learn that the completed diagnostic instruments, which they are to complete before the start of each session, are stored in their personal folders to serve as an ongoing gauge of their progress in the group. By using Young's (Young & Klasko, 1994; Young, 1999) schema questionnaire, therapists can obtain additional data on dysfunctional schemas. They can use the Social Network Inventory (Treadwell, Stein, & Leach, 1993) to map and quantify participants' relationships

with family members, people, groups, and organizations. Each group member signs an informed consent form and an audiovisual recording consent form. The audiovisual recordings form an ongoing record of group activities and serve as a source for feedback when needed.

From our experience, we determined that for optimal results, the preferred size of a group is between 5 and 10 members, the session last 2 to 3 hr, and the duration of treatment is approximately 15 weeks. Patients need to be screened carefully before matriculation into the group. We found that individuals with self-centered and aggressive disorders display strong resistance, especially when assuming auxiliary roles. They lack spontaneity and tend to be rigid in their portrayals of significant others; that is, they either insulate or attempt to dominate others in the group. We believe that it is better to exclude individuals with narcissistic, obsessive compulsive, and antisocial personality disorders because individual therapy is more suitable for them. Furthermore, we found that individuals with cluster A personality disorders and impulse control disorders, such as intermittent explosive disorders, have difficulty functioning in a mixed diagnostic-group environment.

Application of CBT Techniques to Psychodrama

Dysfunctional Thought Records (DTR)

During the initial didactic sessions, we found that it is extremely helpful to teach the group members how to complete a Dysfunctional Thought Record (DTR). It is important to introduce the DTR as a self-reflection strategy for recognition of automatic thoughts that occur within and outside the therapy sessions and for improving problem-solving and mood-regulation skills. The DTR forms consist of columns in which participants record details of upsetting situations, automatic thoughts, moods resulting from having those thoughts, evidence for and against those upsetting automatic thoughts, formulation of balanced thoughts, and changes in moods as a function of formulating balanced thoughts. Thought records can be written in longhand, which some members prefer, or on a computerized form stored on one's computer. Completing the form is a useful homework exercise. A copy of the DTR is retained in each group member's folder. An examination of several DTRs can help the director to recognize the various dysfunctional core beliefs and schemas that a group member habitually uses in daily living.

To explain how to complete a DTR properly, the therapist gives the group members two handouts, an already completed thought record as a sample (see Beck, 1995; Greenberger & Padasky, 1995) and a list of cognitive distortions (see Burns, 1980). After explaining the various terms (i.e., automatic thoughts, balanced thoughts, cognitive distortions) in the two handouts, the

therapist asks the group members to complete a DTR during the session. During the first one or two sessions, group members often need assistance in completing the form.

Having participants share and discuss the DTRs during the first one or two sessions builds rapport and a supportive atmosphere within the group. When the volunteers from the group reveal the content of their DTRs (on a white or black-board, or paper), the group can focus on clarifying the various terms in the DTRs. The therapist can stress the usefulness of completing the DTRs, not only as a way of improving one's moods through the process of reframing but also as a tool for self-reflection to discover and understand one's habitual ways of thinking in stressful situations.

In later sessions, the therapist notes links between automatic thoughts, such as beliefs about hopelessness and unlovability, or other schemas (e.g., dependence, entitlement) and helps group members understand what triggers automatic thoughts and how in turn the thoughts activate dysphoric moods and emotions. Thus, actively completing DTRs helps participants evaluate automatic thoughts and place them within particular contexts on an ongoing basis. Group members often report feeling better after completing a DTR.

During the opening sessions of the program, therapists can expect some resistance to sharing DTRs openly. Before asking for a volunteer, the therapist needs to discuss confidentiality issues and clarify the participants' responsibility to ensure confidentiality.

We suggest avoiding the use of psychodrama techniques in the first one or two sessions. Once a few members voluntarily reveal their DTRs, the ice is broken, and the stage is set for the action component of psychodrama. A volunteer's DTR is put into action, using role-playing techniques to address the situation listed on the DTR. The director introduces the notion of auxiliary egos, defines the terms and asks the protagonist to select group members to portray significant others in the ensuing role-play. At that stage, the double and auxiliary ego concepts are further defined and used. The didactic approach combined with role playing helps bridge the cognitive and psychodramatic models and illustrates how an action intervention helps explore the underlying meaning of automatic thoughts to promote an understanding of one's dysfunctional schema or core beliefs and behaviors. The therapist can then use such understanding to facilitate further problem solving and to fracture the cycle of the protagonist's negative moods, thoughts, and dysfunctional behaviors.

In subsequent sessions, a discussion of the DTRs, completed as homework, opens the warm-up phase of psychodrama. The situations listed in the DTRs become the basis for role playing during the action phase and for selecting a protagonist. The therapist can use sociometric techniques to select a protagonist (see Kumar & Treadwell, 1986). The classic psychodra-

ma techniques of role reversal, doubling, self-presentation, interview in role reversal, mirroring, future projection, surplus reality, empty chair, and other action techniques (Moreno, 1934; Blatner 1996; Kellerman, 1992) can be applied directly to situations indicated in the DTRs. The therapist encourages the group members to take an active part in one another's dramas, enabling the protagonist to bring the situation as close to real life as possible. During the action component, doubles and other auxiliaries suggest automatic thoughts, emotions, cognitive distortions, and alternative interpretations of the protagonist's automatic negative thinking processes. Thus, psychodramatic role playing provides group members with opportunities to generate new ways of thinking and behaving and to use those new techniques in the group to test the impact on those around them before applying them in their everyday life.

After the action component and during the closure phase, the protagonist and other group members are de-roled, bringing forth the sharing of thoughts, feelings, and behaviors that the role(s) elicited (Blatner, 1996; Karp, Holmes, & Tauvon, 1998). Before closing the session, group members look at their respective DTRs and make any changes that they think are appropriate as a result of the insights they have gained during the action phase. Changes can be made in writing or in action. Supplementary sharing may be used to bring closure to the session.

At the end of the session, group members complete at least one DTR as homework during the week. Requiring homework is a common technique in the cognitive behavioral model, used for practicing new ways of thinking and behaving. The DTRs completed during the week serve as the warm-up at the following week's session. It is our experience that the momentum for fostering action occurs prior to each session when group members complete DTRs. The clients come to be regard the DTR as a between session(s) warm-up technique that allows them to prepare for each successive session. With practice, participants are able to complete DTRs mentally as they confront stressful situations and their habitual dysfunctional thoughts.

Automatic Thoughts (ATs)

The automatic thoughts themselves can become the focus of psychodrama action. Automatic thoughts (e.g., "I am such a jerk") are habitual, unconscious responses to difficult experiences. Together with images, dreams, and memories, they form the cognition part of schemas or core beliefs, that perpetuates a negative-thinking spiral that maintains problematic behavior(s) and mood(s).

During the initial sessions, group members learn about how automatic thoughts (ATs) emerge and how to identify them in the context of completing a DTR. An AT picked up from any member during the warm-up phase or

sharing stage can set the stage for further role-playing scenarios and spin-off psychodramas.

An example of an automatic thought, in the case of a student who is having trouble speaking up to her roommate, may be expressed as follows: "That bitch—she makes me feel responsible for her error." That AT leads the therapist to develop a scenario to explore the situation that led to the student's AT. The therapist then has the protagonist select a double and an auxiliary to portray her roommate in the following scenario:

> The situation began as an argument between the protagonist and her roommate. The situation escalated when the protagonist's roommate yelled and demanded for her to come in the room so they could talk about something.

Automatic thoughts usually contain one or more *cognitive distortions.* The auxiliaries and the therapist may help the protagonist discover the possible cognitive distortions in the protagonist's stated AT, as in the following illustration:

> *Double:* If I can't take care of my roommate, I'm a failure.
>
> *Therapist:* Did the double correctly express your thoughts? If so, what might be a possible cognitive distortion that is reflected in the double's statement?

(If the protagonist has difficulty, then an auxiliary or the therapist may ask, "What would be the worst thing that could happen to you if you paid no attention to your roommate?")

> *Protagonist:* I have failed.
>
> *Double* (echoing): I always fail so I have to help her,
>
> *Therapist* asks the protagonist: What might be a cognitive distortion in your double's statement?
>
> *Protagonist:* All or nothing or black and white thinking.

To follow up on the identified all-or-nothing cognitive distortion, the therapist develops a scenario to explore it in an action format to get an in-depth, concrete explanation of the protagonist's thought processes. That may be accomplished by using additional auxiliary egos or by using the self-presentation technique to represent the many conflicting selves. The cognitive double, as an additional auxiliary ego, can aid the protagonist and the auxiliaries in expediting constructive decision making by emphasizing the affirmative components of the protagonist's thought configuration. The technique of self-presentation provides the protagonist with opportunities to identify and expose competing conflictual beliefs that make decision making difficult and result in confused behavior and negative thinking.

Downward Arrow Technique

To gain a deeper understanding of what automatic thoughts might mean, we used the *downward arrow technique* to harvest evidence that supports or does not support core beliefs and schemas. The double and auxiliary egos assist the protagonist in using the downward arrow technique.

The downward arrow technique consists of challenging the protagonist by repeatedly asking the question: If that were true, why would it be so upsetting? The technique can be used during any stage of psychodrama to explore the core beliefs underlying an AT. The following situation illustrates how to use a thought record to identify an AT and then how to the use of the downward arrow technique to isolate the core belief or schema. The double and the auxiliaries also respond to the repeated question, and the protagonist verifies or denies the statement.

Situation: The situation began with an argument between the protagonist and her roommate. This situation escalated when the protagonist's roommate yelled for her to come into the room so that they could talk.

Mood (0 to 100 scale):
Irritated—90
Angry—80
Guilty—25

Automatic Thought: "That bitch."

Possible Meanings of Automatic Thought: With the downward arrow technique, the double (D) and auxiliary ego (AE, perhaps a close friend) respond to the therapist's questions, as does the protagonist (P), with help from the therapist (T).

P: I am selfish, but I can't let my friends know this.

T: Feeling selfish means what to you?

D: I'm not sure—I am not fond of myself.

P: I put others first. I give into others easily.

AE: She never pays attention to me! She doesn't put others first.

T: Giving in means what to you?

D: I detest myself!

P: It triggers my angry side. I get mad at myself!

T: And getting mad at oneself means what to you?

P: I can take care of others but not myself

AE: That is such bullshit! You never take care of others.

T: And not taking care of self means what to you?

P: I am bound to be alone! I am a selfish loser!

With the assistance of the double and auxiliary ego, we learn about the protagonist's dysfunctional thinking, behavior, and mood, and hypothesize alternative behavioral strategies based on her notion of feeling "left-out and thinking I am always going to be alone."

Case Conceptualization

The case conceptualization technique is applied as an ongoing therapeutic tool. After three or four sessions, the therapist explains the main ideas behind the technique to the group members and asks them to complete the case conceptualization forms on an ongoing basis as the group progresses. A members discusses his or her completed forms with the group on an assigned day. Case conceptualization may help the group members reflect on their various rules, conditional assumptions, beliefs, and means of coping. It is also a good way of introducing the cognitive triad to patients who characterize their situations to reflect themes of loss, emptiness, and failure. Beck (1995) referred to such bias as the negative triad, viewing oneself ("I am worthless"), one's world ("Nothing is fair"), and one's future ("My life will never improve") in a negative manner. This pessimistic view is usually a distortion, and the purpose of designing a case formulation is to challenge the patient's views of self, the world, and the future. Data for the case conceptualization comes from psychodramatic role playing of one's own situations and observing those of others. We illustrate below how such data can be gathered in action and how the data can later be used in completing a case conceptualization form (see Table 1).

Gathering data. Interview in role-reversal technique and designing scenarios to gather relevant data.

In this situation, the protagonist took on the roles of mother, sister, grandmother, and father. To put scenes in action, the protagonist selected members from the group to role-play family members or significant others. Cognitive and contained doubles (representing both negative and positive dimensions of protagonist) were selected from group members. The protagonist then set the stage and identified needs that were not being met.

