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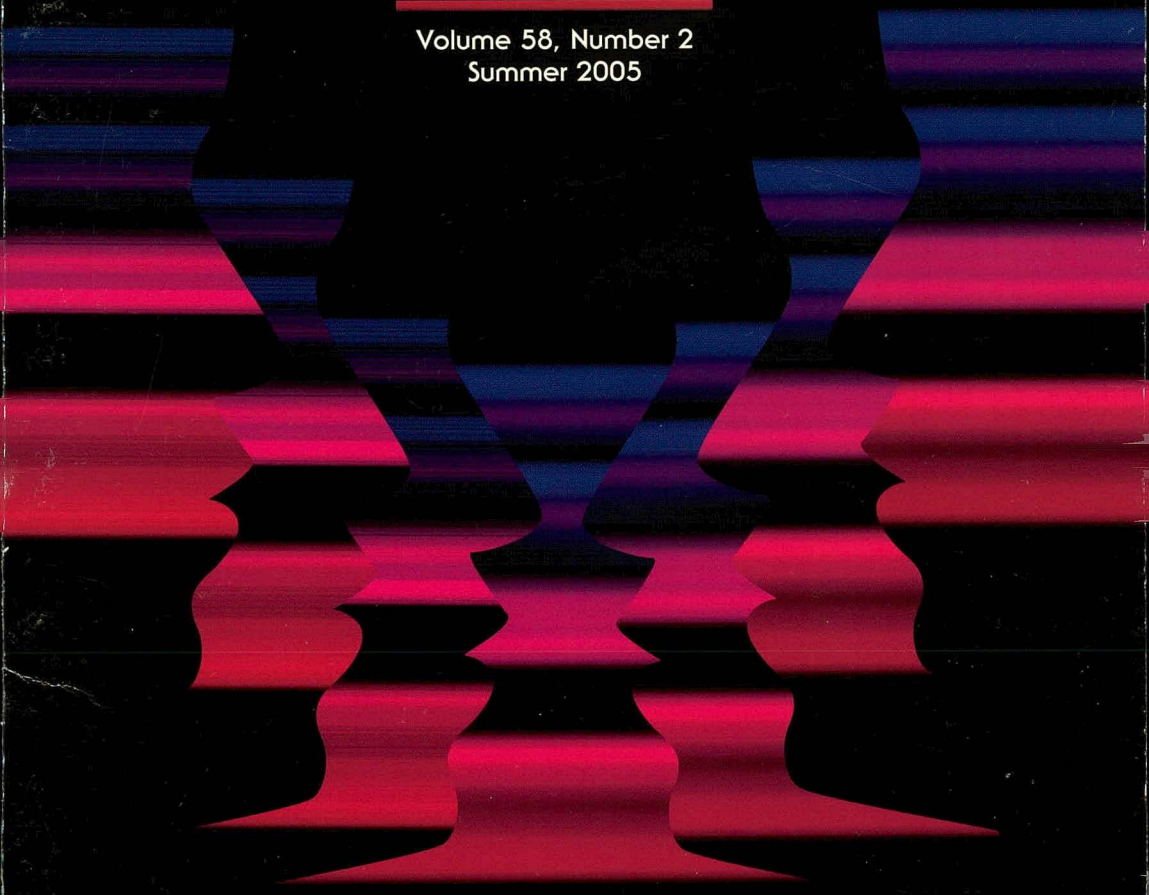

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Contents

Founded by J. L. Moreno

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Introduction to the Special Issue on the Treatment of Couples and Families With Psychodrama and Action Methods: The Case of Generic Psychodrama

When, in the first half of the 20th century, J. L. Moreno proposed the structure of traditional psychodrama, it pertained, primarily, to the composition of the individual treatment session. Moreno (1964) described the individual psychodrama session as having three phases: the warm-up, the action portion, and the sharing phase, which is the part that brings the session to closure. In the early days, adherence to this internal structure was not rigid, and there was an overlap between the phases. In the ensuing years, however, some of Moreno's students provided more detailed descriptions of the dynamics and characteristics of each phase and drew clearer boundaries between them (e.g., Blatner, 2000; Kipper, 1986; Starr, 1977; Yablonsky, 1976). For instance, the action portion was composed of several scenes, all connected by clues generated either by the protagonist or the auxiliaries. The plot of the scenes within the action phase was to be in an upward, ascending manner with progressively increased involvement, reaching a peak before the end of this part of the session (e.g., Hollander, 1978). For the most part, the focus on the single session and its internal composition remain the foundation, the core, of contemporary practice. In an analysis of psychodrama case illustrations published in the last 25 to 30 years, Kipper and Hundal (2003) wrote, "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 session has a predetermined (usually three phases) structure." (p. 143).

