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The Effects of Being the Protagonist in Psychodrama

KWANG WOON KIM

ABSTRACT. In this study, the author reports his investigation of the effects of psychodrama by quantitative methods. Twelve adults voluntarily participated in psychodrama sessions directed by the researcher and 3 other directors. They administered Yalom's Therapeutic Factor Scale (YTF), Emotion Appraisal Questionnaire (EAQ), and Session Evaluation Questionnaire (SEQ) to evaluate the effects of psychodrama. From the YTF results, the researchers concluded that the experience of the protagonist in each session was more therapeutic than that of the audience members. The changing trend of therapeutic factors before, during, and after the sessions was highest during the sessions and was reduced after the session. The most therapeutic factors were universality, family reenactment, instillation of hope, self-understanding, and existential factors. The protagonists experienced less negative emotions, such as disappointment and nervousness, than the audience members in the EAQ. Emotions before, during, and after the sessions were maintained. The protagonists evaluated the session outcomes more positively than the audience members. The protagonists perceived the process of the psychodrama more deeply than did the audience. The author offers suggestions for future studies.

Key words: assessing the effects of psychodrama, effects of psychodrama, protagonist in psychodrama, therapeutic change

PSYCHODRAMA IS A METHOD OF GROUP PSYCHOTHERAPY in which people are helped to solve their problems by acting them out in addition to talking about them (Moreno, 1984). Recent increased interest in psychodrama is fundamentally attributable to learning by doing, which is more effective than purely verbal modes of learning. During the last few decades in Korea, there has been increased interest in psychodrama among psychotherapists. It was first introduced to Korea in 1969 by Dong-Se Han and since then has been applied in mental health clinics, student counseling, juvenile reformatory schools, and other kinds of counseling service centers (Han, 1996; K. W. Kim, 2000; Yoo, 1999).

Although psychodrama receives increased attention and has garnered more interest, many controversies about the therapeutic effects of psychodrama exist. Many therapists report strategies and case studies, but their conclusions drawn from empirical studies are inconclusive (D'Amato & Dean, 1988; Kipper, 1978). Because previous studies on the effects and validity of psychodrama have not yielded consistent results (Yoo, 1999; Kipper, 1978), psychodrama therapists are confronted with serious challenges. For a long time, researchers who studied the effects of psychodrama did not realize the significance of quantitative approaches and failed to recognize and develop an alternative evaluation method that conveys strong and significant results to other researchers and practitioners. In spite of those problems with research methods, most researchers maintained that the validity of psychodrama could be proved by quantitative results. Some researchers, however, took a critical view of psychodrama and refused scientific support because most research on psychodrama takes an ethnographical approach and consists of commentaries of directors based on a client's personal experiences.

For this study, I examined the effects of psychodrama in a quantitative way to gain an understanding of participants' experiences throughout the entire process of a psychodrama. I provide information about the process of change, and I endeavor to show the factors of the psychological state that the protagonists and the audience members experience in a psychodrama group.

To examine the effects of psychodrama, I used Yalom's (1985) Therapeutic Factor Scale (YTF) and Emotion Appraisal Questionnaire (EAQ). Corsini and Rosenberg (1955) found 220 statements about therapeutic factors after reviewing more than 300 study records and classified them into 9 categories, using factor analysis. Yalom described 12 statements based on previous studies (Berzon, Pious, & Parson, 1963; Corsini & Rosenberg; Dickoff & Lakin, 1963) and his own clinical experiences. To Kellerman (1992), emotional catharsis, self-understanding, and learning about relationships appeared to be the significant therapeutic factors in his psychodrama groups.

In Korea, researchers explored the effects of psychodrama on various groups, especially groups of mental patients, juvenile delinquents, and adults. From studying those groups, Kim and Kim (1988) found three therapeutic factors: universality, altruism, and insight. Park, Kim, and Kim (1989) reported that self-understanding, existential factors, and instillation of hope were significant therapeutic factors for mental patients. In another study of mental patients, Lee and Park (1995) found five therapeutic factors—emotional catharsis, instillation of hope, providing information, group cohesiveness, and interpersonal learning—to be significant.

In his study for juvenile delinquents, Ko (1996) identified the following significant therapeutic factors: instillation of hope, universality, existential factors, self-understanding, and family reenactment. J. H. Lee (1998) reported four factors: family reenactment, group cohesiveness, existential factors, and self-understanding. In a study of high school girls who showed delinquent behaviors, Cha (1998) concluded that guidance of group members, altruism, group cohesiveness, and catharsis were significant therapeutic factors. The results of those studies were diverse, depending on the researchers and participants of each study, but shared some common therapeutic factors, such as existential factors, self-understanding, family reenactment, insight, catharsis, and instillation of hope. I believe that it is important to verify these therapeutic factors so that therapists better understand the process of group psychodrama.

As a method of group psychotherapy, psychodrama has proved helpful in solving problems, especially emotional catharsis, anger control, and emotional conflict resolution (Cha, 1998; K. H. Kim, 1983; M. J. Kim, 1996; Kipper, 1996; Lee, 1992; Y. K. Lee, 1981; Sung, 1983). Blanco-Venzala, Martin-Munoz, and Sevillano (1994) demonstrated that the level of anxiety and depression was decreased in diabetic adolescents after psychodrama therapy.

In measuring the effects of psychodrama, the evaluation of sessions is important because it gives information about the outcome of the counseling process (Lee, Kim, Jeong and Cho, 1997). Using the Session Evaluation Questionnaire, J. H. Lee (1998) evaluated all 10 sessions of her psychodrama group of juvenile delinquents and reported that depth and smoothness were rated high, especially in later sessions.

Research Questions

In this study, I sought to investigate the changes or process that participants acting as a protagonist experienced before, during, and after the psychodrama. In line with the previous studies on the effects of psychodrama that I reviewed, I developed the following research questions:

1. Are there significant differences in therapeutic factors and emotional changes between the protagonists and the audience?
2. As the sessions continue, do the treatment factors become different and do participants show emotional changes?
3. How do protagonists and the other group members evaluate the sessions differently?
4. How do participants evaluate the sessions?

Method

Participants

Participants were 12 adults (ages ranging from 22 to 46, $M = 30.4$), and the group consisted of 1 man and 11 women. Four were married, five were engaged in full-time work, four were college students, and three were engaged in home duties. There were 10 psychodrama sessions, and all 12 people participated in each session. Ten people took turns being the protagonist for one session each, while the remaining two people participated only as group members for all 10 sessions.

Measures

Therapeutic factors and their effects. To measure the therapeutic effects of the psychodrama, I administered two scales. The first scale (YTF) was originally developed by Yalom in 1975 to measure the various effects of psychodrama in each session. However, in this study, I used the TFS, which Yoon (1997) revised for the Korean sample based on Yalom's study, to measure the immediate aftereffects of each session. Yoon reported 13 therapeutic factors, whereas Yalom suggested 11 factors. Yoon divided two subscales (*identification* and *guidance*) into two subparts with the same items applied to the therapist and the client. Yoon's scale is a 13-item, self-report inventory. After each session ended, participants had to indicate in each of the statements how much they were helped, using 5-point Likert-type scales ranging from *not helpful* (1) to *extremely helpful* (5). In the present study, I found excellent internal consistency for Yoon's Therapeutic Factor Scale ($\partial = .93$).

At the end of the last session, I administered the second scale, a Korean form of Therapeutic Factors, to assess the delayed outcomes of the psychodrama. This scale was another variation of Yalom's Therapeutic Factors (1975), which Chun translated into Korean two decades later for his study (Chun, 1995). The scale is a 60-item questionnaire that yields 12 therapeutic factors. I used 7-point Likert-type scales in my questions to the participants to learnt which factors were most helpful. The scale demonstrated good internal consistency in this study ($\partial = .90$).

Emotional effects variable. I assessed the emotional effects of psychodrama E. Y. using, Lee's (1991) EAQ. Lee developed the EAQ by selecting and revising relevant items from several previous studies (Gotlib & Meyer, 1986; John, 1988; Strauman, 1989). The EAQ is a self-reporting measure of two emotional dimensions, *disappointment* and *nervousness*, for which the participants report the degree to which each of 20 positive and negative adjectives describes their

mood, using a scale from *not at all* (1) to *extremely* (7). Cronbach's alpha for the EAQ total score and two subscales (*disappointment* and *nervousness*) were .93, .83, and .82, respectively.