In the role play, the protagonist explored her future (without guilt), attempted addressing her needs (being more assertive), broke away from her mother, and continued her education. She agreed to explore her overwhelming feelings of needing to care for others. She also explored how to find a summer job

TABLE 1. Example of a Completed Case Conceptualization Form

Childhood Data
Parents separated; depression within the family; attention focused on sister (bi-polar); grandmother demanded attention.
Schemas or Core Beliefs
Defective (something is wrong with me)
Bound to be alone (abandonment)
Conditional Assumptions, Rules, and Beliefs
If I cling to others, then they won't leave me.
If I keep anger to myself, then others can't get upset with me.
If I take care of others, then they'll need me.
If I show the real me, then people will leave me.
Compensatory Strategies
I do for others; I put them first.
I make sure that others see me in a good mood (smiling).
I never let others see the hurt and angry Me.
I avoid situations that require me to ask for help.
I avoid people when I am angry.
Situation
Dealing with roommate
Automatic Thought
Bitch—she makes me feel responsible for her error.
Why do I get angrier when I take care of her.
I hate myself.
I am not important.
I am not good enough; I'll never meet others' expectations.
I am scared that I am going to be left alone.
Meaning of Automatic Thought
I give in so that people do not see my real needs.
I let everyone think that I am always a caretaker.
That makes me unimportant.
I am scared that I am going to be alone; I'm paralyzed by that thought.
Emotions
Sadness, anger
Behavior
Cries, withdraws, avoids people

with financial stability so that she could save money for graduate school. The protaginist chose several individuals to play the roles of mother, sister, father, double, and cognitive double.

The group gathered the following data from the role playing and then completed the case conceptualization form.

Hypothesis formulation. The protagonist offered her hypothesis about her situation: If I can always take care of people, then I won't ever be alone.

Evidence that supports the core belief of abandonment. The protagonist has not spoken to her father in 17 years. Her father and mother never married. Her mother has not been able to maintain significant relationships. Her mother never married, but her father did marry. Her mother worried that if her daughter left home, she would be left alone.

Evidence that does not support the core belief.

Positive family support system

Affirmative social support/friendship relationships

Develops friends easily

Graduated from college

Secured a meaningful job

Financially responsible, has apartment, and lives on her own

Applied to graduate schools to continue education

Her younger sister left home and lives successfully on her own

Core belief or schema. Abandonment—the protagonist believes that she is bound to be alone.

Conclusions

After our experience with CBT techniques, we believe that they can be used effectively within the context of psychodrama. Students and clinical populations respond well to the CBT techniques and find them helpful in becoming aware of their habitual dysfunctional thought patterns and belief systems that play an important role in mood regulation. Therapists can use techniques not illustrated in this article, such as an advantages/disadvantages matrix and the preparation of coping cards during role playing or as homework. Therapists can expect some resistance from group members, especially with regard to their not completing DTRs on time or their unwillingness to share their DTRs with the group. We found, however, that group members quickly begin to see the usefulness of the various structured CBT techniques.

One of the most important elements of CBT is that it is data based—group members keep track of their dysfunctional thoughts, depression scores, anxiety scores, and helplessness scores from week to week. They are able to see changes that result from group therapy that makes the therapeutic process a tractable one. The use of CBT techniques allied to psychodrama helps provide

a balance between an exploration of emotionally laden situations and a more concrete, data-based, problem-solving process.

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Real-Life Role Play: A Cognitive Therapy Case Study With Two Young Sex-Abuse Survivors

JULIE E. JACOBS

ABSTRACT. The author of this case study describes the use of an adaptation of role-playing in cognitive therapy with two adolescent sex-abuse survivors who were treated in individual and conjoint sessions. Each girl had been sexually abused by a male caregiver. Both men committed suicide after the girls disclosed the abuse. Both girls benefited from sharing insights in the conjoint sessions, with the older girl enacting the role of teacher and the younger girl that of learner. Both were able to challenge and change beliefs about their trauma histories and emerged with different beliefs about themselves, others, and the future, and consequently were able to react differently to their pasts.

Key words: real-life role play, role play in cognitive therapy, treating sex-abuse survivors

RESEARCHERS HAVE DOCUMENTED THE USE OF ROLE PLAY in a variety of therapeutic contexts, including its use as one technique among many in cognitive therapy (cf. Beck, 1995) and as a separate mode of therapy in psychodrama (cf. Moreno, 1964, cited in Kipper, 1996). In this case study, I present an adaptation of the role-playing process, which I used in cognitive therapy with two children who survived similar traumata. I describe details of the case and offer a brief discussion of the various aspects of role playing in different therapeutic contexts.

In its broadest context, as Kipper (1996) outlined in a historical overview, role playing has been used for thousands of years, in religious ceremonies, among children practicing for adulthood, and, since the 1930s, in a variety of systems of therapy. As he writes, "Role-playing has been associated with the alleviation of feelings of helplessness and uncertainty; with reducing the

discomfort caused by fears; with instilling hope; with forming a coherent sense of self-identity; with healing; and with efforts to enhance understanding among people" (p. 101). In psychodrama, role-playing has been seen as creating a "therapeutic culture in miniature" (Moreno, 1964, p. xxii), in which an "unsatisfactory natural habitat" (Moreno, 1964, p. xxii) can be replaced or extended to allow healing to take place. In that context, therapists use group role playing as a strategy when working with abused children (cf. Bannister, 1997), building from the observation that once the safety of the therapeutic context is established, the interactions among a group of children can be as powerful a healing mechanism as those between the therapist and client.

Among cognitive behavioral therapists, role playing is one of many written, artistic, and play-based techniques used in treating children who have been sexually abused, with goals that are parallel but differently defined. Role playing is seen as one way to help decrease children's blame of themselves for the abuse and, more accurately, to attribute blame to the perpetrator (Celano, Hazzard, Campbell, & Lang, 2002). As in other forms of therapy, a sound alliance between the child and the therapist is necessary before the shift in attribution can take place.

In the present case, I treated two girls in the same small community who had each experienced prolonged sexual abuse by a male caregiver. When girls disclosed the abuse, the perpetrators committed suicide. That left each girl devastated; each felt responsible not only for the sexual abuse but also for the additional trauma of having "caused" the adult perpetrator's death. The two girls, who did not know each other, disclosed the sexual abuse at age 10. One girl is now 15 and has undergone additional traumata in the subsequent 4 years. The younger girl was brought into treatment at age 10, right after the perpetrator's suicide. The current intervention involves bringing the two girls together for several conjoint sessions. In essence, each girl provided a real-life role-playing experience for the other, which allowed both to progress in their healing. The older girl was able to make meaning of her trauma by experiencing the new role of teacher and helping the younger child avoid some of the pain that she had experienced. The younger girl was able to be comforted in a way that was much more immediate to her than adult interventions had been. In the role of the learner, she received the undivided attention of another survivor. The older survivor, in the role of the teacher, described how she had not only survived but also had thrived after hard work in therapy, in school, and within her family. I hope that my report of this case study, which illustrates one possible strategy for helping young abuse survivors, encourages other therapists to adapt the process of role playing for use as a powerful tool for healing and growth. The girls' identities have been altered to protect their privacy.

Case Histories of the Two Girls

Jamila

Jamila, a 10-year-old African American girl, lived in a small rural town in the southeast part of the country. Her father had been raping her for 18 months when she confided in a friend. Within the next 36 hrs, the friend told her own mother, who contacted the school's guidance counselor, who contacted Jamila's mother. The same day Jamila's mother learned of her daughter's disclosure and confronted the father, who committed suicide. Jamila was left with the terrible belief that she was guilty not only of causing her father's death but also of somehow causing or at least allowing the original abuse to take place.

Shantira

In the same small community, Shantira, a 15-year-old African American girl, had a similar history. She was raped by a babysitter when she was 5, then years later was raped repeatedly for more than 2 years by her mother's boyfriend. She disclosed the latter abuse to another relative, extracting the promise of strict confidentiality. A week later, after news of the disclosure had sped around the family, her mother's boyfriend committed suicide. Shantira too believed she had caused the man's death and was furious at the relative for telling anyone of her history, especially for disclosing it to her mother. For the 2 years after the perpetrator's suicide, Shantira dressed only as a boy, in baggy rap-style clothing, had a man's haircut, and wore a baseball cap. In her role as a boy, she began to proposition other girls and went to juvenile prison for assault after violently attempting to rape another girl.

I first began to treat Shantira for posttraumatic stress disorder. She, her mother, and her younger brother were all known well at the clinic where she was being seen. Shantira's mother, a drug user and alcoholic with her own history of childhood abuse, had lost custody of her daughter and son during Shantira's elementary school years. She had regained custody and was attempting to remain sober but had a history of anger and violent acting out. Shantira had been in treatment on and off since early school age because of acting out in school. Although she had not disclosed the earlier sexual abuse at that time, the neglect and physical abuse she endured were severe enough that she was removed from her mother's home. A variety of behavioral problems caused her to be referred for care by her foster parents. When I began seeing her, Shantira had recently refused treatment from another therapist at the clinic. Both she and her mother were furious at the previous therapist and, in general, were hostile toward the personnel at the clinic. Each had refused to be treated by two or more previously assigned therapists and was known in the clinic for her temper.

Despite her initial skepticism, hostility, and mistrust, Shantira made steady progress; she was ready to improve her life and worked in therapy to do so. We first focused on the relationship she had had with her earlier therapist, the most recent woman she had rejected. Shantira reported that that therapist had suggested that her relationship with her pet might have erotic overtones. Without disparaging the therapist, I began to discuss issues of mistrust with Shantira, explicitly giving her permission to give me honest feedback if she disagreed with my comments or found them unhelpful. Shantira also felt betrayed by the previous therapist in terms of confidentiality issues with her mother. We hammered out specific agreements as to what would be discussed and decided together that Shantira's mother would attend occasional sessions and that I would always allow Shantira to hear everything that I told her mother. After Shantira's trust in me increased somewhat and with her permission, I also worked with school personnel (with whom I already had a relationship) and with the for-profit company that furnished her with an individual aide at school to help facilitate a productive re-entry into school after her incarceration. With the aide's help, she began avoiding fistfights at school and earned A's and B's for the first time. She found her new success enormously gratifying, even though she knew it represented a rebellion against the norms for her neighborhood. Her attitude also was reinforced by her aide, who arranged special events (e.g., dinners out, group trips to sporting events) because of her increasing compliance at school. As the weeks went by, she tested me with verbal challenges and with information that we had agreed I would not share with her mother. I consistently upheld my part of the confidentiality bargain and never rose to the bait when she was hostile or sullen; I simply tried to process her moods and to redirect her to her original therapy goals.

Despite Shantira's reluctance to discuss her prior trauma, she genuinely made an effort to process it and to overcome her own avoidance. She rarely carried out standard cognitive therapy homework assignments, even though we set the homework collaboratively and she agreed each week that she would do the exercises. Nonetheless, Shantira demonstrated insight into the strategies that I presented and used appropriate techniques, such as challenging and changing her own distorted beliefs, when she was confronted with difficult situations.

Oprah-Style Role Technique

After 8 months, Shantira was so proud of her own successes that I spontaneously asked her if she wanted to tell other people what she had learned. Collaboratively, we came up with the idea of making a videotape of a mock Oprah-style talk show, in which she told an imaginary studio audience all of the things that she had endured and how she had overcome her problems. During the session when I pretended to be Oprah and videotaped her responses,

she disclosed additional details of shame and pain that she had never discussed before, speaking in a calm and dignified way, in contrast to her earlier coarse and angry style. For example, although she had refused previously to revisit specific details regarding the rapes and sodomies she had endured, she courageously described events in detail on the tape, without being asked, with the goal of educating her imaginary audience. She explained why she had identified so strongly as a boy, reporting that she had felt so disempowered and weak as a girl. She explained that she was beginning to understand that she could be powerful and have some control over her life and within her own skin as well. As she said, "I never thought I was strong enough to protect myself. I thought being a man would put me in charge. Now I'm starting to see that I can have power and not have to change who I am." The Oprah-style role technique seemed to allow her to challenge her own role misperception.

For the tape, Shantira described how she and her mother were working on their difficult relationship, saying that she was beginning to forgive her for failing to protect her from both abusers. In addition, she said that she no longer felt paralyzing guilt, terror, or extreme rage at her male abusers. For her, she said, the multiple traumata—being sexually abused by two different men, being taken from her mother's custody, having her mother's boyfriend commit suicide, having lost years of nurture and protection from her mother because of her mother's substance abuse—had been difficult, but ultimately had helped her develop a strength of character that she had not believed possible.