Among the characteristics of psychodrama, the use of role-playing enactment became the hallmark of this psychotherapeutic modality. Indeed, there has been a pervasive notion among contemporary psychodramatists that because psychodrama is a psychotherapy based on role playing, enactment is always preferable, even advantageous, to nonaction verbal interactions. The maxim "actions speak louder than words" seems to have turned into "action (always) speaks better than words." The elevation of the importance of role-playing enactment to such a high level is also manifested in spontaneity training. Psychodrama trainees are taught that spontaneity is best evoked through enactment. Most practitioners conduct the warm-up phase (the part of the session that is supposed to produce spontaneity) using action and role-playing exercises, rather than having the group members sit and talk. In fact, there is no evidence that actions always speak better than words, and clinical experience disputes the veracity of such a belief. In his defense, Moreno, the originator of psychodrama, made no such claim. Quite to the contrary, he asserted that it is incorrect to assume that spontaneity is best associated with action. Moreno made this point abundantly clear when he wrote:

> Spontaneity is often erroneously thought of as being more closely allied to emotions and action than to thought and rest. This bias probably developed because of the assumption that a person cannot really feel something without at the same time being spontaneous and that a person who is thinking can have a genuine experience without spontaneity, but this is not the case. . . . . As we know now these are fallacies. 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. (Moreno, 1964, pp. 111–112).

During the last 25 to 30 years, there has been a growing realization among psychotherapists of all theoretical persuasions that different psychological dysfunctions require different therapeutic interventions. It became clear that, contrary to the old belief, no one therapeutic format is best suited to deal with all forms of psychopathology. To maximize effectiveness, more dysfunction-specific treatment varieties are required. This change of approach is also becoming evident in the practice of psychodrama. New models of psychodrama intervention are being proposed for different psychological disorders. These dysfunction-specific interventions depart from the classic psychodrama in at least two ways. First, they involve much more verbal interaction, which is interspersed between the enactment. Second, they may not follow the traditional internal structure of the session or the flow of the scenes within the action phase. Recent examples of this development are evident in the work of Hudgins (1998) in the treatment of trauma, the treatment of clients with intellectual disability (Razza & Tomasulo, 2002), and the incorporation of cognitive behavior techniques in psychodrama (Treadwell, Kumar, & Wright, 2002).

These new developments suggest that we may witness a shift from a model of psychodrama intervention based on the classical approach to one that may be described as generic psychodrama. Generic psychodrama, when compared to the typical session of the classical model, has different requirements with regard to the conduct of the individual session. The individual session may still contain the traditional three-part structure—the warm-up, the action, and the closure, but these are not conducted as discrete parts. Rather, they flow as one continuous phase. The last part of the session in the generic model involves feedback and analysis of the lessons gleaned from the session rather than the traditional sharing. Most important, the action part is not necessarily based on different scenes from the past. Instead, it involves the enactment of feelings, thoughts, and behaviors in the here-and-now, in the therapist's office, rather than on the psychodrama stage.

The first two articles in this issue represent the use of psychodrama interventions that illustrate the generic model (a term that is mine, not the authors'). The characteristics of the treatments described in the articles are as follows:

1. The treatment is of one couple (or one family), usually a married couple, rather than a group of strangers.
2. The role playing does not necessarily follow the classical internal structure of a session.
3. There is a considerable amount of discussion and reflection about the enactment on the part of the therapist.
4. The therapist or the cotherapist takes the role of the auxiliary in role reversal, and doubling.

The two articles illustrate the treatment of couples similar to the one described by Moreno early in the 1960s. In his famous film featuring a psychodrama of a married couple, he illustrated a similar format. In the absence of a group, the therapist can invite a professional auxiliary (in the film, it was Zerka Moreno) to participate.