Session outcomes variable. In this study, I used the SEQ to evaluate the general outcome of each session. Two subscales, *depth* and *smoothness*, comprise the SEQ. According to Stiles and Snow (1984), *depth* refers to a session's perceived power and value, and *smoothness* refers to a session's comfort, relaxation, and pleasantness. Each subscale is made up of five pairs of contradictory adjectives. Each pair was rated on a 7-point Likert-type scale. The alpha coefficient was .89 for depth and .85 for smoothness.

Program

I and three coleaders directed the psychodrama sessions. Each session included various dynamic activities, recognized for stimulating group members' spontaneity and creativity, and consisted of three stages—warming up, enactment, and sharing.

Procedure

To recruit voluntary participants, I had a poster advertising the Psychodrama for Self-Growth sessions placed in a counseling center for adolescents in Kwangju City, Korea, where the sessions were to be held. Twelve adults signed up for participation, and a total of 16 people, including the researcher and three coleaders, participated in the group of 10 sessions for 4 days. Each session lasted approximately 3 hr. To determine the therapeutic factor changes and the emotional effects of experiencing a protagonist role, I gathered the following three scores: before the participants acted as the protagonist (the before score), immediately after they left the protagonist role (the during score), and after attending the rest of the psychodrama sessions as a member of the audience (the after score).

Statistical Analyses

I used a paired t test to compare the differences between the protagonist group and the audience group. I conducted multiple regression analyses, especially linear and quadratic analyses, to describe the trend or process of the before-and-after experience of being the protagonist.

Results

The Therapeutic Factors of Psychodrama

The comparison of the protagonist group and the audience members. To provide a comparison between the two groups, the protagonists and the audience members, I used the paired *t* test. In Table 1, I show a significant difference in the therapeutic effects between the two groups ($t(9) = 6.55$, $p < .001$). That indicates that the protagonists found the therapeutic factors more helpful to them than the nonprotagonists did.

The trend before, during, and after the psychodrama regarding change in therapeutic factors. I obtained a trend analysis through multiple regression analyses to examine the change of the protagonists' experiences, assuming that the scores of the 12 therapeutic factors would be the highest during the psychodrama. I completed the analyses based on the scores that I and the coleaders gathered before, during, and after the psychodrama. I present the results in Table 2.

Table 3 contains the results of the quadratic trend analysis of therapeutic factors and indicates curvilinear therapeutic effects ($\beta = .46$, $p < .01$). The effect increased gradually, reaching its peak during the psychodrama and declining at the end of the psychodrama. That result means that even though the therapeutic factors had a significant effect, it was not sustained and did not increase again after the psychodrama ended. The linear analysis, however, did not show any statistically significant result.

The therapeutic factors that emerged in the psychodrama sessions. Using Yalom's Therapeutic Factors, I investigated the therapeutic factors. According to the findings, the most therapeutic factor is universality, followed in order by family reenactment, instillation of hope, self-understanding, and existential factors (see Table 4).

TABLE 1. Comparison of the Protagonist and the Audience Members

	M	*SD*	*t*
Protagonist	3.93	.30	6.55***
Audience	3.26	.18	

***$p < .001$.

TABLE 2. Corrected Scores of the Therapeutic Factors Before, During, After Psychodrama

Session	Scores of the experience of protagonist role		
	Before	During	After
1	2.99	4.00	3.64
2	3.62	4.00	3.04
3	2.52	3.54	2.62
4	4.05	4.00	4.22
5	4.00	4.00	4.57
6	2.80	3.67	4.04
7	2.86	4.31	2.85
8	2.19	3.38	3.23
9	3.38	4.15	3.56
10	3.03	4.23	3.56

Note. The last person among the participants who acted as the protagonist did not have the after-experience score, so it was replaced by the average value of the other members.

TABLE 3. Comparison of the Protagonist and the Audience Members

Step	R^2	ΔR^2	β	*SS*	*df*	*MS*	*F*
Quadratic	.21	.21	.46**	2.43	1	2.43	7.63**

**$p < .01$.

Emotional Effect

The comparison between the protagonist and the audience. The participants completed the paired *t* test for a comparison of the emotional effect of the two groups. As shown in Table 5, I found a significant difference between the two groups ($t(9) = -2.66$, $p < .05$) and concluded that the experience of the protagonist produces emotional stability.

The trend before, during, and after the psychodrama regarding change in emotional effect. Assuming that the emotional effect would be highest when the participants experienced being the protagonist, I obtained a trend analysis through multiple regression analyses to identify the trend of the emotional effect. The completed analyses were based on three scores assembled before, during, and after the protagonist experience.

TABLE 4. Mean and Standard Deviation of the Therapeutic Factors

Factor	*M*	*SD*
Altruism	4.63	1.04
Group cohesiveness	5.15	.90
Universality	5.68	.86
Interpersonal learning—input	4.54	.98
Interpersonal learning—output	4.67	.72
Guidance	4.35	.85
Catharsis	5.05	1.02
Identification	5.09	.81
Family Reenactment	5.50	.83
Self-understanding	5.28	.87
Instillation of hope	5.48	.74
Existential factors	5.18	.93

TABLE 5. Comparison of the Emotional Effect Between the Protagonist and the Audience

	M	*SD*	*t*
Protagonist	2.52	.75	–2.66*
Audience	3.14	.25	

*$p < .05$.

I completed linear and quadratic trend analyses to identify the trend of the emotional effect of being a protagonist, based on the corrected scores of Table 6. Table 7 contains the significant quadratic and linear trend (Quadratic: $\beta = -.45$, $p < .05$; Linear: $\beta = -.43$, $p < .01$). The emotional effect increased gradually, but it was the highest during the experience of the protagonist role. The postexperience score of the protagonist role was significantly higher than the preexperience role.

Session Evaluation

The session evaluation of the psychodrama. I appraised the outcomes of the 10 sessions. I observed a significant difference between the protagonists and the audience through a paired *t* test (see Table 8). From the test, I concluded that the participants who experienced the protagonist role evaluated the ses-

TABLE 6. Corrected Scores of the Emotional Effect Before, During, and After Psychodrama Sessions

Session	Scores of the experience of protagonist role		
	Before	During	After
1	3.20	1.40	1.90
2	3.73	2.15	2.96
3	4.46	3.40	3.36
4	2.58	3.65	2.39
5	2.58	3.65	2.92
6	3.05	3.15	2.98
7	4.39	1.50	3.25
8	3.33	2.70	3.02
9	3.34	2.50	2.73
10	3.38	2.15	2.73

Note. Because the last protagonist could not report the "after" score that was collected after the experience of being audience member right after the protagonist experience, the score was replaced by the average of the other protagonists.

TABLE 7. Results of Two Trend Analyses on the Emotional Effect

Step	R^2	ΔR^2	β	*SS*	*df*	*MS*	*F*
1. Quadratic	.20	.20	–.45*	3.21	1	3.21	6.99*
2. Linear	.39	.19	–.43**	6.19	2	3.01	8.45***

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

TABLE 8. Comparison of the Session Evaluation Between the Protagonists and the Audience

	M	*SD*	*t*
Protagonist	1.93	.47	–6.86***
Audience	2.89	.27	

***$p < .001$.

sions as being deeper and smoother than those in the audience role did ($t(9) = -6.86, p < .001$).

Discussion

In this study, I assessed the immediate and the delayed effects of being the protagonist in psychodrama sessions. From the findings of this investigation, I concluded that the experience of being the protagonist influences the therapeutic factors and their effects, the emotional effects of psychodrama, and the evaluations of the sessions. The experience of being the protagonist helps the protagonists to be absorbed in their problem situations more directly and intensely than the audience members are because they are acting them out rather than just talking about them (Moreno & Moreno, 1969). In the present study, the protagonists experienced the therapeutic effects more deeply than the audience members did. According to the trend analyses about how the therapeutic effects changed, a curvilinear trend was evident, which I concluded meant that the therapeutic effects were highest during the experience of being the protagonist. The effects increased gradually before the participants became a protagonist and decreased right after they left the role. Because there was no significance in the linear trend analysis, I concluded that it is uncertain whether the effects would continue later on.