At one point in the taping, I, as Oprah, asked her what her biggest problem had been 4 months earlier in therapy. I fully expected her to discuss her pattern of dressing and acting as an aggressive boy. Instead, she quickly stated that her therapist had been her biggest problem. At that, I laughed out loud and then, regaining composure, asked her what the problems had been. She told the imaginary studio audience that she had originally been turned off by my efforts to conduct therapy with her and considered me flaky, but that she gradually believed that even with my somewhat irritating flaws, I was genuinely trying to help her. I believe she was suggesting that she might have dismissed me as well and continued her pattern of mistrusting therapists. Had I not continued to hang in there, irreverently at times, even when she was doing her best to test limits and push me away, she might have dismissed me too. It made sense to me that Shantira mistrusted me; in her past relationships, people in the authority role frequently had harmed her. She had discovered in the course of therapy that when the authority role was somewhat redefined, a person with power in her life could help her.

As we closed the taping session, I realized that Shantira believed that the video would somehow actually be shown on television. I assured her that I believed she had a lot to tell other people, particularly other people her age, but that I believed for her own privacy now and in anticipation of her adult self's

desires for privacy, it was best that she keep the only copy of the tape. She decided to keep it rather than to destroy it, so that she could look at it in the future and review her own progress, without any risk of losing anonymity.

In the session after the filming, Shantira said that she had enjoyed making the video as much as she remembered enjoying her first play therapy sessions, when she was referred to the clinic by her foster parents at age 6. At that point, she had not disclosed the sexual abuse by her babysitter; her memories of play therapy were that it was always fun and never involved discussing painful issues. She associated that therapy with a woman who had long since left the clinic as her first experience of a relationship with an adult that was secure, warm, and supportive.

Working With Jamila

I began to see the second girl, Jamila, after I had been seeing Shantira for some time. I was immediately struck by the similarity in their stories. Unlike Shantira, Jamila herself had requested to come to therapy, telling me astutely in her first session that her goal for therapy was to cease to believe that the abuse and the suicide were all her fault. Again unlike Shantira, Jamila enjoyed doing her therapy homework and was thoughtful in doing so. From her earliest sessions, she began keeping a therapy notebook, in which she laboriously summarized our insights from each session and even wrote down notes detailing how she had benefited from her various homework assignments. She was quite invested in her homework and benefited from it greatly.

One strategy in Jamila's therapy that she found useful was derived from the fact that she had been learning fractions and decimals at school. I asked her to estimate the extent to which she felt responsible for the abuse and suicide. In the first weeks of therapy, she estimated that she felt 95 percent responsible for both the rapes and the suicide. Each week, we checked in to see if her assignation of blame had changed. Some weeks, our work led to a reduction in the percentage of responsibility that she assigned herself. Other weeks, her own pain led her to take back percentage points of responsibility.

I was amazed by Jamila's insight and nuanced thinking as we discussed her ambivalent thoughts about her father. She loved him and craved the attention he gave her, but she had been ashamed of participating, even unwillingly, in the sexual acts themselves. She missed him and felt guilty at having disclosed the situation, thus leading to his suicide. She also had been badly hurt and betrayed by him and believed he had been cowardly in leaving her life when he did. She was furious with her father, but she yearned for more love from him. She blamed herself but did not believe she was to blame. Because she had occasionally responded sexually to some of the acts, she felt intense guilt and shame about those confusing physical responses. As one strategy in therapy, she wrote

letters to her father, aware of course that he would never read them, in which she articulated in her childish handwriting all her complex thinking about the pain he had caused her and the aching way she yearned for him after his death.

Possibility of a Joint Session

After several months of seeing both girls individually, I began to think about seeing both girls in the same session. I obtained permission from the girls' mothers, both of whom sometimes attended sessions with their daughters but showed limited insight into their daughters' problems, to discuss with each girl the possibility of the girls' having several joint sessions. My rationale was that both had experienced similar extremely painful traumata. In addition, the older girl, who clearly wanted to teach others what she had learned, might be better able than I to help the younger girl come to terms with the fact that she ultimately was not to blame and could not control any of her father's actions, especially his decisions to rape her and kill himself. I believed both girls would benefit from a sense of connection with an expert, someone who understood their personal situations explicitly. I also thought each might challenge her pervasive mistrust of others by discussing painful and private issues in a confidential setting with someone else who obviously understood. As each learned to trust the other, I hoped that they might trust themselves and their ability to cope and to succeed.

I then presented to each girl the idea of having joint sessions, explaining that there was at least one girl in the community who could understand her experiences in detail, having endured much the same pain. Each might be able to communicate with the other in a way she could not with me. I explained that each might be able to find new meaning in her history by sharing it. I told the older girl that I thought she would be able to teach the younger through her experiences, and I told the younger that I thought she could learn a great deal from the older girl. I spoke of mistrust to each, and said I hoped that each would see, through the experience of sharing her experiences in a safe place, that it was possible to trust some people some of the time. I discussed confidentiality, stressing its importance, and explained that if either felt any misgivings about the process, each could refuse to continue for any reason. Each was frightened and thrilled simultaneously by the idea of a few shared sessions with a fellow survivor. For several weeks, I discussed the advantages and disadvantages of holding the sessions with each girl individually. Both ultimately decided that the potential pros outweighed the cons and agreed to meet for three sessions as a triad (the two girls and me).

I was initially surprised by the changes in the girls' presentation styles in their first meeting. Shantira displayed the tough, "gangsta"-type demeanor that she had demonstrated to me in our first sessions, soon after her release

from "juvie jail," as she referred to her incarceration. She was blunt, coarse, and forceful, unlike her calm and contemplative behavior in the most recent months of therapy. Shy, gentle, and bookish Jamila, similarly, surprised me with an initially tough presentation. By the end of the first session, she clearly was enamored with Shantira, looking at her with adoration and awe that Shantira took time to talk with her. I moderated the first part of the first session, asking questions of each girl consecutively. By the last 15 minutes of the session, however, each girl was spontaneously asking questions of the other and comparing stories. In retrospect, I imagine that they had mentally gone through the process of summing each other up and had created their own agendas for the rest of their time together.

As Jamila became increasingly more worshipful, the older girl warmed to her task of passing on wisdom. During the second session, she described her incarceration, again revealing painful details in this more public forum than she had with me alone. She told the younger girl that she did not want her to have to live through the pain and degradation of such an experience, encouraging Jamila to learn from her own ordeal. She also offered to answer any questions the younger girl might have. The girls were remarkably open and explicit, given that they had only met once previously.

In the third session, without prior discussion with me, Shantira spontaneously brought up the issue of self-blame about the unwanted sexual contact, the sensations of physical arousal, the appeal of being nurtured in any fashion in a life of deprivation, and the ultimate betrayal and guilt about the perpetrator's suicide. Shantira straightforwardly told Jamila that although it was normal to feel responsible for what had happened, that in fact there was no way Jamila was responsible, that Jamila would not have blamed another young girl in a similar situation, and that to feel better, Jamila needed to begin to have hope and confidence in herself. Again, I was struck by Shantira's understanding of the therapy process, despite her refusal to do most of the homework that we had agreed she would do. She did not use the jargon of "challenging and changing distorted beliefs" but clearly had learned the process of working through a thought record. Shantira told Jamila that she could call her any time, which of course thrilled the younger girl. Both agreed they did not need to meet again.

Closure

In the weeks after those sessions, I discussed their impact with both girls and ultimately with their mothers. Shantira had a calm sense of mastery at having influenced someone else's life, thus imbuing her own suffering with meaning, knowing that it had ultimately helped a younger person. Within 2 months, she decided that it was time to take a break from therapy. She knew

it was available to her in the future but did not believe she had issues that she needed to work through at the moment. She had begun to have a relationship with a boy at school, her first boyfriend; she had decided that it would not become sexual at this time, and he was respectful of her decision. She was seriously considering applying to college in the future and would be the first from her family to attend.

Jamila remained in awe that someone as "amazingly cool" as Shantira had spent any time with her at all, let alone that she would confide in her and try to help her. I asked Jamila how responsible she thought Shantira had been for her own abuse. She was stunned and somewhat outraged that I could imply that her new idol bore any responsibility for the trauma. When I gently pointed out that her own situation had been remarkably similar to Shantira's, she grinned and said maybe she was changing her mind about "that stuff." She nonchalantly said she now believed she was 0 percent responsible for the abuse and the suicide. Although she still missed and loved the perpetrator, she believed both of his decisions had been his responsibility and had been wrong. I had more evidence of her healing at the next session. Typically, at the end of each session, Jamila would summarize her understanding of the importance of the material we had covered. When she was finished, I would offer my own commentary. She would diligently write down each insight. I knew things were different when she politely nodded at one of my offerings but did not attempt to write anything down. She was becoming her own therapist.

Jamila's mother, who had a low IQ and showed very little insight into caring for her daughter (in an early session with me, for example, she had angrily and tearfully accused her daughter of causing the perpetrator's death), even agreed with her daughter's courageous request that, at this time, her mother not invite her new lover to live with the two of them because it made the girl feel unsafe. Given the fact that the mother openly stated that the new lover was using drugs, I was relieved that the mother showed new respect for her daughter's concerns, and that Jamila had a new sense of self-efficacy.

Discussion

When I began to work with these girls, I had read nothing about working with just two people (rather than a group) on similar abuse issues when the survivors were at such different developmental points. I was apprehensive that one or both of the girls would feel overwhelmed by the other's stories, would betray the other's confidentiality, or would somehow feel worse after the encounters than they had before. I believe that the rapport I had with both girls before the shared meetings allowed them to consider potential risks before giving informed consent to participate. I was surprised by many aspects of the shared meetings but was ultimately heartened by the fact that both girls

appeared to have grown from the experience. By offering the girls the structure of cognitive therapy and the security of a strong alliance, I was able to pave the way for them to meet. Of course their work together was entirely their own doing, and I was humbly impressed by their courage and strength in processing such difficult material so openly together.

The intervention, in essence a real-life, Oprah-style role play, provided a new set of experiences to each girl that helped change profoundly their interpretations of the painful experiences they had undergone. Although those new experiences were in the artificial setting of a therapist's office, they were as potent as if they had taken place in daily life, in that the enactors were uniquely able to understand each other and thereby to help each other modify emotions, attributions, and dysfunctional thoughts and behaviors. Their interactions simulated reality and created a reality, invoking emotional and cognitive processes that were identical to those that might have been created instead in the outside world (Kipper, 2000). The adverse consequences of each girl's earlier trauma were profoundly altered within the therapy room. The girls' new experiences with each other were incompatible with their earlier experiences, in that they afforded a sense of control, competence, and mutual support where none had existed before. Their interactions were in that sense a rehearsal for life (Yablonsky, 1976), in which each girl made meaning of her own experience, gave to the other, and emerged with a greater sense of hope and potential for positive bonds with others, even in connection with the most painful aspects of their young lives.