In the first article, Eva Leveton describes the treatment of two couples, when only one therapist is available. She focuses on the issue of mutual blame, which is so common among couples beset by a strained relationship. Leveton takes the reader through the process of helping each member of the couple to be open with himself or herself and with the partner and to see personal behavior from different perspectives. The author presents two vignettes to illustrate her treatment approach. As the reader will notice, the use of a double is the primary psychodrama technique in the treatment of the couples. The double is a versatile technique that offers myriad possibilities. Leveton also discusses the theoretical issues concerning crossing the boundaries when the therapist becomes an auxiliary, a phenomenon typical in situations in which only one therapist is available.

The second article, by Chris Farmer and Marcia Geller, contains a description of the treatment of couples when two therapists are present. One serves as the therapist, and one is a cotherapist (auxiliary). Obviously, the availability of two therapists creates different dynamics from those described in the first article. To illustrate their approach, Farmer and Geller provide five clinical vignettes. They use psychodrama techniques within the theoretical framework of Bowen, which is one of the most popular family treatment approaches. The reader will notice the extensive use of the role-reversal and double techniques.

The third article, by Daniel Wiener and Laurie Pels-Roulier, is an extensive review of action methods techniques and exercises that have been described in family therapy literature. Unlike Farmer and Geller in the previous article, the authors do not present any case illustration or clinical vignette. Instead, they describe an array of action methods interventions. The authors distinguish between psychodrama-influenced techniques and those that were not inspired by psychodrama. The later were developed and used in approaches that differ from psychodrama in their underlying premises, structure, design, and implementation.

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Escaping the Blame Frame: Experiential Techniques With Couples

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ABSTRACT. In couples therapy, the therapist often finds it difficult to shift to a more productive process. Experiential techniques can break the destructive pattern and introduce new, more effective ways of communicating. In this article, the author explores couples work through case examples using specific dramatic techniques and considers a broad range of clinical thinking, with particular attention to the challenges of using psychodramatic techniques in a group of three. The author also addresses the question of the therapist taking a role in an enactment.

Key words: blame, couples therapy, psychodrama techniques

PSYCHODRAMATIC GROUPS AND COUPLES who enter treatment come with different expectations. Although group members expect to work actively and on their own problems, the couple arrives with the expectation that the therapist will help them solve their problems by talking while they assume a more passive stance. Using psychodramatic techniques with a couple represents a break in an expected pattern. J. L. Moreno illustrated his work with a couple in a psychodrama group in one of his earliest articles (Fox, 1987). On the West Coast, active techniques were tried early on. Fritz Perls (Perls, Hefferline, & Goodman, 1973) introduced the notion of having couples address each other directly, rather than speaking to the therapist about their problems. Virginia Satir (1972) also discovered that family members were more effective when communicating directly. Thus, the first request to a couple to play a role may have been, "Play yourself," because speaking directly to a partner in a social situation in which one expects to address the therapist is a shift away from ordinary conversation.

Satir developed a technique called family sculpture (Jefferson, 1978), which she incorporated into her work with couples and families. Since then, there has been a widely accepted blend of family and couples therapy and experiential work (Fisher, 2002; Gladding, 1985; Guerin, 1976; Jefferson, 1978; Kipper, 1986; Papp, 1976). Psychodramatists also began to work with families and couples. Zerka Moreno, for example, describes her psychodramatic work with families in a chapter that illustrates the adaptibility of role play to the family therapy setting (Holmes & Karp, 1991).

In this article, I consider the ways a clinician who has completed some training in psychodrama or drama therapy can incorporate role playing into work with couples. I explore the techniques that, over a period of 40 years, I and my students have found most rewarding. Because the negative consequences of therapeutic work are so seldom discussed, I also address what may go wrong (Fisher, 2002).

Couples usually enter therapy with each person blaming the other. Taking no responsibility for what has gone wrong, each partner expects the therapist to join in blaming the other person. Without active intervention from the therapist, blame can easily dominate the therapy sessions, and verbal intervention alone is often insufficient.