The most meaningful therapeutic factors that were reported by the participants were universality, family reenactment, and instillation of hope. That finding is partially congruent with research in which the participants were part of self-help groups for people who were widows, parents who had lost their children, activists for women empowerment, and cardiac surgery patients (Lieberman & Borman, 1979). Universality, guidance, and altruism were the most powerful therapeutic factors for those groups. In another study, J. H Lee (1998) found results that were analogous. Lee reported in her study of Korean juvenile delinquents that the most therapeutic factors were family reenactment, group cohesiveness, self-understanding, existential factors, and universality.

After evaluating the emotional effects, I concluded that the experience of being the protagonist enhanced the participant's positive emotions. That is consistent with other studies that suggest that protagonists experience emotional catharsis through deep emotional absorption and intense emotional expression. Catharsis is achieved by releasing suppressed feelings and leads to a therapeutic understanding (Blatner, 1988; Moreno & Moreno, 1969; Nicholas, 1984). Trend analyses of this study proved that the emotional effects lasted until the end of all the sessions.

The protagonists rated the outcomes of the sessions higher than the audience members did. That finding was identical with the study on outcome of psychodrama sessions (J. H. Lee, 1998).

After assessing the results of this study, I developed several suggestions for further studies. First, it is essential to compare the control groups with the psychodrama groups so that the researcher can better clarify the effects of psychodrama. Second, it is necessary to study the characteristics of psychodrama, such as the characteristics of the director, the audience, and the topics of the sessions. With these studies, researchers can contribute to the identification of the indigenous features of psychodrama. As my final suggestion, I urge researchers to investigate the delayed effects of psychodrama through an evaluation of the follow-up sessions.

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Combining Schema-Focused Cognitive Therapy and Psychodrama: A Model for Treating Clients With Personality Disorders

LUCY F. GRIFFITH

ABSTRACT. In this article, the author reviews the historical interface between behavior therapies and psychodrama, noting their mutually enhancing elements. She proposes an integration of those elements as a vehicle for providing brief, yet intensive therapy for difficult-to-treat clients, such as those with personality disorders. With a review of relevant principles of psychodramatic practice, she clarifies the compatibility of the 2 types of therapy with basic learning theory concepts. The author provides an overview of schema-focused cognitive therapy, including findings on the validity of Young's schema questionnaire. She also presents and discusses a model for the presentation of schema-focused cognitive therapy through the medium of psychodrama.

Key words: cognitive therapy, psychodrama and cognitive therapy, schema-focused therapy, treating personality disorders

IN THIS ERA OF MANAGED CARE AND LIMITED RESOURCES FOR BEHAVIORAL HEALTH TREATMENT, brief therapy approaches are receiving significant attention. The notion that briefer is better, or at a minimum, cheaper, appears to be a driving force. Many cognitive and cognitive-behavioral approaches are brief therapies, and there is empirical evidence of their efficacy. With difficult or personality-disordered clients, however, brief therapy does not address pervasive underlying factors that contribute to poor functioning. In a review of recent practice in cognitive-behavioral approaches, I found indications of significant use of psychodramatic techniques (Linehan, 1993; Mahoney,

1991b; Young, 1999). Linehan (1993) advocates role playing and behavioral rehearsal in her Dialectical Behavior Therapy for borderline personality disorders. Mahoney (1991b) lists psychodrama and role playing as useful techniques in the cognitive therapists repertoire. Young (1991) suggests the use of role reversal in his point–counterpoint technique. In the model described in this article, I suggest that the cognitive integration of schema principles be used through psychodramatic techniques in a group therapy format.

A model for brief, intensive intervention emerges when the therapist uses cognitive–behavioral concepts that were developed for use with personality-disordered clients, and implements those through psychodramatic and experiential techniques. Young's (1999) schema-focused cognitive therapy (SFCT) is a working theory that is comprehensible to clients and that addresses deeper constructs that underlie their behavior. The schemas are the lenses through which humans see and construe their worlds. Clients who identify and examine their schemas can choose and develop the skills to maintain more adaptive schemas. The treatment approach works well with difficult-to-treat clients but takes more sessions than short-term cognitive therapy. In this article, I suggest that modifying Young's individual therapy format to a group experiential approach marries two compatible concepts: the exploration of schemas through the medium of psychodrama.

The Historical Interface Between Behavior Therapies and Psychodrama

J. L. Moreno, the originator of sociometry, sociodrama, and psychodrama, based his conceptualizations on several common themes. Moreno's concept of mental health involved the multirole personality, meaning that the person has a large role repertoire and can act flexibly in any given situation (Fox, 1987). Moreno proclaimed that the development of optimal role-flexibility occurred in action. He suggested that our perceptions of the world were nurtured in action, and they are most amenable to modification in experiential modalities.

Moreno developed his approaches in reaction to Freud's analytic techniques, which he felt neglected the potential of face-to-face and group therapy and overemphasized verbal interventions. A surprising compatibility with behaviorism emerged as the field of behavior therapy developed in Moreno's later years (Kelly, 1978). In 1958, Moreno noted, "a constructive rapprochement is possible between psychodramatic techniques and some of the current therapeutic philosophies, not only with psychoanalytic theory but also with Pavlovian conditioned reflex principles" (Moreno, 1958, p.127). Moreno went on to note his agreement with some of Hans Eysenck's behavioral conceptualizations (Eysenck, 1967). He agreed with Eysenck that it is more useful to look at a client's relevant learning history than to conjecture on his dynamics; that behavior must be liberated from unawareness to be enhanced,

changed, or extinguished; and that success in treatment should be defined behaviorally, rather than by a subjective assessment of insight or unconscious operations (Moreno, 1963).

An alliance of psychodrama with schema theory has additional historical precedence. Moreno (1958), Adler (1998), and Vaihinger (1984) shared the common viewpoint that the individual is the creator of his or her personality and an active constructor of life's events (Mahoney, 1991a; Monte, 1995). The notion that people develop "fictions" to make subjectively meaningful interpretations of reality is acknowledged in the work of each man. That culminated in another convergence between psychodrama and behavioral approaches that occurred when Kelly (1955) published his *Psychology of Personal Constructs*. Kelly acknowledged his debt to Moreno for such techniques as sociodrama, in which two or more people enact imagined roles rather than those in their own lives. He saw the potential in those activities to facilitate changes in a clients' "constructions" and "reconstructions" of themselves (Stewart & John, 1991). Thus, Kelly's fixed-role therapy draws heavily from Moreno's techniques.

Moreno would be intrigued with the recent acknowledgment of the power of the experiential process to change human behavior in productive ways (Abele, 1989; Blatner, 1988; Blatner, 1989; Hudgins & Kiesler, 1987; Joyce-Moniz, 1988; Kipper, 1989; Mahoney, 1991a; Skafte, 1987). Moreno, as an advocate of the integration of different theoretical constructs, would have been comfortable with a marriage of apparent opposites. He "had a preference for combining contraries into unities" (Kellermann, 1991, p. 29) that achieved a useful synthesis. Thus, a marriage of psychodrama with cognitive-behavioral theory emerges from a complementary history.

Reconciliation of Two Systems: Behavior Therapy and Psychodrama

An examination of particular psychodramatic techniques in behavioral terms and behavioral techniques in terms of their psychodramatic function (Sturm, 1965; Sturm, 1970) provides an illustration of the advantageous interplay between psychodrama and behavioral theory. I present the psychodramatic techniques in the order in which they are typically used to facilitate a group psychotherapy experience.

In a behaviorist's view of the director's warm-up activity, directors encourage interaction and appropriate self-disclosure, and they present themselves as warm, prestigious, and noncastigating models of those behaviors. In the warm up, directors evoke opportunities for reward and discourage opportunities for punishment. In other words, they create an optimal setting for learning new behaviors by creating a safe atmosphere for spontaneous experimentation without undue fear of punishment.

The problem presentation phase of psychodrama occurs as directors elicit the emergence of a problem for the group to solve. In a sociodrama, the problem is a generic one that is of interest to all, and in a psychodrama, the problem is personal and specific to one member but of interest to all. Directors model appropriate self-disclosure, acknowledging their own unsolved problems. The next step in psychodrama is the self-presentation of a participant's problem. Behaviorally, directors identify salient elements of the cue-response-reinforcement system that appear to be operating as the participant describes the issue. Directors then assist the protagonist with the help of the group and the action, either to develop new responses to old cues or adaptive responses to new cues.