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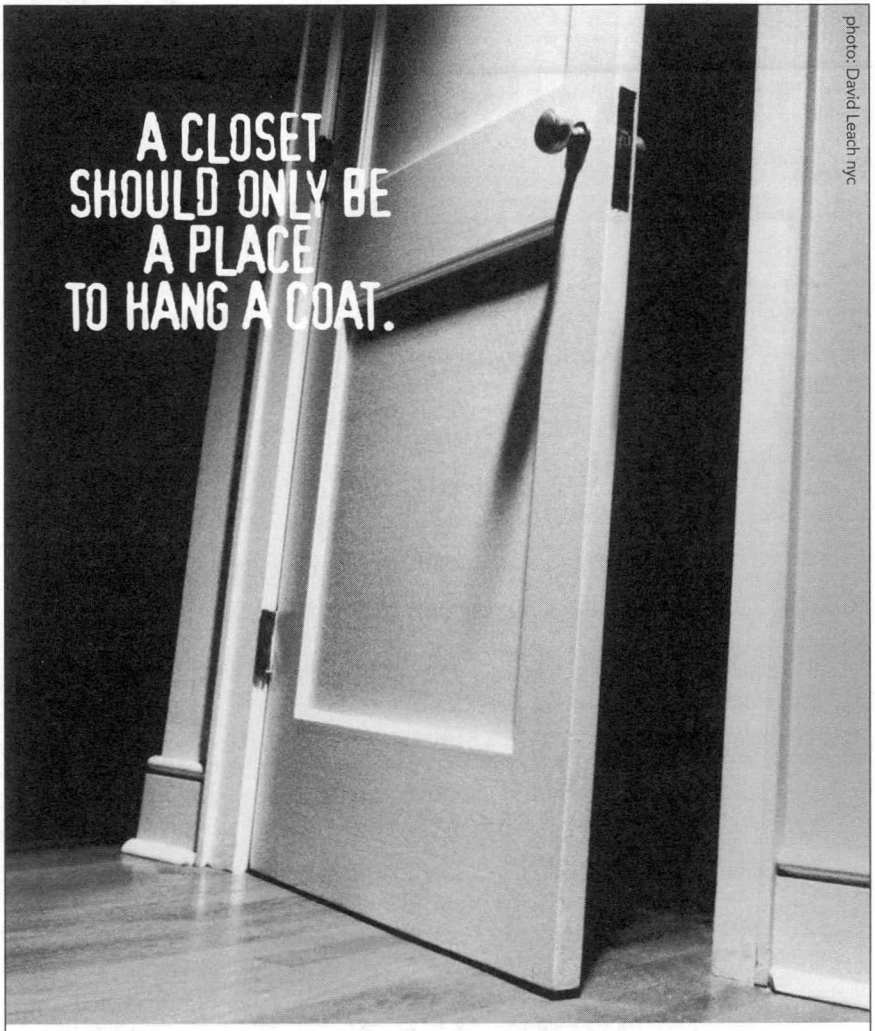

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A Cognitive Therapy Approach for Treating Chronic Procrastination and Avoidance: Behavioral Activation Interventions

J. RUSSELL RAMSAY

ABSTRACT. Traditional cognitive therapy (CT) focuses on identifying and modifying patients' distorted cognitions. Patients often find that they have overgeneralized the severity and pervasiveness of their difficulties, and CT helps them to reassess their circumstances and modify their misconceptions. For many other patients, however, treatment involves dealing with complex problems and recurring frustrations that are not as easily overcome by merely focusing on distorted cognitions. Those pervasive problems can engender a sense of hopelessness that results in chronic avoidance and procrastination. In this article, the author discusses clinical strategies for helping patients overcome avoidance and procrastination associated with longstanding functional problems. Specifically, the focus is on the problems faced by adults diagnosed with attention-deficit/hyperactivity disorder (ADHD) and highlights the use of the cognitive case conceptualization and other clinical interventions to help patients foster a sense of resilience in facing problems and pursuing their goals.

Key words: cognitive case conceptualization, cognitive therapy with ADHD, treating avoidance and procrastination

THE THEORETICAL NOTION THAT UNDERLIES traditional cognitive therapy (CT) is that psychopathology and functional difficulties can be formulated in terms of cognitive distortions and faulty informational processing (Alford & Beck, 1997). One of the canonical questions asked in traditional CT is, What is the evidence for your automatic thought? That question starts the process of cognitive modification by inviting patients to consider alternative interpretations to their initial reflexive conclusions. Not surprisingly, patients tend to dismiss their strengths and abilities and to overgeneralize the

extent of their failures. A patient who is a college student might report the automatic thought, "I'm a failure. I won't graduate from college," after earning a below-average grade on an examination. Socratic questioning may help the student decatastrophize the consequences of the poor grade, to recognize that one grade does not portend whether a student will finish college, and to explore and improve the student's preparation strategies for the next exam. Many patients find that the process of examining the evidence helps them to contest their negative automatic thoughts and generate a sense of resilience and optimism.

The problems that some patients bring to therapy, however, are not solely the result of faulty information processing and may indicate long-standing and complex problems that affect their functioning in various life roles. Some may have had more than their fair share of hardships, losses, and life stressors. For others, the facets of daily living (e.g., work, school, relationships, personal organization) that most people take for granted may pose significant challenges and be sources of significant strife for patients as a result of severe, chronic psychopathology or learning disabilities. That is not to say that those documented difficulties make attempts at cognitive modification moot. On the contrary, those pervasive problems affect a patient's identity, contributing to a negative sense of self in a downward spiral of avoidance and self-recrimination. The ensuing demoralization and learned helplessness (e.g., Seligman, 1991) may well interfere with the patient's willingness to take on subsequent endeavors, including therapy. Patients who present for therapy with complex difficulties often struggle with ambivalence that is manifested in the form of procrastination and avoidance. Unlike Dr. Panglossi in Voltaire's *Candide*, those patients doubt that "all is for the best in this best of all possible worlds" and are skeptical about viewing their problems as resulting from "distortions."

In this article, I suggest clinical strategies for helping patients with chronic difficulties and disappointments to overcome procrastination and avoidance so that they engage in therapy and develop a sense of resilience in pursuing their goals. To give coherence to this topic, I focus on the challenges faced by adults with attention-deficit/hyperactivity disorder (ADHD), a clinical population whose symptoms and difficulties have often gone undiagnosed and unappreciated for years before they seek treatment. Those adults often describe a history of not fulfilling their potential and, though not part of the diagnostic criteria, of struggling with associated problems, such as disorganization, procrastination, and avoidance that further undermine their coping efforts. After presenting a description of ADHD in adulthood, I give specific clinical strategies for conceptualizing and intervening with procrastination and avoidant behaviors, which include using the case conceptualization to make sense of the patient's difficulties, assessing the patient's readiness for change, setting up meaningful and realistic goals, and specific behavioral activation interventions.

ADHD in Adulthood

ADHD affects 3% to 5% of the school-aged children in the United States, making it the most prevalent childhood behavioral disorder (American Psychiatric Association, 1994; Barkley, 1998). The disorder results neither from cognitive distortions nor from deficient parenting or any singular environmental factor. It is a highly heritable neurobehavioral disorder whose hallmark symptoms—developmentally inappropriate impulsivity, hyperactivity, and inattention—have been linked to deficits in the executive functions (i.e., working memory, regulation of affect/motivation/arousal, and analysis and synthesis of information) associated with the prefrontal cortex (Barkley, 1997, 1998; Faraone & Biederman, 1998).

The symptoms of ADHD are often first detected in childhood but continue well into adolescence and adulthood for a considerable number of individuals. Older adolescents and adults with ADHD face a number of unique challenges that include greater difficulty with psychological adjustment, higher incidence of substance abuse, higher incidence of comorbid learning disorders, and lower levels of education and occupational achievement than nonclinical controls (Barkley, 1998; Faraone et al., 2000; Murphy & Barkley, 1996; Weiss, Murray, & Weiss, 2002; Wender, 1995).

Patients who are first diagnosed with ADHD in adulthood often present for treatment with a history of recurring problems that affect their ongoing sense of self. For many of those patients, school and other academic endeavors were difficult at best and torturous at worst. Keeping up with scheduled assignments, completing required reading, and formulating written essays were more difficult for the student with ADHD than for nonaffected peers. Some adults with ADHD were able to compensate for their symptoms with above-average intelligence and earned adequate grades in school. Most adult patients, however, who were undiagnosed and untreated as children and teens had lower grades than their peers had and were at a higher risk for failing a class, being held back a grade, being labeled as underachievers, or dropping out of school altogether (Murphy & Barkley, 1996; Weiss et al., 2002). Furthermore, the student likely received criticism from teachers and family or was told that he or she was lazy and not fulfilling his or her potential. Some students may have functioned adequately until they moved away to college, where they became overwhelmed by both the volume and difficulty of schoolwork, and the loss of the structure and the social support they had while living at home.

For many adults with ADHD, the difficulties extend into the work place, where there is often less external structure than at school. It is commonly assumed that adult employees will carry out their responsibilities with a minimum of supervision. Poor time management and disorganization often reflect

poorly on the worker with ADHD. As the individual increasingly views work as aversive, he or she is more likely to procrastinate, falling further behind in an insidious, self-defeating cycle. The accumulation of on-the-job difficulties or criticisms can lead to frustration and impulsive outbursts of anger that might further alienate the individual from coworkers and supervisors. Not surprisingly, adults with ADHD tend to change jobs more frequently than non-ADHD adults do (Murphy & Barkley, 1996; Weiss et al., 2002).

Finally, the symptoms of ADHD may negatively affect various facets of interpersonal skills. Poor time management and disorganization may contribute to friends' views that the person is unreliable. Others may interpret the patient's difficulty processing and retaining information in the course of a conversation as indicating the patient is not listening to them and does not care about the interaction. Not reading signs of nonverbal communication also interferes with relationship enhancement. Friends and significant others often report that they grow tired of having to repeat things and feel that the patient just doesn't get it.

All tolled, the symptoms of ADHD, especially when they have gone undiagnosed into adulthood, conspire to limit one's perceived life options and prospects. They weave their way through the domains of life from which we fashion our sense of identity. Adults with ADHD who eventually seek help often arrive for treatment with at least one comorbid psychiatric disorder as well as a host of associated functional difficulties, such as disorganization, procrastination, and a tendency to avoid or not complete important tasks (Weiss et al., 2002). Although the manifestations of ADHD are heterogeneous, a common theme for adults with ADHD is a sense that they have gained little fulfillment from school, work, or relationships. Indeed, most adult patients with ADHD describe a sense of not fulfilling their potential and having internalized as valid the many criticisms heard throughout their lives. Mapping out the nature and source of their problems is often the first step in the change process.

Diagnosis and Case Conceptualization

An accurate diagnosis of ADHD in adulthood requires that there be evidence of clinically significant symptoms that were first observed in childhood and that have persisted into adulthood. A careful clinical interview often reveals evidence of long-standing difficulties directly related to symptoms of ADHD, even if they had not been diagnosed as such when the patient was younger. Many of the symptoms of ADHD are nonspecific and may reflect other problems, such as medical conditions and other psychiatric disorders that could mimic ADHD symptoms. These alternative explanations need to be ruled out during a clinical interview.

Having an accurate diagnosis of ADHD provides many patients with the first coherent and constructive explanation of their difficulties. The patient often reprocesses various life events in the light of the newly gained understanding of the effects of ADHD. Sometimes the reprocessing activates feelings of anger or grief related to a sense of lost opportunity and unnecessary suffering. In effect, it is the initial foray into cognitive restructuring, developing an alternative explanation to the standard response of self-blame. When followed up with research into psycho-educational materials about ADHD, the patient's insight can encourage a sense that there is hope for change and there are strategies to help the patient better manage his or her symptoms. Although helpful in its own right, an accurate diagnosis fails to capture the essence of an individual's struggles. As Lakoff (2000) wrote:

> Unlike the individual case, the population had no particular history, no tale of relations with parents or rejections at school—it simply had a set of answers to given questions, and these answers placed patients together in a diagnostic category (p. 159).

Before we are able to foster a genuine sense of resilience in the shadow of pervasive and longstanding difficulties, however, we must first elucidate the nature of the patient's difficulties and the associated belief systems. The cognitive case conceptualization provides a means for understanding the patient's view of the world and serves as a guiding framework for treatment. It shows the patient's presenting problems in terms of her or his cognitive belief system and, in turn, how that belief system grew from particular developmental learning experiences. It accounts for the patient's current problems, explains past difficulties, and helps to anticipate future issues with a particular emphasis on her or his interpretive and attribution styles (Beck, 1995).

Before being diagnosed with ADHD, patients arrive for treatment with their own explanatory narratives for their problems. The narrative themes often reflect strong negative core beliefs such as *defectiveness* ("I'm basically inadequate") or *failure* ("I have not fulfilled my potential and accomplished what I could have"). The insidious nature of such core beliefs is that an individual makes life decisions based on the assumed veracity of the so-called facts. For example, a woman might avoid taking a computer course that could help her advance in her job because she defines herself as a horrible student, on the basis of the difficulties she had in high school.

More specifically, the case conceptualization serves to link together the patient's important developmental experiences, how those experiences have influenced one's core beliefs, and how the core beliefs are then translated into day-to-day conditional beliefs (e.g., If I do X, then Y will occur) about how the world works. In fact, it is sometimes the case that intervention at the level of the conditional beliefs brings about change in the core beliefs themselves.