Couples work is difficult, partly because of its inherent systemic problems (Chasin, Grunebaum, & Herzig, 1990; Fisher, 2002; Papp, 1976; Wile, 1981). As the outsider in a trio in which two members communicate in negative but, at the same time, well-rehearsed, intimate, and protective communication, the therapist may experience frustration, anger, and helplessness, rather like the child of quarreling parents. Through objective identification, a process by which an individual teaches another how to behave in a pattern established earlier (Fisher), the therapist is often induced to join the harmful process. So much recrimination fills the air that the increasingly discouraged therapist begins to want to blame the couple for blaming.

Moreno called sponteneity the ability to respond authentically and appropriately to a new situation and viewed it as the basic building block of mental health (Fox, 1987). When recrimination provides the main content, the therapy has entered what family therapists often refer to as the blame frame, a state in which both clients and therapist have lost their spontaneity.

Often at the beginning of couples work, psychodramatic techniques can make the difference. The therapist's interrupting a couple's demonstration of woe by doubling or requesting to make a sculpture of their relationship can shift a pathological routine to sponteneous interaction.

The following case vignettes are drawn from my own clinical experiences and those of therapists I have trained. Names and identifying information have been changed to preserve privacy, and the dialogue has been edited to make it more readable.

Psychodramatic Sculpture With Stacey and George

Psychodramatic sculpture is a technique by which the individual molds the partner into a shape and expression and then includes the sculptor. It is especially effective with couples because it breaks the couples' expectations of therapy as problem- and content-oriented by asking for active, creative participation. The therapist remains in charge, taking an authoritative role, not as expert advisor but as the director of the sculpture. Directions that discourage talking provide clues to the couples' intimacy that are seldom obvious in talk therapy (Leveton, 2000).

Stacey and George are graduate students in their early thirties. Stacey wants to become a nurse, and George is an art student who paints and sculpts. They are married and have been seeing their therapist for the past month in weekly sessions. George has a serious, somewhat distant air, whereas Stacey fairly bubbles as she talks. In relating the couple's problems, George talks a lot about his resentment of Stacey's need to control him, and Stacey believes that her efforts to take care of George are unappreciated. Both come from large, Irish families; Stacey is the oldest of five, and George is the youngest and only boy in a family of six. When, during the second session, George expressed his anger at Stacey for criticizing his behavior at a party, the therapist suggested that perhaps a sculpture might help bring the argument to a different level.

Therapist: I know that you're angry right now, George, but I wonder if we might try something different because we all know that this is familiar territory for the two of you. Let's not talk it out. Let's do something active and creative. You're a sculptor. I know you usually do more abstract work, but would you consider doing a living sculpture? (George and Stacey look interested.) What I'd like you to try right now, if Stacey will cooperate, is to sculpt her in a pose that expresses how you see her when she's being critical of you. With her cooperation, you can mold her body to the shape you want.

George: Yeah, I could try that.

Therapist: Good. You are to demonstrate a pose by showing her. I don't want you to talk, OK? If you must speak, use very few words. But first, let's ask Stacey. Stacey, would that be OK with you?

Stacey: I guess so. I'd rather do anything than argue this problem all over again.

George: Sounds like something different. OK.

Therapist: Great. Your job, Stacey, is just to be clay and to let George mold you. George, how about it? Is this something you could do?

George: No problem.

Therapist: OK, let's get up and get started. (The therapist rises.)

One of the obstacles, brought up again and again by therapists and students, to the use of active techniques in individual and couples therapy is the diffi-

culty of getting up out of the therapist's chair. Even therapists trained in psychodrama seem to have difficulty initiating action once they have taken on a talk therapist's role. The expectation of being an expert is enough to glue them in one place, talking endlessly. Again and again, participants tell me that, once having got up, the process becomes easy and fun.

The therapist stands back and waits for George and Stacey to stand opposite each other, observing them. George and Stacey stand for a moment, looking at each other. Then Stacey casts her eyes downward, and George starts to raise one of her arms to shoulder height. She has made herself quite passive. He curls her hand into a fist with one pointing finger, stands back and looks at her, smiling. Touch seems to come easily to this couple.

George: Yeah, that's it.

Therapist: (Aware of her own tendency to criticize in her marriage, playing for time.) Maybe you'd like to do a little more.

George: Oh yeah, this!

George takes Stacey's head and cocks it to the side. Then he looks at her sternly, with a gesture that asks her to imitate him. She does so. He looks at her and stands up in a more determined, upright position, again indicating that she should imitate him. She does so. He stands back.