The techniques of role playing are central to all psychodramatic experiences. The protagonist and other members of the group learn new behaviors by assimilating parts of the roles they assume and experiencing selective reinforcement from their environment. Kipper (1982; 1989) describes the use of "actional language" in behavior simulation as a way of "concretizing" cognitive and affective processes. Thus, the role play becomes the *in vitro* laboratory where successive approximations of new behaviors are tested and rewarded in a protected environment. In the language of behavior therapy, Wolpe (1958) and Lazarus (1976) describe "behavioral rehearsal" as opportunities for successful attempts to respond acceptably to anxiety- or fear-evoking scenes.

Doubling also can be a powerful reinforcement experience, because adaptive thoughts and feelings are often expressed by the double. The double is a possible bridge between inner reality and the environment (Hudgins & Kiesler, 1987). The reinforcement cues offered by the double support increased risk taking and self-awareness and reduce any sense of isolation on the part of the protagonist.

The use of future projection can be seen as enacted visualization. Experiences that trigger unproductive response patterns can be enacted, and new responses can be identified and practiced. Thus, the repertoire of role-playing techniques strengthens their specific use as a mechanism for useful learning. As Sturm, an advocate for "behavioristic" psychodrama, put it:

> Role-playing is a crucial and versatile learning device. It has its origins in that aspect of "play" that is the universal problem solving device in children and animals: In one sense psychodrama may be viewed as an extension of the "natural" learning of "play" that is adapted to solve more complex and difficult problems. (Sturm, 1965, p. 55)

In role playing, when a protagonist is presented with cues that would normally elicit high-anxiety responses and then is required to respond with active, assertive behaviors, Wolpe's principle of reciprocal inhibition becomes operational (Wolpe, 1958). A response that is antagonistic to anxiety occurs and

weakens the bond between the anxiety-provoking behavior and the anxiety response. Similarly, systematic desensitization, in which reciprocal inhibition is alternated with relaxation, has its counterpart in psychodrama. The support of the group, the double, and the director supplant the relaxation imagery.

Throughout the session, the group members participate as part of the reinforcement system, cueing and rewarding each other's behaviors, as modeled by the director. They, in turn, are rewarded with the possibility of exploring solutions to their own comparable problems. At the conclusion of the session, group members share what they have learned from participating in and observing the enactment. Significant reward accrues to the protagonist as he or she sees the benefit for others derived from the "experiment." In addition, the sharing, if properly guided and synthesized by the director, results in additional cognitive integration of new constructs for the participants. Psychodrama without cognitive integration can result in catharsis junkies, who do not learn new skills but merely emote to no useful end (Taylor, 1996).

When the principles of operant conditioning and behavior therapy are used overtly as well as covertly in psychodramatic approaches, those approaches provide multiple opportunities for enhancing discriminative learning. As Bandura and Walters (1963) noted, the creation of actual or symbolic social situations, in which desired responses are rewarded and undesirable responses go unrewarded, is a powerful learning tool. Not only the protagonist but also the entire group observe appropriate models being rewarded in multifaceted ways, a proven intervention that creates rapid acquisition of new behaviors (Bandura, 1986). Hence, psychodrama "exerts an influence on the emotional, cognitive, and behavioral aspects of the participants and connects their past to their present and future" (Starr, 1977, p. xiii). The psychodramatist provides brief, effective cognitive interventions, using principles of learning theory.

Schema-Focused Cognitive Therapy

The concept of the schema as it is used in contemporary cognitive science can be traced to the work of Bartlett (1932). Through a series of elegant experiments, Bartlett was able to advance the notion of an underlying organizational mechanism, the *schema.* In those experiments, he showed that memories and perceptions are shaped by prior expectations. Subsequently, a number of definitions of schemas have evolved, but according to Thorndyke and Hayes-Roth (1979), they share three major assumptions:

(a) schemas are abstract organizations of conceptually related elements; (b) schemas develop gradually from past experience; and (c) schemas guide the organization of new material (Thorndyke & Hayes-Roth, 1979).

Schema theory has proved useful in the explanation of various psychological phenomena and such concepts as Bandura's (1978) "self-systems," Kelly's (1955) "personal constructs," and Abelson's (1981) "scripts" possess similarities to schema theory. In his early work with depression, Beck (1967) suggested that schemas explain the repetitive themes that occur in imagery and dreams. Schemas may also account for the confirmatory bias that causes humans to interpret events in consistent ways, despite evidence to the contrary.

Young (1999) adapted the schema theory for use as a convenient clinical tool to work with personality-disordered clients. Whereas short-term cognitive therapy focuses on the modification of automatic thoughts, cognitive distortions, and underlying assumptions, schema-focused cognitive therapy (SFCT) emphasizes the deepest level of cognition, the early maladaptive schema (EMS). Young notes that personality disorders do not meet many of the prerequisites for cognitive therapy. For instance, easy access to feeling and cognitions, the ability to form a collaborative relationship easily with the therapist, and motivation to complete homework assignments are skills that may be absent in a person with a personality disorder. In fact, inflexibility and persistent self-defeating patterns characterize many personality disorders.

The underlying assumptions of SFCT include the following: (a) early maladaptive schemas (EMSs) developed in childhood are templates for processing later experiences; (b) unconditional belief systems are self-perpetuating; (c) EMSs are perpetuated by behaviors that maintain the schema, avoid the schema, or compensate for the schema; (d) schemas, even the maladaptive ones, were adaptive at one time; and (e) schemas are not relinquished without a struggle because they are tied to the client's core identity. The primary focus of SFCT is the ways in which schemas are perpetuated. An EMS is the opposite of underlying assumptions that are typically conditional, as in, "If I can be perfect, then I am a worthwhile person." An EMS is unconditional and irrefutable, as in, "Regardless of what I do, I am worthless." Whenever a schema is activated, individuals persist in the belief that, at best, they can only delay or hide from the expected dire outcome. That results in such schema avoidance behaviors as "blanking out," blocking, depersonalization, compulsive behaviors, and self-mutilative behaviors. Some individuals avoid events that might trigger their schemas by isolating themselves, evidencing agoraphobia, or failing to attempt work or to assume family responsibilities.

Schema-maintenance behaviors are those circular processes that reinforce the validity of the schema. Cognitive distortions, such as those elaborated by Beck (1967), are used to highlight information that confirms the schema, such as, "I am unlovable." The individual also distorts by minimizing or denying information that negates the schema (1967). Self-defeating behavior patterns that may have been essential to survival in an individual's family of origin,

when applied in adulthood, only serve to reinforce the maladaptive schema. For instance, if a child experienced extremely domineering parents, he or she may have developed a subjugation schema, which strengthened his or her skills for coping in the family. However, as an adult, if that person repeatedly chooses domineering partners or bosses, those choices become not only self-defeating but also reinforce and maintain the schema. Moreover, schemas are sometimes maintained by overcompensation strategies. In those cases, individuals evidence cognitive and behavioral styles that are the opposite of what one would expect from their histories. For example, someone whose needs were not met in childhood may behave in a demanding, entitled way as an adult. In a sense, some attempt has been made to challenge the underlying schema, but the lack of awareness of the underlying issue leaves the individual vulnerable to deep pain when the schema compensation fails. EMSs are familiar and comfortable and inextricably entwined with an individual's sense of self. Thus, as those formerly adaptive behaviors are challenged, they are not given up without a fight. The metaphor of a war is inescapable.

Schema-focused cognitive therapy involves several steps: evaluation of the schema patterns; educating the client about schemas; identifying triggers to the schemas; confronting schema maintenance behaviors; and changing schemas through emotive, interpersonal, cognitive, and behavioral interventions. Young (1999) recommends the use of his schema questionnaire to identify a client's salient schemas. On the questionnaire, early maladaptive schemas are grouped in the following four primary domains: (a) autonomy, (b) connectedness, (c) worthiness, and (d) expectations and limits. An example of an EMS in the autonomy domain is dependence, the belief that one is unable to function on one's own. An example of an EMS in the worthiness domain is incompetence or failure, a belief that one cannot perform competently in areas of achievement, daily responsibility, or decision making. A connectedness EMS is abandonment or loss, a fear that one will imminently lose significant others and be alone forever. An example of an expectations or limits EMS is entitlement or insufficient limits in which one insists that one is able to do, say, or have whatever one wants immediately, regardless of the effects on others.