For example, Michael is a 25-year-old waiter who was recently diagnosed with ADHD and Anxiety Disorder NOS. He worked very hard to earn passing grades throughout high school and community college but felt he could have done better. He remembered his parents and teachers telling him that he was wasting his talents and his potential. As an adult, he noticed the familiar feeling that he could be doing more at work but was reticent to take on too much responsibility for fear he would fail and be criticized. After being diagnosed with ADHD, we reviewed Michael's history and determined that he had developed a core belief of failure, based on his construction of himself from past experiences (e.g., I can't compete with others. They are more competent than I am.). From that core belief, he developed several syllogistic conditional beliefs with which he handled life, such as, "If I set a goal for myself, then I will not achieve it and will be disappointed. Therefore, if I do not set goals for myself, then I will not be disappointed." Not surprisingly, Michael's primary compensatory strategy was avoidance. By definition, compensatory strategies are maladaptive because they serve to constrict one's options and maintain negative core beliefs (Young, 1994). Michael came to see that not only did he avoid certain activities through procrastination, but he also avoided thinking about his options and numbed his emotions through excessive use of computer games and various unhealthy habits (e.g., smoking and alcohol use bordering on abuse). Making explicit his tacit core and conditional beliefs allowed Michael to see how they conspired to limit his options. CT helped him to challenge his conditional beliefs so that he could gather new experiences and, consequently, gain a greater measure of self-efficacy in his life, over time altering the core belief of failure.

Establishing the diagnosis of ADHD and developing a companion case conceptualization are only the first steps in the change process. The case conceptualization throws new light on the patient's history of difficulties, illuminating the concordant belief systems, and suggesting the direction of treatment and specific points of intervention. However, clinicians often proceed with therapy, assuming the patient's investment in the change process matches the therapist's own. That assumption can sometimes be faulty, and assessing the patient's readiness for change helps to clarify the patient's objectives for treatment.

Readiness for Change

When working with patients who have faced numerous and chronic disappointments in their lives, it makes sense to conclude that at least some of them are ambivalent (possibly based on past treatment disappointments) about the notion that treatment can help, even if the diagnosis and case conceptualization seem sound to them. It is important to remember that the patients' core beliefs, their distinctive constructions of reality, even when appearing to be

maladaptive in the current context, were born from developmental experiences and environments in which these beliefs were plausible and adaptive. Although an outside observer may see that those beliefs have outlived their usefulness, they may make perfect sense to the patient, considering the patient's developmental circumstances. Thus, the notion of changing those beliefs and compensatory behaviors can be threatening to many patients (Newman, 1994).

In line with CT's focus on beliefs, assessing the patient's attitudes about her or his problems and motivation to change (e.g., Prochaska, DiClemente, & Norcross, 1992) is a useful way to circumvent unnecessary resistance at the start of treatment. Patients in the *preparation* stage recognize the need to change their behavior patterns and are ready to experiment with new strategies. Those individuals might view the diagnosis of ADHD as the missing puzzle piece and eagerly anticipate the prospect of change. Other individuals, however, may be skeptical about treatment. *Precontemplation* is a term to describe the stage of patients who deny their difficulties despite obvious and ongoing negative consequences. Intervening at this stage involves consciousness-raising and helping the patient to define a problem in his or her life that would be useful to address. More frequently, clinicians encounter a patient in the *contemplation* stage. Such a patient probably acknowledges various difficulties but is hesitant about committing to treatment. Motivational interviewing (e.g., Miller & Rollnick, 1991), during which the patient is engaged in a discussion of the relative merits and drawbacks of changing versus staying the same, often helps clarify a treatment goal that the patient deems worthwhile.

That process can be a tricky one to navigate because the process of change itself might seem threatening to a patient who has faced numerous setbacks and grown generally discouraged. First, the notion that treatment could be helpful is antagonistic to the failure schema relevant for many adults with ADHD (e.g., "It won't work for me. I'll fail at this too."). Setting up realistic expectations for treatment and fostering a collaborative therapeutic relationship helps the patient engage in treatment. Educating the patient about the CT process can further head off unrealistic and ultimately self-defeating expectations. That is, the therapist explicitly predicts that there will be ups and downs in treatment and in the behavioral experiments that are developed as therapeutic homework. Those predictable imperfections, however, are normalized as part of the learning curve, providing useful therapeutic information rather than being framed in the all-or-nothing terms of successes or failures.

Some patients might be ambivalent about CT for fear that it will lead to improvements. For example, Kelly is a 20-year-old college student who dropped several courses that she had been failing during her freshman year. She contemplated dropping out of school altogether before being assessed for and diagnosed with ADHD. She started taking a prescribed stimulant medication and

entered CT to address her disorganization, her procrastination, and her shaky confidence. When she reported in a session that she had earned a B- on her first graded assignment since starting treatment, her Beck Depression Inventory-II score (Beck, Steer, & Brown, 1996) for that session indicated elevated levels of depressive symptoms, her highest depression score since her initial assessment. When asked to comment on the incongruity between her high depression score in the midst of an apparent success, Kelly said that she felt sad as she contemplated how her life could have been different had she been assessed earlier. Other patients have described feeling intimidated by the prospect of adjusting their expectations for themselves to take on novel challenges—and the probability of facing occasional disappointments—that promise to reactivate hibernating failure schemata. Reviewing the costs and benefits of engaging in treatment and committing to treatment goals are likely to uncover reasons for ambivalence and enhance treatment compliance. The exercise also acknowledges the myriad factors that make change difficult. Setting goals that the patient thinks are reasonable is another important facet of this process.

Setting Meaningful Goals

Even though a patient may be ready to embark on the process of personal change, it is important to clarify precisely the patient's expected outcome for treatment. Some patients arrive for therapy with reasonable and specific goals for treatment, recognizing the investments of effort and time required for achieving them. However, patients who have experienced such frequent setbacks in life that they approach new challenges warily often set goals that are ripe for re-enacting their disappointments.

First, there is a tendency to set unrealistic expectations or to underestimate the active role a patient plays in the change process. The patient may enter therapy expecting his or her problems to be resolved with a flash of cathartic and transformational insight, accounts of which the patient has undoubtedly read about in self-help books or online. For example, a college student who has struggled in school may expect that being diagnosed with ADHD and getting treatment for it then means that school will become easier, especially if the student has been granted academic accommodations (e.g., extended test-taking time). However, while an accurate diagnosis may explain the patient's recurrent difficulties, active and ongoing coping strategies are required to manage symptoms of ADHD. The prototypical student mentioned earlier might need to attend the college's learning resource center for additional academic support or to attend summer sessions or extra semesters to spread courses out over a longer time period than the traditional four years needed to complete an undergraduate degree. Rather than setting up the expectation that things will be easier, we often frame the student's situation as one requiring

continued hard work, but work that is more likely than old strategies to help the student achieve his or her objectives.

Another common scenario is that a student with ADHD has as a therapy goal to earn an A in a class. Although that is an understandable desire, the goal is an unreasonable expectation for what CT can provide. Socratically exploring the component behaviors of earning an A in a course might reveal that there are more reasonably attained behavioral goals embedded in that objective, such as spending more time studying, preparing adequately for assignments, and improving one's class attendance. The particular grade eventually earned then becomes more of a side effect of those other component skills and not the sole measure of a treatment outcome.

The reworking and rephrasing of treatment goals might seem like an exercise in semantics, with little relevance for CT. However, a central feature in CT is that how we cognitively frame experience, our internal dialogue, and our expectations significantly influence subsequent cognitive, affective, and behavioral experiences. Setting the stage for treatment in this manner helps the patient to make an informed decision about treatment and to anticipate and handle frustrations that could arise in the course of therapy. These issues are important throughout treatment and will be discussed in the next section.

Informed Decision Making and Resilience

The previous section dealt with setting therapeutic goals. Although treated as a discrete topic, setting goals is an ongoing issue. Each session and each therapeutic homework assignment stand as a point of decision for the patient about his or her commitment to a particular goal. At each juncture, the patient must consider the answer to two questions: "What decision should I make?" and "How will I handle the outcome if it is not one that I had intended?" For patients with ADHD, those questions are usually associated with automatic thoughts along the lines of, "I do not make good decisions, and I cannot handle any more disappointments." Not surprisingly, those automatic thoughts frequently result in the patient avoiding a decision or making an impulsive one or giving up prematurely. Two priorities in the treatment for adults with ADHD (and any patient who has faced a history of setbacks) are, first, to help the patient develop trust in his or her ability to make informed decisions and, second, to maintain a resilient attitude in the face of apparent setbacks and delays (Ramsay & Rostain, in press).

In our article for the *Journal of Cognitive Therapy: An International Quarterly,* A. L. Rostain and I use the phrase *informed decision making* to reinforce the notion that competent decision making does not necessarily mean there is a right decision that guarantees a desired outcome. Rather, we strive to help the patient consider all possible options, to anticipate possible

outcomes, and to consider mediating factors. Some patients who have experienced repeated frustrations express a reluctance to face a new challenge and risk their fragile self-concepts unless they are guaranteed a desired outcome. Patients often describe their decision-making styles in terms of a desire to avoid negative feelings associated with a failure, rather than as opportunities for growth. Engaging in an extended discussion of the relevance of the decision and different components of the decision-making process serves as a therapeutic form of exposure to negative emotions associated with uncertainty. Such discussions (including evaluations of the outcomes of decisions made) serve to foster a sense of tolerance for frustration and to increase the patient's sense of competence in making decisions and following through with action (Ramsay & Rostain, 2003).

Resilience is an important partner to informed decision making because it is impossible to make decisions and pursue goals and experience without encountering setbacks and frustrations. Normalizing the role of trial-and-error learning in the decision making and change processes is an important first step. Reframing setbacks as opportunities to gain new information about goals or to revise decisions or plans or simply as an exercise in developing frustration tolerance can be helpful. Using the case conceptualization to understand the patient's personal reactions to undesired outcomes provides an opportunity to enhance personal awareness and to modify beliefs. The patient, in turn, can use those insights to marshal the needed motivation to face those challenges that he or she has avoided in the past.

Behavioral Activation Interventions

The aforementioned cognitive techniques serve a role in helping the patient who presents to treatment with a history of disappointments to engage in the change process. The task then turns to developing personalized interventions and behavioral experiments to help the patient gather new data and have novel experiences from which to shape new beliefs. That requires helping patients step outside their comfort zones to face personally-relevant challenges in a manner and pace reasonable for each patient.

Cognitive Modification Techniques

In the previous sections, I highlighted the importance of the particular belief systems that have been constructed around the developmental experiences of adults with ADHD. Those beliefs have congealed into a network of conditional beliefs, compensatory strategies, and automatic thoughts that work together to limit the patient's perceived options. Modifying the patient's cognitions that arise in specific real-time situations helps make CT relevant

for the patient. Diagramming the case conceptualization with the patient helps create a map showing the connection between developmental experiences, beliefs, and recurring behavioral patterns to which the patient can refer. Socratic exploration of specific instances helps draw the connection between a triggering situation and the cascading sequelae of cognitive, affective, and behavioral responses. The Beck's (1995) Daily Thought Record (DTR) is a tool to diagram that sequence explicitly and to practice developing alternative interpretations of the activating situations. Finally, anticipating such situations and rehearsing the patient's desired response form another strategy for interfering with the cognitions that fuel avoidance and procrastination.

The 10-Minute Rule

Shakespeare wrote that, "Our doubts are our traitors that make us lose the good we oft might win by fearing to attempt." Adults with ADHD might contend that their doubts are supported by evidence. However, when one explores patients' self-reported failures for more specific details, one usually finds the word failure used to describe an avoided or prematurely interrupted activity. For example, a patient overwhelmed by a backlog of voice and e-mail messages at work might cite his avoidance of checking and responding to them as evidence of incompetence and laziness. When reconstructing the patient's automatic thoughts that were activated before the task, one often finds that there was some sort of thought or image of the task being uncomfortable, overwhelming, or affirming the patient's sense of incompetence, as in the case of the patient listed above whose thought was "A customer will ask me something I don't know, and I'll look stupid."