George: Yup. That's it. That's exactly it.

Therapist: Ok, George. That's great. Stacey, good.

(In action work, I find that praise helps clients gain confidence.)

Therapist: I have one more task for you. George, before you finish, I'd like you to fit yourself into the picture.

George: Me?

Therapist: Yes, so if I were looking at this sculpture in a gallery, I would see that it is about relationship.

George: Oh, all right. I get it, like a group.

He squats down in front of Stacey's pointing finger, puts his head down by his knees and both hands over his head so he can neither see nor hear Stacey.

The sculpture is a kinesthetic, graphic version of the couple's problems. The therapist could now begin to explore the relationship by addressing the physical level directly. When emotional states are linked to bodily sensations, awareness is improved (Grinder, 1983).

Therapist (who is experiencing her own guilt about being judgmental in her marriage and is glad she is not taking a role in the enactment): Stay there for just a moment; really tune into yourselves. Don't move. What are you feeling in your body? How does it feel to be in this position?

Stacey and George: (speaking simultaneously) Awful! Ugh! I hate this. No way do I want to stay here!

Therapist: OK, one at a time. Stacey, what are you experiencing?

Stacey: Well, let's see. Oh, I know. I am feeling really, really tense. In the fin-

ger that is pointing, of course, but also in my back and my neck. Real tight. (She pauses, as if asking herself a question, which she then answers.) I know exactly. I feel just like my father. When he used to come home just before dinner time, my mother would tell him everything we'd done wrong. And then he'd call us all into his room and start lecturing and pointing. God, I felt so bad! I usually felt guilty about something and I knew he meant me. There was just no way to get out of it. I hate being in his position now. To make the other person small.

Therapist: So what is that like? Are there any other feelings?

Stacey: Well, whoa, this is a surprise! Wow! I feel strong. I guess that's OK. But not really. I feel so uptight and rigid. I feel like such a jerk, pointing the accusatory finger like that. Oh wow, I wish it weren't so familiar. (She blushes self-consciously.)

Therapist (satisfied that Stacey has arrived at some insight): Good. Thanks. OK, George, how about you?

George (sarcastically): Oh, I love crouching down in fear. It's great! OK, I'll be serious. I actually feel uncomfortable all over. This isn't right. It's awful! I know I was wrong again, but I'm so used to it that I don't even try to find out what I did this time. I just try to cover my ears so I don't have to hear it.

Therapist: Any idea where that comes from?

George: Oh, definitely. That's my dad and me. Every Friday. He'd have a drink with the guys from the office and when he came home, he'd be just spoiling for someone to get mad at. And, of course, my mom would have a note from the teacher about how I'd cut up or not handed in my homework . . . always something. Boy, was I happy when one of my brothers was in trouble.

Both partners were able to respond to the therapist's questions with feeling and introspection. The congruence of their interpretations was startling. Both associated stern fathers with the sculpture. Stacey had identified with hers, whereas George remembered that he had cowered in front of his dad. With some shame, both partners recognized the rigidity of their own roles and resolved to stop repeating this pattern. Both had aquired a new lens through which they could picture the other's situation and empathize with the child who had been trapped in it. The conversation softened; Stacey and George had escaped the blame frame. They became more spontaneous, demonstrated greater role flexibility, and were able to shift their dialogue to important issues and away from the petty squabbles that had alienated them.

Using Doubling With Burt and Ethel

Doubling is a psychodramatic technique that allows unspoken dialogue to become explicit. Psychodramatists vary in the way they apply the doubling technique (Blatner, 1996; Kipper, 2003; Hudgins & Kiesler, 2002; Leveton, 1977, 1991, 2000). I establish two rules. First, the double must use the pro-

noun *I*. Second, because I like to avoid the double being used as a spokesperson, only the client being doubled can hear the double. Therefore, to be effective, the client must repeat what the double says. A client who argues with the double may be voicing an inner conflict. However, a lack of response from the client or a neutral, disinterested response suggests that the double has gone off the track (Leveton, 2000).