In a psychometric study of Young's schema questionnaire, researchers found that it possesses convergent and discriminant validity in relation to measures of psychological distress, cognitive vulnerability to depression, self-esteem, and personality disorder symptomatology (Schmidt, Joiner, Young, & Telch, 1995). Of the 16 factors hypothesized by Young, 15 emerged in the clinical sample, and 13 were replicated in two nonclinical samples. Thus, Young's schema questionnaire has significant validity as a clinical tool for the identification of schemas, particularly in clinical populations.

Once the schemas are identified within the context of the therapeutic relationship, the client and the therapist "go to war" against those schemas, using

experiential, affective and standard behavioral techniques to substitute more adaptive schemas. First, the therapist educates the client about schemas and the enormous emotional strength behind them. The therapist may recommend that the client read Young and Klosko's 1993 book, *Reinventing Your Life,* and *A Client's Guide to Schema-Focused Cognitive Therapy* by David C. Bricker and Jeffrey E. Young (1993). The therapist then triggers schemas, using imagery, discussing recent upsetting events or distressing memories from the past, assigning books or movies that elicit schematic themes, or prescribing group therapy to activate interpersonal schemas.

The therapist confronts the client's schema-avoidance behaviors, such as somatic symptoms or going "blank," and identifies such schema-driven behaviors as self-defeating patterns that reinforce the schema. As Young (1999) describes them, those "partially reinforced responses" are an essential ingredient in the clinical assessment of the client. Once the therapist has identified the primary and secondary schemas and the schema-maintenance behaviors, he or she presents the information to the client for feedback so that they can cocreate a battle plan.

As the therapist and the client begin to modify the schemas, Young (1999) recommends several interventions. Early in the process, the therapist uses emotive techniques to expose the schemas and to identify the constructs that underlie them. As the schema becomes reflected in the client–therapist relationship, the therapist uses interpersonal techniques. Cognitive techniques give the client an arsenal of cognitions with which to fight the schemas, whenever they arise. Young reports that the last stage, which is behavioral change, requires the most time because the self-defeating behavioral patterns are intensely ingrained in the client.

Thus, schema-focused cognitive therapy is lengthier and more confrontational and involves more childhood issues than short-term cognitive therapy. It reflects its cognitive heritage in emphasizing the therapist's active role, an organized approach, homework, and an empirical emphasis on the analysis of evidence. Young (1999) has taken up the challenge of adapting cognitive-behavioral approaches for work with long standing maladaptive patterns and has developed a comprehensive approach.

A Model for Schema-Focused Therapy Using Psychodrama

In this section, I propose variations to Young's approach, describe a typical group format, and outline a sequence of possible group experiences. The primary modifications to Young's schema-focused cognitive therapy that I propose cluster in three arenas. Those include the group therapy format, the use of primarily experiential methods, and the avoidance of pathological language in the presentation of schemas.

Rather than following Young's (1999) one-on-one approach, I maintain that learning takes place in a group and in action, rather than in a didactic format. I ask group members to show, rather than to tell. Each 2-hr group follows a similar sequence: (a) begin with group-building warm-up activities for approximately 15 min, (b) move to sociodramatic or psychodramatic action for 40 to 50 min, (c) allow for cognitive integration of the action by having the protagonist relate the action to his or her EMSs for 15 min, (d) have the director give a brief closure to the action, (e) share the effects of the action on the rest of the group members for 20 to 30 min, and (f) end with a 5-min closing ritual. Productive closing rituals include such activities as choosing props to represent EMSs and putting them in safe places, or having the group recite an affirmative mantra. Although I assign homework as needed, the predominance of the work is experiential. Group members commit to 8 to 10 sessions.

In the last modification of Young's approach, I place greater emphasis on the adaptive nature of early schemas. Rather than label them as early maladaptive schemas, I prefer to call them early schemas. I highlight the adaptive nature of the schema in protecting a vulnerable child. I intend that strategy to minimize the clients' further self-criticism and devaluation. As the group members decide which schemas are no longer productive for them, they label those unproductive schemas. They then strive to acquire the productive schemas that they have identified for acquisition.

It is possible to present this approach to schema-focused cognitive therapy in a variety of nonpathological ways, including as an enrichment class for the general public, with a schema club in a day program of a psychiatric hospital setting, or with a specialized group for outpatients. The therapy is appropriate for personality-disordered clients because the experiential components are powerful, and the group support teaches the usefulness of social support for behavioral change. A mix of clients with varying ego strengths are ideal candidates. If the group members evidence high levels of nonproductive behavior, the group leader increases the safety components of the group as needed. The addition of an assistant or of coleaders, extension of the course of the group, and integration of the input of an individual therapist are ideal safety components.

At the first session of a prospective group of 6 to 10 participants, the focus is on building sociometric connection through the use of warm-up activities that elicit commonalities and build cohesiveness. One technique is to create a series of dyads from the group members in which the two share their reason for attending, one thing they want to change, their favorite song from high school, and so forth. The group leader provides an overview of schemas, using volunteers from the group to illustrate several common schemas and types of schema-maintenance behaviors. The therapist gives the schema questionnaire,

available from Young's Web site at http://www.schematherapy.com, as the homework assignment.

Once the members make the initial connection between themselves and the basic educational process, the therapist uses psychodramatic modalities to deepen the change process. For example, in successive sessions, the members achieve the identification of salient schemas through such exercises as "Walking a Lifeline." As a group member lays out significant events in his or her life, the double and the director assist in linking those events to current nonproductive schemas. The director and double support the group member in identifying the usefulness and the formerly adaptive nature of the schemas.

To identify the costs and benefits of early schemas, the therapist can use a variation of the "Magic Shop" exercise (Leveton, 2001). In that exercise, the group members brainstorm all the benefits associated with holding on to their schemas, and the director marks those on a flipchart as items that can be sold to the Magic Shop. The group also brainstorms a list of payoffs associated with developing a more productive schema, which can be purchased at the Magic Shop. In short vignettes, each member visits the store and symbolically relinquishes a benefit of an old schema to purchase a reward for a new schema. Group members select someone to impersonate the old schema and dialog about the negotiation with each member. The director serves as the proprietor of the Magic Shop.

After describing the principles of schema maintenance, avoidance, and compensation, the group members sculpt the particular ways by which they hold on to their early schemas. They talk with those "behaviors," discussing where and how the behaviors are triggered, what obstacles they plan to use to evade change, how they experience the behaviors physically, and so forth. Playfully concretizing resistance to change defuses its power and eliminates its potential for further undermining a participant's confidence.

As needed, group members keep diaries of triggers or emotions to identify skirmishes that occur outside of the group. The participants can sociodramatically play out generic scenes common to several group members, or they can play out an individual's experience psychodramatically. As additional behaviors emerge that need to be developed as part of a more productive schema, the therapist can use role training to increase the strength of a habit. In a role-training experience, the director sets a scene and when the protagonist evidences a need for new skills, asks group members to come into the scene with suggested behaviors. The protagonist and the entire group are thus exposed, *in vivo*, to numerous models and can acquire the behavior that best suits them.

As the group progresses, the therapist discusses with them the possibility of a relapse and frames it not in pejorative terms but as a visit with an old,

familiar friend. The discussion can include action, in which the protagonist discusses the "old" behavior, reviewing what it was like to experience it again, identifying its costs and benefits, and stressing the new alternatives. In dyads or with the group as a whole, the members develop relapse-prevention strategies and put them on flashcards for easy-access in emergencies. The entire group process models effective, supportive reparenting and conveys a metamessage to the members that invalidates early schemas.

The termination of the group should also convey positive reparenting, as the group members are unlikely to have experienced appropriate closure. Reminiscences, testimonials, and the director's reflections about separation are appropriate material for termination sessions. Whenever possible, each group member should keep some concrete representation of his or her effort and progress as the group ends.

Presenting schema-focused cognitive therapy in a group therapy format that uses psychodramatic approaches has a synergistic effect. The benefits of group process broaden the impact of the therapy, and psychodramatic approaches address the behavioral and modeling aspects of changing deep-seated patterns. Moreover, shifting to nonpejorative language increases the palatability of a challenging task.

Discussion

A few caveats are in order. For this type of intensive group-therapy experience, experienced directors of psychodrama are necessary. The methods are powerful, and a safe environment must be created by the group leaders to avoid deleterious effects. In addition, an overly homogeneous group, such as clients with extremely loose boundaries, is unlikely to provide enough appropriate models for the experience to be beneficial. A variety of levels of functioning is the ideal for a group. Severely compromised clients require the additional support of an individual therapist to complement the group experience. Caveats aside, the model presents a cost-effective, brief alternative to long-term individual intervention for personality-disordered clients.