We use the *10-minute rule* as the general name for the smallest increment of time that a patient could stay on a task, even if the task were to prove as overwhelming as anticipated. The objective is to help the patient get started on the task and gather experiential data rather than make a decision to avoid the task because of negative thoughts or images of what might go wrong. (The exercise can be varied from a time increment to a certain number of tasks that the patient can commit to, such as to listen to five voice mails.) After completing the initial commitment, the patient is then encouraged to reassess the task with regard to anticipations of it that he or she had beforehand. We describe this as making an informed decision based on experience rather than an avoidance decision based solely on negative anticipations.

Consider and Research Options

Sometimes avoidance has become such a pervasive compensatory strategy that the patient automatically dismisses potential problem-solving options or

opportunities for personal growth. As should be clear by this point, however, that avoidance is often based on recollections of past frustrations and the overgeneralization of negative beliefs about one's abilities. Encouraging a patient to research possible options is a form of exposure to counteract pervasive avoidance. Similar to the 10-minute rule, consideration of options is meant to serve as a manageable middle ground between complete avoidance and total commitment to an emotionally intimidating challenge. It may sound simple, but such an exercise often assuages many doubts about a potential undertaking. Sometimes the exercise removes doubts based on points of fact (e.g., cost of a computer course, schedule), effectively weakening negative automatic thoughts. Other times the exercise involves the patient in agreeing to a minimal and manageable exposure to a feared situation (e.g., attend a party for at least 15 minutes). Those strategies increase the likelihood that patients will gain experiential data by trying activities that they otherwise would have avoided. If the patient remains ambivalent about an activity, the relevant doubts can be formulated in terms of beliefs and fears and dealt with on a cognitive–emotional level, and the patient's readiness for change can be reexamined.

Fashioning a Good Fit

One of the primary cognitive distortions seen in adults with ADHD is that of comparative thinking. That distortion deals with the tendency to base one's self-assessment on how well or poorly one's accomplishments match with some standard. Of course, the individual often makes patently unfair comparisons that reinforce his or her sense of failure, does not consider his or her unique circumstances, and bases decisions on the life trajectory taken by others, rather than respecting his or her own personal strengths and needs and tailoring decisions to those factors.

These scenarios are recipes for chronic frustration because they virtually ensure that one's personal strengths are underutilized and that they find themselves in inappropriate environments. For example, many adults with ADHD, whose symptoms were not assessed during childhood, are diagnosed during their first or second year at college. The student who moves away to college experiences a total reorganization in his or her environment and immediate support system at the same time that he or she faces the increased amount and difficulty of academic work. For many of the students with ADHD, continuing in school might require a change in their modus operandi. Students may have tacitly assumed that college would progress as smoothly and in as regimented a trajectory as did high school. Instead, some students might find they need to take longer than the traditional four years to complete an undergraduate program. Other students may decide to enroll in a community college.

Some other individuals may come to the determination that college is not a good match for their skills. The point is to encourage the patient to evaluate important life decisions, considering whether they have been made because they are appropriate for the individual or if they have been made on the basis of some unrealistic notion of what should be done.

Summary

Adults with ADHD often present with personal histories replete with recurring problems. Those life difficulties result from impaired executive functions that are manifested as the core symptoms of ADHD. However, the difficulties that they engender result in a learned pessimism that contributes to procrastination and avoidance in facing life's challenges, including the therapeutic process. CT is a treatment paradigm that can help adults with ADHD (or any other chronic disorder or complex problem) to modify their belief systems; to develop coping skills with which to manage their symptoms better; and to become more active, competent, and confident in handling life challenges. As Candide concluded at the end of his extensive travels and hardships, "we must cultivate our garden," regardless of whether this is the best of all possible worlds.

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The Cognitive Double: Integrating Cognitive and Action Techniques

DAVID A. KIPPER

ABSTRACT. In this article, the author describes the Cognitive Double, an original role-enactment technique that combines the procedure of cognitive restructuring (cognitive therapy) with the psychodramatic double. All group members need to be taught the principles of cognitive interventions in the beginning stages of the group. The director teaches the cognitive double to follow 6 prescribed steps: awareness, validation, identifying the irrational thoughts in context, confronting the automatic thoughts in action, articulating the erroneous belief (schema), and creating a new rational belief. The author also describes an auxiliary technique called the Automatic Thoughts Ticker.

Key words: cognitive therapy, experiential therapy, psychodramatic interventions, role playing

THE COGNITIVE DOUBLE IS A ROLE-ENACTMENT TECHNIQUE based on a model called the Experiential-Cognitive Reintegration (ECR), which integrates two existing psychotherapeutic procedures. The experiential component follows the psychotherapeutic interventions used in classical psychodrama (Moreno, 1946). Its primary focus is the emotional aspect of human experiences (Blatner, 2000; Kipper, 1986; Starr, 1977; Yablonsky, 1976). The cognitive component is based on cognitive therapy techniques and addresses the rational aspect of human experience, focusing on the influence of beliefs, attitudes, and conceptual learning (Beck, 1976; Beck, 1996; Leahy, 1997; Sharoff, 2002). Recently, there has been an increased interest in the experiential approaches to psychotherapy. Some of the underlying psychological principles in the experiential approach were borrowed from Gestalt therapy (e.g., Greenberg & Pavio, 1998); others are based on literature about the role of emotions in psychopathology (Epstein, 1998; Flack & Laird, 1998; Plutchik, 2000). Several studies have been published about the experiential process and

its effectiveness (e.g., Greenberg & Van Balen, 1998; Greenberg, Watson, & Leitaer, 1998; Paivio & Greenberg, 1998). A similar interest in experiential methods is also evident in the psychodrama literature (Hudgins, 2002, Kipper, 2001a).

Classical psychodrama is perhaps the earliest therapeutic modality to espouse the principles of experiential psychotherapy. I (Kipper, 2001b) proposed an Experiential Reintegration Model (ERM) in which I conceptualized psychodrama as a treatment modality aimed at altering clients' existing repertoires of dysfunctional experiences and creating functional ones. Most major theories of personality and of psychopathology maintain that much of human behavior—feelings, perceptions, beliefs, attitudes, and coping modes—is shaped by the experiences one accumulates during one's life. Those theories state that, ordinarily, experiences acquired earlier in life appear to have a far greater influence than others acquired later. They also share the view that experiences associated with intense emotional reaction tend to have a dominant role in a person's behavior.

The early version of the ERM suggested that by reliving painful experiences and altering their meaning and/or endings, and by having the opportunity to experience missed experiences as well as fantasized ones, a client's repertoire of experiences is altered for the better, replacing old, dysfunctional beliefs and interpretations with new ones that lead to more functional behaviors.

The rationale for changing one's repertoire of experiences through role enactment and psychological simulation follows. An experience acquired in the artificial environment of the therapist's office must be potent enough to compete successfully with or to override an existing dysfunctional interpretation of an experience. The extent to which an in vitro-acquired experience can have a powerful impact depends, in part, on its relevancy and intensity. The ERM suggests that the probability of achieving a potent effect increases when the new experience (in vitro) is attained in a manner that comes as close as possible to the way experiences are acquired in vivo. A psychodramatic enactment enables the best approximation to reality by means of a psychotherapeutic (role playing) simulation. The same rationale applies to the treatment of cognitive experiences. Cognitive techniques can also be used as role-enactment interventions, addressed in the context of psychodramatic (simulated) scenes. Such an application is likely to increase the probability that the intensity and immediate relevancy to the situation contributes to its effectiveness.

Two Interventions

In the following section, I describe two related role-enactment interventions, the Cognitive Double and the Automatic Thoughts Ticker. The two can be used together or separately.

The Cognitive Double

The cognitive double is a modified version of the classical psychodramatic double technique (Moreno, 1946), and its purpose is to explore irrational beliefs and distorted thoughts, which guide protagonists' modes of relatedness. The double technique has been long considered a particularly powerful psychodramatic intervention. Blatner (1996) described it as "perhaps the most important technique in psychodrama because it helps protagonists to clarify and express a deeper level of emotion and preconscious ideation. This technique is readily integrated with more conventional types of individual, family, or group psychotherapy" (p. 28). A decade earlier, I (Kipper, 1986) suggested that the double "stands out as perhaps the most ingenious and therapeutically powerful clinical role playing intervention" (p. 152). It is not surprising, therefore, that the double became the basis for designing new tailor-made psychodramatic interventions. Two recent examples of this trend are the Containing Double (Hudgins, 2002) and the Split Double and Cultural Double (Tomasulo, 2000). The former is a special form of enactment used in the psychodramatic treatment of clients with Post-Traumatic Stress Disorder (PTSD). The latter is an adaptation of the classical double for the teaching and training of sensitivity to cultural diversity. The cognitive double technique follows this trend; that is, it integrates other psychotherapeutic procedures. The classical double is transformed into a new technique that combines cognitive therapy techniques (Beck, 1976; Beck, 1996; Leahy, 1997; Sharoff, 2002) with psychodramatic enactment.

Rationale

The rationale for use of the cognitive double rests, in part, on the one provided for the original, classical, double technique (e.g., Hudgins & Kiesler, 1987; Kipper, 1986) and, in part, on additional psychological reasoning. In classical psychodrama, the double involves an auxiliary, usually a group member, who acts as a psychological twin to the protagonist. The double establishes identity with the protagonist and engages in an open internal dialogue that brings to the surface deeper levels of feelings and thoughts that the protagonist is either unaware of or afraid to recognize or confront. The role of the double, therefore, is to establish a close relationship with the protagonist, acting as an inner voice. The psychological mechanism that facilitates that task is empathic bonding and active experiencing. Empathy provides a feeling of safety through understanding. The willingness to have active experiences provides an opportunity, and readiness, to venture into new experiential reintegration. Both mechanisms serve as preconditions to the onset of the change process (Gendlin, 1981).

According to classical psychodrama, the auxiliary who assumes the role of the double has two functions. The first is to serve as a voice that communicates with the therapist, that is, to act as an extension of the protagonist, thereby enhancing the therapist's understanding of the protagonist. The double continuously strives to provide the therapist with clues and explanations regarding the protagonist's feelings and thoughts and to be certain that those messages are heard. The second function is to serve as an extension of the therapist, essentially acting as a cotherapist or an intermediary agent, through whom the therapist can implement desirable changes in the protagonist.

In principle, the basic psychological dynamics of the cognitive double are identical to those that characterize the classical psychodrama double. The success of the cognitive double depends on his or her ability to establish empathy, and thus the safety of understanding, with the protagonist. Also, the therapeutic responsibilities of the cognitive double are the same as the two described for the classical double. The difference between the cognitive and the classical versions of the double is that the former role is more restricted, focusing on eliciting and clarifying cognitive contents, whereas the latter role is unrestricted, focusing on affective reactions. The classical double may be characterized as a general psychological twining to the protagonist, and the cognitive double as a specific cognitive twining.

Typically, the instructions given to the classical double include a statement that his or her role is to become the protagonist's inner voice and to try to voice aloud what the protagonist is feeling (e.g., Blatner, 1996 p. 30; Goldman & Morrison, 1984, p. 16; Yablonsky, 1976, p. 120). Others instruct the double to voice the protagonist's feelings and thoughts. Although the focus of the double's mission seems to address feelings, in reality the double expresses the protagonist's feelings as well as thinking. It is true that emotions and cognitions are inherently intertwined facets of human experiences.

Various theoreticians of experiential therapy (e.g., Greenberg & Paivio, 1998; Greenberg & Van Balen, 1998; Paivio & Greenberg, 1998) make a point to stress the close relationship between affect and cognition (Epstein, 1998) and their dialectic nature (Greenberg, Watson & Leitaer, 1998). Nonetheless, in the context of psychotherapy, working with emotions and working with cognition represent different approaches. Therefore, it might be helpful to make a clearer distinction between the processes that the double needs to address. The classical double focuses on the protagonist's feelings, whereas the cognitive double focuses on the thinking, specifically on identifying and assisting in the correction of irrational thoughts and beliefs. Thus, there is an added value in introducing the cognitive double in the context of the psychodramatic enactment; it creates a reality in which thinking and feeling emanate directly from the simulated experience, making the simulation highly personal and relevant.