Burt and Ethel have been seeing their therapist for about three months. Burt is a well-known lawyer, and Ethel has a cosmetics business. They are in their early fifties with problems that date back to their honeymoon, when, according to Ethel, Burt left her to take her first meal alone in the hotel dining room because he was talking to another couple he had met in the bar. Married 15 years, they are well rehearsed in mutual blame. Ethel's manner is dramatic, self-pitying, and off-putting. Burt is quietly intelligent, rational, and in denial about any responsibility for the marital conflicts. When blame esca-lated as they recalled the events of a recent dinner party, the therapist began to double.

Ethel: Even though we'd been over and over it, he was one hour late, leaving me with these people I didn't know and the dinner to take care of. I just can't understand why he keeps doing this to me. Why?

Burt: I'm a lawyer, Ethel. I had to stay with my clients. You know I'm working on a corporate problem. What else can I do? You tell me. Tell me what else I could do.

Therapist: (Recognizing that the blaming would continue its familiar tracks, the therapist moves to Burt's side and because this is a new technique for this couple, gives a short introduction.) I'm going to say some of the things that you, Burt, might be feeling or thinking but not saying. If you agree, repeat what I have said. OK?

Burt nods his assent.

Therapist as Burt's double: I'm asking Ethel what else I can do. I wish she would tell me. I wish somebody would tell me.

Burt (with a sardonic smile): Yes, I wish somebody would tell me because I can't seem to get out of this any other way.

Therapist as double (hoping to break through Burt's denial and also expressing some irritation with his persistence at playing the innocent): But I do know what else I could be doing now?

Burt: No, I don't.

The therapist attempted to break through Burt's denial and avoidance of responsibility by doubling. When she challenged him with the statement, "But I do know what else I could be doing now," hoping to shift the level of his response, he rejected the challenge, possibly responding to her impatience. Realizing that she had made an error, she addressed his resistance by changing course and led him to explore Ethel's state of mind, guessing that he was

quite capable of empathizing with his wife but avoided doing so because he would have to face his own feelings of guilt.

Therapist as double: Don't I know how Ethel was feeling?

Burt: Of course, I know. She's upset and mad. What else is new?

The therapist then gives words to his denial.

Therapist as double: And I don't want to hear about it.

Burt: And I don't want to hear about it.

When the therapist doubled for Burt's frustration with Ethel's complaints with those words, she was moving toward a more emotional level. She discovered that Burt needed to express more negative feelings.

Therapist as double: I don't want to hear about it. But I can understand it.

Burt: Not really. We've been married for 20 years. She knows this could happen.

Therapist as double: I wish she were different. But I do understand she's kind of left holding the bag here, don't I? It's hard for me to admit because I don't want to justify what she's blaming me for but—

Burt (breaking in): OK, OK, that's true. I don't want to be blamed.

Therapist as double: And I forget that she's in this too, and she was probably feeling—

Burt: overwhelmed. Yeah, OK. Otto and Helen can be a pain, I guess. And they don't know her all that well.

With Burt's acknowledgement of his own fear of blame and his beginning empathy for Ethel's dilemma, the therapist could start to work with Ethel's side of the complaint. Although she had hoped that Ethel would be able to elaborate her own feelings without blaming Burt, Ethel was not yet ready to do so.

Therapist: So, Ethel, is that right, did you feel overwhelmed?

Ethel: Sure! That's just the beginning, though. He just has no idea how complicated my life is with all this stuff that he expects me to do and then . . .

Therapist (sensing Ethel's moment of sadness and moving to her side): Let me try the same thing I tried with Burt, OK? (Ethel nods).

Therapist as Ethel's double: (she gives expression to Ethel's depression): I just don't have a lot of hope left, that's all.

The double was taking a chance, hoping that Ethel would be able to acknowledge her own depression, instead of blaming Burt.

Ethel: You can say that again.

Therapist: (Therapist drops out of the strict doubling role for a moment) If it fits, you say it.

Ethel (sighing): I don't have much hope. It's been so long.

As the doubling continued, Ethel could answer the double's questions with a new ease and softness. Had the therapist intervened with a similar question without doubling, she believed that Ethel would have continued the blame game, disqualifying earlier positive experiences.

Therapist as double: (Therapist is relieved that Ethel could express a deep feeling.) And that makes me feel?

Ethel: Really, really sad. Sad, Burt. (Ethel looks at her husband.)

Therapist as double: Because it was different earlier in our marriage?