The use of a group modality to implement a model developed in individual therapy is not uncommon. When the issues are predominantly interpersonal or when the scarcity of resources precludes individual therapy, group therapy is frequently considered as an alternative. In this model, however, an attempt has been made to choose specific approaches that have sound theoretical underpinnings to construct a valid method. By carefully attending to the learning-theory scaffolding that supports much of psychodrama, one can make a cogent case for the use of psychodrama with cognitive models. Thus, with this model, I avoid watering down SFCT and concentrate its concepts where they will have the greatest effects.

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A Survey of Clinical Reports on the Application of Psychodrama

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ABSTRACT. The authors selected 34 case illustrations of psychodrama for a review of the characteristics of that intervention modality. From the data, they concluded that, in general, the practice is consistent with the theoretical model. The main features of psychodrama are that its sessions are based on role playing enactment, that the focus is on one protagonist, and that the basic unit of the intervention is the structure of the single session. The authors suggest that conceptualizing the treatment as a series of successive single sessions, each repeated many times with different protagonists, may place the methods in an ideal position to be easily incorporated into other traditional and modern forms of group psychotherapy.

Key words: applications of psychodrama, clinical reports on psychodrama, survey of psychodrama applications

PSYCHODRAMA LITERATURE OF THE PAST 25 YEARS featured five reviews in English in which the authors assessed the effectiveness of that intervention modality (D'Amato & Dean, 1988; Kellermann, 1982; Kipper, 1978; Kipper & Ritchie, 2003; Rawlingson, 2000). Three of the reviews were based on evaluations of experimentally controlled studies (Kellermann; Kipper; Kipper & Ritchie), The authors of the other two articles used a less rigid inclusion criterion, addressing a mixed bag of controlled studies and case illustrations. The most compelling evidence of the effectiveness of psychodrama comes from experimentally designed studies. Therefore, it is advantageous to separate experimentally generated data from data retrieved from clinical and case illustrations and to focus the analysis on quantitative studies. The advantages in following such a path are, notably, providing scientific validation; influencing economic, third-party-payment consequences; and demonstrating compatibility with mainstream practices. An example of this research strategy is the meta-analytic study reported by Kipper and Ritchie.

At the same time, one must not lose sight of the fact that there is a wealth of information to be gleaned from clinical reports and case illustrations. Therapists frequently contend that certain aspects of their clinical experiences cannot be adequately conveyed by the use of quantitative data and are best expressed through narratives. Consequently, there is a benefit in differentiating between experimental and narrative data. The former contains information about the validity or therapeutic effectiveness of psychodrama, whereas the latter is a description of the psychological dynamics and procedural aspects of the therapeutic process. The focus of the present study was on the clinical narratives.

The Model as Described in the Theory

For a description of the treatment model, we suggest a study of psychodrama theory, notably Moreno's landmark books (1946, 1953). Those provide information about a unique approach to the practice of group psychotherapy. Salient features of the model, gleaned from the theory, are as follows:

The treatment is based on a group format that, for the better part of the session, centers on a single person (*protagonist*).

The function of the group members is to serve as therapeutic agents (*auxiliaries*) the protagonist, to facilitate the concretization (*the enactment*) of various facets of the protagonist's life.

The primary focus of the roles portrayed by the group members is related to the protagonist's presenting problem(s) and not to the personal issues of the participating auxiliaries.

Auxiliaries may gain indirect personal insights from the portrayals of such roles, although such benefits are not always the explicit purpose of the auxiliary role.

Although the model seems to represent an approach that might be considered an individual treatment in the context of the group, some, albeit smaller, parts of the session address the group members. Every session proceeds in a set course, consisting of three parts (*stages*)—a warm-up, the enactment (action portion), and the sharing (*closure*) and processing. The theory places great importance on the concept of *spontaneity* and holds that spontaneity leads to creativity. Hence, the overall goal of the therapy is to train the protagonist to become more spontaneous.

This model, known as the classical model, remained intact for many years, and is the dominant model even today. It is prevalent among recent formulations of the applications of psychodrama, those that use the classical psychodrama method while subscribing to theories other than J. L. Moreno's. Parenthetically, it should be noted that there are a few different versions of

psychodrama enactment procedures that vary from the classical tradition. Those were inspired by the development of a new theoretical outlook suggesting a separation between the actual practice of psychodrama and its original Morenean theory. There was the realization that "[p]sychodrama is more of a praxis than a separate school of thought" (Blatner, 1996, p. 157). The most notable examples of authors reflecting that trend are found in the writings of Farmer (1995), Holmes (1992), Kipper (1986), and Williams (1989).

Other intervention modalities representing a modification of the classical model were evident in psychodramatic models designed for the treatment of special clienteles, such as young children (Banister, 1997), trauma survivors (Hudgins & Drucker, 1998), or the intellectually disabled (Razza & Tomasulo, 2004). Others proposing revised models include Emunah (1994) for the application of psychodrama in drama therapy and Wiener (1994) for the use of improvisation techniques in family therapy.

Regardless of the version of the psychodrama model being practiced, the rationale for the practice retained three characteristics. The session is based on role-playing enactment, focused on one protagonist, and the single sessions have a predetermined (usually three phases) structure.

In this review, we explored the characteristics of the practice of psychodrama as reflected in published case illustrations and clinical reports during the period of 1970–2000. Specifically, we hoped to provide a clearer description of the model that emerged from the clinical descriptions of treating clients with psychodrama. To the best of our knowledge, this is the first review that is based exclusively on such data.

Method

Definition

To maximize the number of case illustrations and clinical reports in the present review, we adopted a broad definition of psychodrama; that is, we viewed a psychodrama treatment as a therapeutic method based on the dramatization of human experiences by means of role-playing enactment under a variety of simulated conditions (concretized scenes). We determined that a case illustration had to describe a therapy session or a series of such sessions that used at least one scene and one psychodramatic technique in a single session (Kipper, 1988). That definition excluded descriptions of techniques for the purpose of demonstrating their procedure or effectiveness, rather than illustrating a therapy case.

Inclusion Criteria and Selection Procedure

It was necessary to resolve two issues as we were determining the inclusion criteria. The first was the differentiation between a description of a therapy ses-

sion and that of a technique. That was important because we wanted to base the review on the ways psychodrama treatments are rendered in ordinary clinical practice. We concluded that articles presenting descriptions of new psychodramatic techniques did not fit that objective and, therefore, we excluded those. Usually, we found no difficulty in identifying such illustrations of techniques, mostly those concerning warm-up, because the authors always indicated when their article was a presentation of a new technique. The second issue was the need to adopt clear inclusion criteria. The reason for that was that several articles, which clearly were case illustrations, lacked vital information about the protagonist and the issue, and other basic data were lacking. In cases of such ambiguity, we opted to exclude the article from our review.

Therefore, to be included in the present review, we decided that case illustrations and clinical reports had to meet with certain requirements. They had to be written in English and had to be published in a professional, refereed journal. We made exceptions to the last requirement for the reports published between 1970 and 1979 in the journal *Group Psychotherapy and Psychodrama,* whose title changed to *Group Psychotherapy, Psychodrama and Sociometry* in 1976. During that decade, the journal was not considered a rigorously refereed publication. In that time period, however, a relatively high percentage of all clinical reports about psychodrama were published in that journal. If we discarded those articles, we would greatly reduce the available sample of case illustrations. As a result, we decided to leave them in the review. The article had to include the following information: the number of participants, both group members and protagonists; their gender and age; the number of sessions reported; the length of a session; the duration of the treatment; the setting; and the psychodramatic techniques employed. We recognized that the inclusion criteria adopted had a few limitations.

We considered only reports that appeared in English and only those published in professional journals, not in books. We also excluded any case illustrations that were conducted as empirical research, which provided quantitative data. We only considered those reports that were strictly narrative. It should also be noted that the articles accepted for publication in the journals of psychodrama are likely to favor the classical format.