Schemas, Basic Assumptions, and Automatic Thoughts

Beck (1976) and Beck, Rush, Shaw, and Emery (1979) proposed a theory that explains the relationship between irrational, unrealistic, and erroneous beliefs and psychopathology. They argue that there are deep, unconscious thoughts called core beliefs or schemas that screen and then react to incoming stimuli. Schemas are attitudes or assumptions that screen, differentiate, and code events. They mold experiential data so that the information is categorized, evaluated, and interpreted in a way that is consistent with existing schemas. In other words, schemas shape the meaning ascribed to events and stimuli. According to Sharoff (2002, p. 16), "Everyone has a set of schemas. Some are more active than others, while some are inactive but can become dominant in certain situations or times."

Schemas have a vital impact on information processing. Over time, they turn into elaborated and deeply entrenched rigid patterns. They distort situations by selectively highlighting some facts and ignoring others. As a consequence, information is processed with a bias to justify the existence of the schema. Experiential data are construed to be consistent with existing schema, rather than with objective reality, which is not known, or only partially known, to the protagonist. By disallowing facts that dispute the validity of the existing schemas, the data become self-perpetuating and remain resistant to change. Considered uncontested truth, they are taken for granted. Schemas guide the individual to respond often in an unrealistic manner because the responses are based on preconceptions, not on objective reality. The result is the formation of unrealistic self-images and self-concepts. Young (1999) proposed 18 early maladaptive schemas that produce psychopathology. Those follow:

1. Abandonment or instability. One has the perception that one cannot rely on the emotional support, strength, or protection of significant others because they are emotionally unpredictable and unavailable (impending death or imminent leave).
2. Mistrust or abuse. One has the expectation that one will be hurt, humiliated, lied to, manipulated, or taken advantage of by others. The perception is that such harm is intentional and may result in extreme neglect.
3. Emotional deprivation. One has the expectation that emotional support from others will not be forthcoming. There may be deprivation of nurturance, empathy, or protection.
4. Defectiveness or shame. One has the feeling that one is bad, unwanted, inferior, and invalid in significant respects and, therefore, will not be loved, if exposed. Sometimes that involves hypersensitivity to criticism, rejection, blame, comparison to others, insecurity, and shame. It includes the feelings of being sexually undesirable, physically unattractive, or socially awkward.

5. Social isolation and alienation. The person feels isolated from other people and not a part of the group or the larger community.

6. Dependence and incompetence. The belief that one cannot handle regular, everyday responsibilities in a competent manner without considerable help from others. It may involve a sense of helplessness.

7. Vulnerability to harm or illness. The client lives under an exaggerated fear of imminent catastrophe, such as medical in nature (e.g., heart attack), emotional (e.g., becoming depressed) or an external event (e g., an airplane crash).

8. Enmeshment or underdeveloped self. The client has an excessive emotional involvement with one or more significant others (often parents) at the expense of individuation, self-gratification, and social development. This could be associated with feelings of emptiness, floundering, and in extreme cases, questioning one's own existence.

9. Failure. One believes that one is fundamentally inadequate relative to others, has failed, and will fail in the future. There is a feeling of being stupid, relative to others.

10. Entitlement or grandiosity. The client has the perception of being superior to others and that one should get whatever one wants, regardless of how unrealistic it is or at what cost to others. It can be associated with competitiveness, controlling behavior, asserting power, and domination of others.

11. Insufficient self-control and self-discipline. The client shows pervasive difficulty or refusal to exercise self-control as well as difficulty in expressing one's emotions and impulses. There is an emphasis on avoiding discomfort.

12. Subjugation. The client surrenders control to others and has the feeling of being coerced to behave in order to avoid feeling anger, retaliation, or abandonment. The perception is that one's own opinion and feelings are not valid, and there is a hypersensitivity to being trapped (passive-aggressive mode). That can lead to withdrawal of affection, acting-out, and substance abuse.

13. Self-sacrifice. The client has an excessive tendency to address the needs of others at the expense of his or her own gratification, ostensibly to avoid pain and guilt from being selfish. There is an acute sensitivity to the pain of others (codependency).

14. Approval-seeking or recognition-seeking. One has an excessive need for approval from others and for gaining recognition. One's self-esteem depends primarily on the reactions of others, rather than on self-skills and accomplishments. That is also manifested when the client places a great emphasis on status, money, the need to be admired, and hypersensitivity to rejection.

15. Negativity or pessimism. One focuses on the negative aspects of life (e. g., pain, death, loss, guilt, and betrayals), is pessimistic, and has inordinate fear of making big mistakes (e.g., financial or humiliating). It can be associated with chronic worry, complaining, or indecision.

16. Emotional inhibition. The client avoids spontaneity, feelings, and com-

munication, usually to avoid disapproval by others. The most common areas of inhibition are those concerning inhibitions to anger and aggression, expressions of vulnerability, communicating feelings, positive impulses, and an excessive emphasis on rationality.

17. Unrelenting standard and hypercriticalness. The client believes that one must strive to meet extremely high standards in order to avoid criticism. That involves impairment in pleasure, relaxation, health, self-esteem, and satisfying relationships. It is also associated with perfectionism, adhering to rigid rules, high moral and ethical norms, religious precepts, and preoccupation with time and efficiency.

18. Punitiveness. One believes that one should be punished for making mistakes. It is often associated with being angry, intolerant, impatient with those who do not meet one's expectations (of both others and self), and a difficulty in forgiving mistakes.

People may have more than one of those schemas and may invoke one or more at different times. For a fuller description and discussion of the schemas, see Young (1999, pp. 12–16).

At the subawareness level, the schemas often lead to the formation of assumptions (basic and secondary) about oneself, others, and the future. In turn, those assumptions lead to automatic thoughts—those random, rapid thoughts that flash through one's mind intermittently. Of those three cognitive manifestations, the automatic thoughts are the closest to consciousness and, therefore, the easiest to access. So, the royal route to routing irrational schemas is first to identify the automatic thoughts, then to identify the assumptions that lie behind those thoughts, and lastly, by inference, to discover the schemas behind the assumptions. The therapist can use the cognitive double technique to have the client explore his or her assumptions and schemas. Use of the automatic thoughts ticker technique (described later), in a psychodramatic format, promotes exploration of the client's automatic thoughts.

Cognitive Restructuring and the Cognitive Double

In principle, the task of the cognitive double is similar to the process known in cognitive behavior therapy as cognitive restructuring. From a cognitive theory perspective, pathology occurs because of a closed feedback system, in which cognition is not examined, challenged, tested, and updated when new data are received. The goal of cognitive restructuring is to establish an open feedback system, enabling the protagonists to challenge their thinking. Cognitive restructuring seeks to develop a habit of slowing down the process of thinking, giving protagonists sufficient time to examine their

thinking for cognitive distortions. It also increases awareness for the need to learn about recurring and stereotypical thinking and brings to consciousness subjective interpretations and private meanings. "In this way, subjectivity and objectivity become more congruent" (Sharoff, 2002, p. 17).

Training the Cognitive Double

The therapist needs to train all group members to act as a cognitive double because, unlike the classical double, the role follows a prescribed set of steps and requires familiarity with the cognitive restructuring process. In an ongoing group therapy, the director teaches the entire group the principles of cognitive restructuring, the 18 schemas, and schema maintenance or compensating behaviors because any member can serve as a cognitive double in any subsequent session. The group members also train to be able to elicit automatic thoughts and identify their underlying assumptions. Young's (1999) instruction book or similar manuals are useful educational resources. The director demonstrates the cognitive doubling process and devotes at least one session for a practice run. Such structured doubling is no stranger to psychodramatic enactment and has been used in Hudgins's (2002) containing double technique.

Moreno (1946) wrote: "Spontaneity can be present in a person when he is thinking just as well as when he is feeling, when he is at rest just as well as when he is in action" (p. 112). The cognitive double relies on such spontaneity. As in the selection of a double in classical psychodrama, the cognitive double can be chosen by the protagonist or suggested by the therapist with the consent of the protagonist.

Six Steps to Explain the Cognitive Double

The therapist conducts a discussion about the cognitive double with the protagonist in a sequence of six steps. Typically, they consider one step at a time and, as much as possible, in the order in which the steps are described below. But the cognitive double may skip any step, depending on the responsiveness of the protagonist and the situation. The six steps are as follows:

Step 1. Awareness. The purpose of this step is to make the protagonist aware of the nature of the situation and his or her own emotional and physical reaction to it. It is also important because it helps the protagonist, who might be emotionally charged, to relax. The cognitive double describes the situation (in the middle of the scene) and identifies the feelings that the protagonist is experiencing. Although the double is a cognitive auxiliary, addressing the feelings is often a necessary preliminary step. The cognitive double aims to reduce anxiety, which otherwise may adversely affect the protagonist's

ability to concentrate, and describes the protagonist's physical reactions and response to the situation. The cognitive double's awareness of those reactions helps the protagonist relax and stay calm.

For example, let us imagine a psychodrama with a protagonist who complained about the stress that he was having at work. His presenting problem was that, although highly qualified for the position he held, he felt that work was too hard, making him unduly stressed. He described a situation in which he was meeting with his superior who appointed him to be in charge of an important project. As the two were discussing the details of the assignment, the protagonist became restless and began to shake and experience a panic attack.

Director (to the protagonist): OK, John (an assumed name), I'd like to give you a cognitive double. You know what that is, right? (John nods in agreement). How about Mike? Mike, would you be John's cognitive double? (Mike gets up and stands beside John, so that he can see John's face and the front part of his body).

Director (to Mike, the cognitive double): I'd like you to be the cognitive part of John, that is, the part of his mind that thinks and analyzes everything that happens. Talk with John as if you and he are two parts of the same brain having an internal dialogue. Only this time, the internal discussion is aloud, so that we all can hear it. I want you to follow the six steps of the cognitive double, slowly. Go ahead.

Cognitive Double (Mike addressing the feelings to reduce anxiety, a preliminary phase): Here I am facing my boss, and I feel awful. I feel small and humiliated. My breathing is fast, and my blood pressure is going up. I've a lump in my throat. (The protagonist says: "No, I feel as if I am going to faint."). I feel as if I'm going to faint. My hands are shaking, and I'm perspiring. Well, this is not a new situation for me. It's also not a new way for me to react to him. This has happened many times before. Every time we speak, he makes me feel this way. He's sitting there, and I'm sitting here. Now I need to relax, make myself breathe slowly, and pay attention when I inhale and when I exhale. Just let me breathe slowly and calm down. Nothing bad is going to happen here.

(Such an articulation need not take the format of a monologue. It can be broken down to smaller parts in the form of a dialogue between the cognitive double and the protagonist.)

Step 2. Validation. The purpose of this step is to support the protagonist for the strengths that he or she displayed in the scene, difficulties notwithstanding.

Cognitive double (Mike): I'm OK. I'm not going to fall into pieces right now. I don't feel like this in every situation. There's something special about this situation that I do not understand. I'm not always like this. Usually I'm OK. I've a lot of evidence that I'm OK, right?

(Cognitive double turns to the protagonist and engages in a brief dialogue about this point.)

Step 3. Identifying the irrational thoughts in the context. The purpose of this step is to identify the automatic thoughts that pass through the protagonist's mind as he or she encounters the situation psychodramatically.

Cognitive double (Mike): So, what do I think might be going on here? Why might I be reacting like this?

(Before the protagonist responds to that question, the therapist designates an auxiliary who serves as the automatic thoughts ticker (see below) who stands behind the protagonist and says, "I'm your automatic thoughts ticker. Please tell me what might be going on in your head, tell me your thoughts." The auxiliary clicks his fingers and repeatedly says, "What might I be thinking now?" The protagonist offers all sorts of thoughts, which the cognitive double repeats aloud as follows:)

Cognitive double (Mike): So, I feel I'm in some kind of a test. There must be something I've done wrong. He (the supervisor) trusts me, but I'm not worth it. This is too big a job for me; I don't think I can handle it. I need to stop this. (Laughs) Boy, those guys at Enron were something else! I think I sound stupid now. I'm afraid to look him in his face. He speaks very nicely. My math teacher at high school spoke like that. I hated math. I don't know why he thinks that I can do this. I don't think he knows me very well. (The cognitive double turns now to the protagonist and asks, "Did I get all these thoughts right?")

Step 4. Confronting the automatic thoughts in action. The purpose of this step is to provide the protagonist with the opportunity to confront his or her automatic thoughts in action (facing them as represented by auxiliaries), argue with them, and disprove their validity. If sufficient noncorroborating evidence is presented to disprove the assumptions behind the thoughts, then the protagonist understands that his or her beliefs are invalid. The cognitive double stays with the protagonist and encourages the person to argue with the (talking) thoughts. The cognitive double continues to ask the protagonist to look for evidence from his or her life that proves that the thoughts are irrational. That may be done in the following way:

As the protagonist provides automatic thoughts and the special auxiliary repeats them, the therapist may pull a few chairs into the action space and ask several group members, one in each chair, to represent each of the thoughts. Once the action space is filled with six to nine such thoughts, they are arranged in a circle with the protagonist in the center. At the director's instruction, they begin to explain themselves, representing the thoughts and their underlying assumptions and speaking simultaneously. The director has the protagonist listen to those voices and argue with each about the irrational or dysfunctional thinking process.

Step 5. Articulating the erroneous belief (schema). The purpose of this step is to identify the erroneous core beliefs that were responsible for the protagonist's past behavior, argue with each about the irrational thinking, and label it.

Cognitive double (Mike): OK. So, now I'm done with these guys. I don't like them. I wonder why I ever thought that way?

The cognitive double and the protagonist discuss what has happened in the completed encounter and agree that the protagonist was operating under fear of failure. The protagonist realizes that, in reality, there is no justification for that fear and that there is ample evidence of his or her competence.

Step 6. Creating a new (rational) belief. The purpose of this step is to develop a rational belief and a set of behaviors that will counter the earlier irrational beliefs. To facilitate this step, the therapist may ask the cognitive double and the protagonist to sit side by side and discover an alternative rational belief that can replace the irrational belief.

> *Cognitive double:* I'm a very good manager and a very good team leader. If I have concerns about the projects, I should share those with the project team so that we can solve those together.

(At that point, the therapist asks the protagonist to role play the situation again in the light of the new conceptualization.)

(Ordinarily, the process of going through the six steps lasts about 15 min. Typically, the cognitive double is introduced in the middle of a psychodrama scene, when the director suspects that the protagonist's portrayals are guided by an irrational belief. At that point, the director freezes the scene and introduces the cognitive double. Once the six steps are completed, the director unfreezes the scene, and the psychodrama continues.)

The process of the six steps may help the protagonist to realize his or her erroneous thinking and the causes of that and to change his or her role-play responses immediately in a more rational manner. Sometimes, however, the cognitive double procedure needs to be repeated in subsequent sessions before a noticeable change occurs.

I recommend that the cognitive double be used routinely in cognitive therapy sessions. I caution, however, that the cognitive double not be introduced at the beginning of the action portion. Protagonists who display strong emotional reactions may first need to have opportunities to express their pain psychodramatically and let their inhibitions dissipate before they engage in cognitive work.

The Automatic Thoughts Ticker

The automatic thoughts ticker is a simple technique routinely used either in conjunction with the cognitive double or as a stand-alone technique.

Rationale

This technique is essential to the search for protagonists' erroneous assumptions about themselves and their irrational beliefs. Beck (1976a) and

Beck (1976b) noted that core beliefs are largely at the unawareness level. Automatic thoughts, on the other hand, are on the conscious level and conceptually are similar to the technique of free-associations used in psychoanalysis. Automatic thoughts are easily accessible because they represent a cognitive way to reach the cognitive unconscious.

Instructions

At the beginning of the action portion of the session, the therapist designates one group member to serve as a special auxiliary in the role of the automatic thoughts ticker. The designation and the instructions are carried out with the full knowledge of the protagonist and the group. The therapist's instructions are as follows:

> You're the automatic thoughts ticker. Whenever we need your help, I'll point to you, and you'll get up from you chair and say to the protagonist, "I'm going to be your automatic thoughts ticker." Then you stand about a foot behind the protagonist, saying the following sentence, "What might I be thinking of now? What thought just went through my mind?" and click your fingers. Please repeat aloud every automatic thought that the protagonist says and then click your fingers rapidly about every one to two seconds. Do that repeatedly, until I ask you to stop. Then return to your seat.

Whenever the cognitive double is in the scene, the therapist calls in the automatic thoughts ticker at the beginning of the cognitive double's third stage of the process described earlier. The technique can also be used as a stand-alone technique to help protagonists convey their automatic thoughts. In turn, the therapist may either engage the protagonist in a discussion or use any of the thoughts as a topic for a classical psychodrama session.

Concluding Remarks

Blatner (1996) noted that psychodrama procedures have been integrated into numerous therapeutic approaches. The techniques that I describe in this article represent a trend in the opposite direction and evidence that interventions that have originated in other therapeutic modalities can be integrated into psychodramatic procedures. The integration process, therefore, goes both ways. That feature lends further credence to the therapeutic scope of psychodrama. Cognitive therapy, along with the psychodynamic approach, has emerged as the most significant contemporary form of psychotherapy. The ability of psychodrama to absorb cognitive principles and interventions is a sign of its flexibility and, therefore, its strength. That ability opens new opportunities for therapists. The role of cognitive processing in the reintegration stage of psychotherapy is a feature hitherto scarcely attended to in psychodrama. The

Experiential–Cognitive Reintegration (ECR) model (Kipper, 2001a, 2001b) represents an attempt to address that feature and other issues.

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BOOK REVIEW

Psychodrama in the 21st Century: Clinical and Educational Applications, edited by Jacob Gershoni. 2003. New York: Springer.

This volume is an important contribution to the literature about psychodrama. Seventeen psychodramatists from all over the world describe how they apply psychodramatic methods in their work, illustrating, in the words of Robert Siroko in his foreword, "some of the power, depth, breadth, and scope of Moreno's work." Whether one is a student or an expert, the book is well worth reading and indeed owning. Readers will find a wealth of ideas for their own praxis. Most authors integrate theory with clinical examples, which facilitates understanding and makes for enjoyable reading. The first part of the book deals with psychodrama and other methods, the second with the application of psychodrama with specific populations, and the last part with applications in training and consultation.

In the first chapter: "The Triadic System: Sociometry, Psychodrama, and Group Psychotherapy—An Overview," Louise Lipman deals with the theoretical foundation of Moreno's system. The intimate connection and the three branches of Moreno's approach to therapy are important, which makes Lipman's essay essential reading.

Sandra Garfield, in the chapter titled, "Transference in Analytic Psychodrama," explains the complex subject matter of transference and analytical theory clearly, with the help of clinical examples. She shows that despite Moreno's denial, transference occurs in psychodramatic treatment and that it is important for psychodramatists to be aware of that possibility and to deal with it appropriately.

In the chapter on "Applying Psychodrama in the Family System Therapy of Bowen," by Chris Farmer and Marcia Geller, and in the one on "The Use of Structural Family Therapy and Psychodrama: A New Model for a Children's Group," by Jacob Gershoni, the authors illustrate their approach clearly with the help of clinical cases. Gershoni gives an overview of the literature and makes the point that Moreno was the first to realize that the therapy of individuals needs to take their social system into account.

In "The Body Talks: Using Psychodrama and Metaphor to Connect Mind and Body," Mary Ann Carswell and Kristi Magraw describe their unique approach of combining body therapy with psychodrama. Their well-written and accessible essay contains helpful points for psychodramatists and indeed, for any therapist, about the importance of being aware of one's own and one's clients' physical reactions.

In "The Synergism of Art Therapy and Psychodrama: Bridging the Internal and External Worlds," art therapist Jean Peterson gives practical considerations for integrating art therapy into psychodrama. She also offers a brief history of expressive arts, including drama from prehistoric and shamanic times.

Adam Blatner, in his essay "Not Mere Players: Psychodrama Applications in Everyday Life," elaborates on Moreno's conviction that his approach is not only for the treatment of the mentally ill but also for the benefit of all mankind. Blatner offers a wealth of ideas for how Moreno's philosophical insights and action methods can be useful in everyday life for individuals, families, and other groups.

"The Magic Carpet Ride: Psychodrama Methods With Latency-Age Children," by Mary Jo Amatruda, contains references to the literature on group psychotherapy with children and an explanation of the similarities and differences to doing psychodrama with that population and with adults. Her delightful examples make for easy reading, and her essay is full of ideas that may be useful to other therapists working with children.

"Taming Puberty: Utilizing Psychodrama, Sociodrama, and Sociometry with Adolescent Groups," by Mario Cossa, contains specific case examples, an overview of the difficulties of working with adolescents, and a rich collection of psychodramatic and sociometric tools that can be used safely and effectively with that population at each stage of group development.

"Psychodrama With Veterans: The Cincinnati Veterans Affairs Medical Center Experience," by Elaine Camerota and Jonathan Steinberg, begins with a summary of the long and interesting history of psychodrama at that hospital. That is followed by a case example that is unique because of its description of a difficult drama with a veteran, which in turn affected a staff member, and the report on how that staff member dealt with her secondary trauma by being a protagonist in a staff group.

Deniz Altinay in "A Psychodramatic Approach to Earthquake Trauma" describes his work with trainees and support groups after a severe earthquake, dealing with the severe fears of the survivors. He distinguishes between the fears directly related to the earthquake and irrational fears that are based on earlier trauma. He gives abbreviated examples of how those fears are worked through and some ideas about how to prevent trauma.

In "Psychodrama and the Treatment of Addiction and Trauma in Women," Tian Dayton explains why she uses psychodrama and gives detailed instructions

for how to use action methods, psychodrama, and pen-and-paper sociometric exercises with that population.

In "Towards Acceptance and Pride: Psychodrama, Sociometry and the LGBT Community," Jacob Gershoni introduces readers to the context of life in the gay communities and the difficulties with self-acceptance and coming out. He gives specific examples to illustrate how the support of group therapy and psychodrama can help that community. Joseph L. Romance, in his chapter called "It Takes Two: Psychodramatic Techniques With Straight and Gay Couples," describes a rich variety of techniques that he uses at various stages of treatment—from assessment and working through to termination.

In "Psychodrama as Experiential Education: Exploring Literature and Enhancing a Cooperative Learning Environment," Herb Propper reports his use of action methods with students to deepen their appreciation for literature and mythology and his use of sociometry to facilitate group cohesion, trust, and group work. He includes a brief overview of relevant literature.

With "Psychodrama and Justice: Training Trial Lawyers," James D. Leach opens what will be for many practitioners a new field application for psychodrama. He describes the use of psychodramatic techniques in assisting trial lawyers to prepare for the various stages of trials, from understanding their clients to jury selection to the final summation.

The final chapter of the book is "A Psychiatrist's Use of Psychodramatic Techniques in Systemic Consultations With Primary Care Physicians" by Chris Farmer. Farmer gives details about five sessions in which family doctors present difficult patients from their practice in role play and gain insight into how family dynamics influence the situation.

This collection of essays is one of the best books on psychodrama that I have seen. I recommend that it be part of every psychodramatist's library.

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CALL FOR PAPERS

The editors of the *Journal of Group Psychotherapy, Psychodrama, and Sociometry* are issuing a call for papers for a special issue on the use of action methods with children and adolescents. The purpose of this special issue is to highlight a range of therapeutic practices, techniques, and diverse interventions in working with troubled children and adolescents. The editors are also interested in articles addressing the use of action methods by those working in schools and addressing social and community issues. They seek manuscripts in which the authors focus on group psychotherapeutic, psychodramatic, sociodramatic, and sociometric practices, techniques, and procedures with children and adolescents. The editors will review submissions on a first-come first-served basis. Authors are to follow the journal's guidelines for authors, which are printed on the journal's inside back cover, and send manuscripts to:

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- Write straightforward sentences and use strong verbs in the active voice. What you are trying to convey is a sense that "this worked for me, and you can do it too."

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The *Journal of Group Psychotherapy, Psychodrama, and Sociometry* 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.

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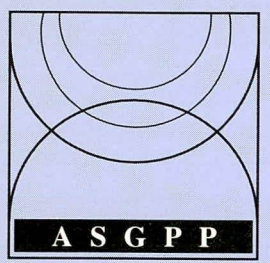
The American Society of Group Psychotherapy & Psychodrama



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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 *Journal of Group Psychotherapy, Psychodrama, and Sociometry,* founded in 1947 by J. L. Moreno as the first journal devoted to group psychotherapy in all its forms.