Literature Retrieval

The publications base for the articles on case illustrations and clinical reports was the main psychodrama journal published in the United States and other journals published between 1970 and 2000. During that period, the main psychodrama journal appeared under three different titles—*Group Psychotherapy and Psychodrama; Group Psychotherapy, Psychodrama and Sociometry,* and *The International Journal of Action Methods: Psychodrama,*

Skill Training, and Role Playing. Those publications that we could not access in the library were located by computer through PsychLIT and Social Sciences Index. The vast majority of the published case illustrations and clinical reports (95%) appeared in the abovementioned psychodrama journal.

The original retrieval yielded a list of 289 articles. In the first round, we selected the relevant ones and considered approximately 100 as potentially relevant. Each of the selected articles was read and evaluated on a 14-point information-gathering form, relating to the kind of description reported in the article. On the basis of those evaluations, most articles had to be excluded for insufficient information. Finally, 34 articles were admitted to the review. The two researchers agreed completely about the final selection. The appendix contains the list of the articles accepted for our study.

Results

Table 1 contains the data for each of the 34 case illustrations under review. At the left of the table is a list of the authors of the articles and the years in which the articles were published. The next eight columns, from left to right, contain information about the treatment, including the number of protagonists involved in the case illustrations, the gender of the protagonists, their age, the number of sessions conducted with each protagonist, the length of the psychodrama session, the duration of the entire treatment, the setting in which the psychodrama took place, and the main psychodramatic techniques used in the enactment.

The Sources

The extreme left column of Table 1 contains the names of the authors of the selected articles and the date of their publication. The dates reveal that, notwithstanding the effect of the bias created by our inclusion criteria, over two-thirds (70.5%), or 24 of the 34 cases, were published between 1970 and 1979. Only three appeared during the 1980s. The number of the selected reports remained low for the 1990 to 2000 period, featuring only 7 sources. The drop is not necessarily an indication that fewer case reports were published but rather indicates that fewer published case illustrations successfully met our quality screen. The meaning of this is not entirely clear.

The Number of Protagonists

In the column entitled Number of Protagonists, we indicate that about half of the reports (47%), or 16 out of 34, involved a single protagonist (Boylin, 1971; Danielsson, 1972; DeCarvalho & Manteiro, 1990; Deeths,

TABLE 1. Characteristic of Psychodrama Therapy Sessions: Clinical Reports 1970–2000

Source	Number of protagonists	Gender	Age	Number of sessions	Length of sessions (in minutes)	Duration weeks	Setting	Techniques used
Friedman, 1970	5	M/F	—	MP			Youth employment office	RR, MI, Hot seat
Deeths, 1970	1	M	18	S			Residence hall	DB
Olson & Fankhauser, 1970	4	M	—	S			Hospital	RR, DB, EC
Clayton, 1970	7	M/F	—	S	60		Hospital	RR
Hittson, 1970	2	F	—	S			Church	DB, EC, Auxiliary ego
Wolf & Hall, 1971	1	M	30s	—			Church	RR
Boylin, 1971	1	F	—	MP				DB, EC
Pankratz, 1971	1	M	—	MP			Hospital	RR, MI
Olson, 1972	3	M	19	S				RR, DB, SOL
Danielsson, 1972	1	F	—	S				RR
Abraham, 1972	2	F	45	—		3 days		Magic shop
Friedman, 1972	2	M/F	—	S			Training session	RR, DB
Garber, 1973	1	M	30	22			Moreno Institute	RR, EC, Future shop, Psychodrama chest operation

Baum, 1973	9	M/F	8	MP		1 year	Educational setting	RR, DB, Magic shop
Gumina & Gonen, 1973	1	F	30	S	60		Hospital	
J. L. Moreno, 1973	1	M	18	S				DB
Lockwood & Harr, 1973	3	M/F	9	S				RR, DB, Auxiliary ego
Haskell & Larr, 1974	6	M	26	MP	100	10		Auxiliary ego
Naar, 1974	1	F	—	S		2 yrs	Private office	RR, Hot seat, letter writing
Z. T. Moreno, 1974	Several	F	—	S				RR, DB, Future projection
Pisa & Lukens, 1975	4	F	26	2			Treatment center	RR, DB, MI, Pillow
Farnsworth, Wood, & Ayers, 1975	1	F	31	S				RP, DB
Hill, 1977	1	M	17	S			Detention center	RR, DB, Hitting the ground with rolled-up towel
Gagnon, 1979	2	F	21	MP	120	32		RR, DB, fantasy
Guldner, 1982	2 families	M/F	—	—				RR, DB
Sidorsky, 1984	3	F	—	S			Hospital	RR, DB, Age regression

(table continues)

TABLE 1. Continued

Source	Number of protagonists	Gender	Age	Number of sessions	Length of sessions (in minutes)	Duration weeks	Setting	Techniques used
Nordin, 1987	6	M/F	60+	S			Hospital	RR, EC, Role training, Future projection
DeCarvalho & Manteiro, 1990	1	F	34	S			Private office	RR, Auxiliary ego
Sasson, 1990	1	M	—	S	150		Psychiatric treatment center	Fantasy play
Dushman & Bressler, 1991	1	M	17	S			Treatment center	RR, EC, Past projection, Surplus reality
Holmes, 1993	1	F	17	12	120	12		RR, DB, RP
Siegel & Driscoll, 1995	Several	M/F	—	S		1 day	Training session	RR, DB, MI
Wolk, 1996	1	F	—	S			Training session	DB, "Alter ego"
Naar, Doreian-Michael, & Santhouse, 1998	2	F	—	S		36		Judgment technique

Note. M = male; F = female; S = a single session; MP = multiple psychodrama sessions; RR = role reversal; DB = double; EC = empty chair; SOL = soliloquy; RP = role playing; and MI = mirroring.

1970; Dushman & Bressler, 1991; Farnsworth, Wood, & Ayers, 1975; Garber, 1973; Gumina & Gonen, 1973; Hill, 1977; Holmes, 1993; J. L. Moreno, 1973; Naar, 1974; Pankratz, 1971; Sasson, 1990; Wolf & Hall, 1971; Wolk, 1996). About an equal number of cases (15) presented psychodramas with several protagonists, ranging from 2 to 9 per report (Abraham, 1972; Baum, 1973; Clayton, 1970; Friedman, 1970, 1972; Gagnon, 1979; Haskell & Larr, 1974; Hittson, 1970; Lockwood & Harr, 1973; Naar, Doreian-Michael, & Santhouse, 1998; Nordin, 1987; Olson, 1972; Olson & Fankhauser, 1970; Pisa & Lukens, 1975; Sidorsky, 1984). Two reports (Z. T. Moreno, 1974; Siegel & Driscoll, 1995) did not provide an exact number of participating protagonists, and one case (Guldner, 1982) reported a psychodrama session with two families treated together as one group. Some of the psychodramas that were conducted with several protagonists, however, actually were multiple sessions with each involving a single protagonist. Altogether, the picture that emerges is the tendency of the authors to describe psychodrama of a single protagonist.

The Gender of the Protagonists

In Table 1, the third column from left contains information about the gender of the protagonists, the letters M standing for men, F for women, and M/F for sessions with male and female protagonists. There is a slight skew in the gender of the participating protagonists, tending toward a greater number of females. The reports featured 15 cases about women and 11 cases about men. In 8 cases (23.5%), the reports described the psychodramas of male and female protagonists, but in two of those—Friedman (1970) and Clayton (1970)—had more women than men protagonists. Although the protagonists in psychodrama case studies were men and women, there was a slight preponderance of descriptions of female clients.

The Age of the Protagonists

Only about half (18) of the sources in the present review provided information about the age of the treated protagonists. For the other 16 reports, such data were not available. The present data show that the ages of the protagonists ranged from 8 and 9 years (Baum, 1973; Lockwood & Harr, 1973, respectively) to 60 years and older (Nordin, 1987). We disregarded the extremes, the very young and the elderly participants, and determined that the mean age of the protagonists was 24.8 years. In 14 of the 18 cases (77.7%), the protagonists' age ranged from 17 to 34 years. From that information, one can conclude that psychodrama is applicable with a very wide range of ages, from young children to adolescents, adults, and the elderly.

The Number of Sessions for Each Protagonist

In the column about the number of sessions conducted with each protagonist, the letter S stands for a single session and the letters MP for multiple sessions. In three instances, the researchers did not include the exact number of multiple sessions. Thirty-one of the 34 case illustrations contained information concerning the number of psychodrama sessions that served as the basis for the report. More than two-thirds of those (70.9%) were case illustrations consisting of a single session. Of those, 11 reports (35.5%) contained descriptions of a single session for a single protagonist. Nine reports were based on descriptions of multiple sessions. Five articles described multiple sessions with a number of protagonists (Baum, 1973; Friedman, 1970; Gagnon, 1979; Haskell & Larr, 1974; Pisa & Lukens, 1975). Four of these were single sessions for each participating protagonist. Boylin (1971) and Pankratz (1971) reported multiple sessions for one protagonist. The overall picture that emerges for these data is that the majority of the reports depicted a single psychodrama session for one protagonist.

The Length of the Psychodrama Session

In only 6 out of 34 case illustrations did researchers provide information about the length of the psychodrama sessions. The available data show that the sessions varied from 1 hr (60 min) to 2½ hr (150 min). In three cases, the length of the session was within the traditional length of group psychotherapy (e.g., Clayton, 1970; Gumina & Gonen, 1973; Haskell & Larr. 1974). In three cases, the sessions lasted considerably longer, that is, 2 or more hr (e. g., Gagnon, 1979; Sasson, 1990; Holmes, 1993). The paucity of information about that issue makes it impossible to detect any definite trend.

The Duration of the Treatment

Only 8 of the 34 case illustrations, or 23.52%, provided data concerning the length of the entire course of treatment. In two instances, researchers reported intensive and relatively short treatment, lasting one to three days (Abraham,1972; Siegel & Driscoll, 1995). Those were workshop or intensive weekend-type psychodrama experiences. The remaining six descriptions had varied length of a treatment course, such as 10 weeks for Haskell and Larr (1974), 12 weeks for Holmes (1993), 32 weeks for Gagnon (1979), 36 weeks for Naar et al. (1998), 1 year for Baum (1973), and two years for Naar (1974). The paucity of information about that aspect of the treatment makes it impossible to detect any definite trend. That conclusion notwithstanding, readers need to remember, when considering the findings in the table under the Number of

Sessions column, that two-thirds of the 34 cases of the present reviews conducted psychodrama treatments that lasted a single session, whereas only 9 cases extended beyond that one-time intervention.

The Treatment Setting

The second column from right in Table 1 lists the settings in which the psychodramas took place. Twenty-one of the 34 articles (61.7%) provided such data. The list of the treatment venues covers a wide range of settings, including hospitals, detention centers, private offices, churches, and training facilities. Evidently, psychodrama has been practiced in a full range of educational and mental health facilities.

Psychodrama Techniques

Researchers for all case illustrations and clinical reports used in this study provided information about the specific psychodrama techniques that they employed. We were not surprised to note that authors described a wide use of the basic psychodrama techniques, as reported in the extreme right column of the table. Of the list of techniques used in each report, role-reversal (RR), double (DB), and the empty chair (EC) constitute the most frequently used strategies. The mirror technique (represented by the letters MI) was not as frequently used. That technique was explicitly mentioned only in four case reports (Friedman, 1970; Pankratz, 1971; Pisa & Lukens, 1975; Siegel & Driscoll, 1995).

Discussion

Our analysis of the case illustrations led us to interesting observations about the salient features of the practice of psychodrama. We concluded that there is evidence that the practice is consistent with the theoretical model as described in the professional literature. We also concluded that regardless of the different nuances of its underlying rationale, the psychodrama method with its three fundamental characteristics, was evident in the cases studied. The illustrations repeatedly demonstrated that the three facets of the treatment served as the foundation of the clinical intervention. All the reports included descriptions of the use of role playing techniques with a focus on a single protagonist, and most of them were psychodramas of single sessions.

In searching for evidence of the therapeutic effectiveness of the enactment, we found it useful to differentiate between two aspects. The first is related to the hypothesis that the concretization of internal and external realities in the form of role playing or behavioral simulation (Kipper, 1982,

1986) has a therapeutic advantage. That has been the long-standing theoretical stance of classical psychodrama (J. L. Moreno, 1946, 1953, 1966). Although that position appears intuitively true and has been supported by clinical experience, it still awaits scientific validation. The other hypothesis concerns the therapeutic value of each individual psychodramatic technique, most notably role-reversal, double, the empty-chair, and the mirror techniques. The hypothesis claims that those techniques, and perhaps others as well, are therapeutically meritorious, partly because each tends to activate a different psychological process (Kipper, 1986). To a great extent, that claim has been empirically validated (e.g., Kipper & Ritchie, 2003). The clinical practice reflects that scientific reality. The techniques constitute the foundation of the psychodramatic enactment. They are introduced as essential instruments to facilitate role-playing explorations in classical psychodramatic scenes. Also, they are used intermittently to intensify members' interactions and reach deeper explorations of psychological conflicts in the context of verbal therapy (e.g., Farnsworth et al., 1975; Naar, 1974).

The second aspect concerns the vast majority of the clinical reports that presented descriptions of a single session, suggesting to us, implicitly and explicitly, that the single-session-per-protagonist format is the basic unit of the treatment. In fact, both the theoretical model and the clinical practice treated the entire course of the psychodrama therapy as a series of successive, same-structure, single sessions in which each session focuses on a different group member. That model of psychotherapy is becoming increasingly popular among newer modalities, for example, Cognitive Group Therapy or Interactive Behavior Therapy (Razza & Tomasulo, 2004), in which the design of the single session is repeated many times over, thus comprising the entire course of the treatment.

Conceptualizing the entire course of treatment in such a manner differs from the traditional view held by verbal forms of group psychotherapy. According to the latter, the course of the treatment follows a process that recognizes three or four phases. Each of those elicits unique interpersonal dynamics and is characterized by different themes and issues and different levels of intensity and depth. Although the names of the phases vary from one approach to another, all address a similar fundamental structure. For example, when describing psychodynamic group psychotherapy, Rutan and Stone (1993) distinguished among four phases that they described as follows: the formation of the group, the reactive phase, the mature phase, and the termination phase. Yalom (1995) identified three phases, which he described as the beginning, the advance group phase, and termination. Corey and Corey's (1997) four phases were labeled the initial stage, the transition stage, the working (or working through) stage, and the ending stage. The system-centered group therapy (Agazarian, 1997) developed through three phases classified around the issues of authority, intimacy,

and life and dependency. The emphasis of those group psychotherapies focused on the phase structure of the entire course of treatment, paying little attention to the internal structure of the single session. The psychodrama model reflects the opposite approach. It has placed a heavy emphasis on the composition of the single session. The reason for the absence of published discussions on the phase structure of the psychodrama therapy is unclear. To the best of our knowledge, there has not been a serious discussion about whether there is a difference regarding the themes, the issues, and the conflicts between psychodramas portrayed in the beginning of the group therapy and later in the group's existence. From our review, we concluded that the single-session structure has become the hallmark of the psychodrama intervention.

One thought that comes to us as a result of our discussion is that the strength of psychodrama seems to rest in the potentially powerful outcomes that result from a well-executed single session. Because it is easy to transport a model based on a single session intervention, as a unit, from one form of treatment to another, perhaps the strength of psychodrama lies in the element of its transportability. Therefore, one might encourage the incorporation of a psychodrama single-session format into other modalities of group psychotherapy.

It is not clear to us why there was a drop in the publication of clinical reports during the last two decades. Two-thirds of the 34 cases reviewed appeared during the 1970s. After that, very few clinical reports appeared in the psychodrama journals. Also, we would be remiss not to mention the issue of the quality of the case illustrations we reviewed. We wished that they provided complete information about the protagonist, the circumstances of the therapy, the intervention, and its outcomes.

It is fitting here to raise a note of caution. The inclusion criteria that guided the selection of the material made certain that the cases to be reviewed contained the necessary information for our analysis. In so doing it excluded clinical reports that were deemed incomplete or lacking basic, necessary data. We considered only clinical reports and case illustrations published in English and in professional journals. We did not review cases that appeared in books or that were part of experimentally designed, quantitative studies. Therefore, although our sample may represent the best of the case illustrations, it may not represent all the studies that have been published.

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APPENDIX
Published Case Studies Included in the Kipper–Hundal Survey Study of Published Articles on Psychodrama Techniques

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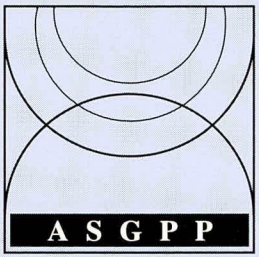

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