Ethel: Oh, yes. Burt is so much more social than I am, and I used to love it when he brought people over.

Sensing that the ground had been prepared for Burt to do some internal work, the therapist introduced the soliloquy (Blatner, 1996).

Therapist: Burt, how would you feel about exploring this business of being blamed a little further? We'll still use doubling, but we'll just be thinking out loud about what's going on inside you, not Ethel. This is called a soliloquy.

Burt: Oh yeah, like Hamlet, sort of. That's OK. Go ahead.

Therapist rises and gestures to Burt to do the same.

Therapist: Let's just walk around the room together for a bit. That way you're not looking right at Ethel, and you can concentrate just on yourself. You can talk this out, just as you might think it out, and I'll help you where I can. (Both are walking now) Why don't you start by saying, "Sometimes I just don't want to listen because I'm so afraid of being blamed." Talk about what blame means to you.

Burt: OK. It's true. I'd do anything if I could just come home late sometime and not hear what I already know.

Therapist: (doubling Burt for a moment) I just can't stand all that blaming.

Burt: Oh, blame. Well, I hadn't thought about it for a while, but I guess my mom was the world's expert on this.

Therapist: (still doubling) I had a great teacher.

Burt: I used to try to get away from the dinner table just as fast as I possibly could just to avoid hearing my mom lay it on my dad.

Therapist: (Therapist switches back to the therapist role) There's that dinner table again. What did she blame him for?

Burt: For swearing about politics or for not complimenting her on the dinner. You name it, she could blame it! Hey, I made up a rhyme!

For the first time, Burt was metacommunicating, talking about blaming rather than doing it. To deepen and anchor the experience, the therapist decided to shift to a role reversal and to explore the relationship with his mother. She was satisfied that she knew enough to portray Burt's mother while simultaneously doubling Burt; in addition to her new role, she needed to keep in mind Burt's original process with his mother and Ethel's reaction. The therapist's goal was twofold: to help Burt understand his fear of blame and to show Ethel that Burt's avoidance had roots that predated their relationship.

The therapist decided to stop the doubling and shift to role reversal so she stopped the walk and faced Burt.

Therapist: Let's talk to her about that. But first I'd like to meet her. Could you take the role of your mom for a minute and let me talk to her?

Burt: I could try, I guess.

Therapist: (She shifts to the interview technique) OK, so you're Burt's mom. Was he easy or hard to raise?

Burt, as mom: Oh, he wasn't that hard. We really saw to it that he did what he was supposed to do, and most of the time, he did it.

Therapist: How did you do that?

Burt: (He drops out of the interview and speaks for himself in the present.)—and boy, could she be disappointed!

Therapist: (She addresses Burt directly.) So you'd like her to know how that felt?

Burt: This is the day for trying this new stuff!

Therapist: OK, where does this take place?

Burt: I know! She's in the kitchen, waiting for me to come home from school.

Therapist: Good. OK, let's start.

Therapist as mom: Burt, did you bring your paper back? How did you do?

Burt: (He drops his role and addresses the therapist directly.) I wish I hadn't come home yet.

Burt is demonstrating that he is not confused. When he needs the therapist to empathize with him, he recasts her in her original role. The therapist then demonstrates her own role flexibility and helps Burt return to the enactment.

Therapist: (The therapist, breaking out of her role, is glad that he could address her when necessary.) I can certainly understand that. You know, you can always speak your thoughts. Just turn your head this way, when you're just thinking aloud (the therapist demonstrates).

Burt: I get it. Oh God, I'm heading straight for her martyred look. She's going to be so disappointed.

Therapist (in her role as mom): Where is it?

Burt: Mom, I don't have it.

Therapist as mom: But you said—

Burt: But mom—

Therapist as mom: Don't tell me. No. Don't tell me.

Burt: Mom, I left it at school.

Therapist as mom: You know your father and I wanted to see it. What kind of grade did you get? I'll bet it wasn't what you wanted. (Burt looks down at the ground).

Therapist as mom: Tell me. Tell me.

Burt (hardly audible): I got a C.

Therapist as mom: Oh no! What does that mean for your course grade? That is so terrible! I'm so worried about what Dad's going to say.

Burt (smiling): Mom, I've got to go to soccer practice.

Therapist (as herself): So at this point you'd be willing to do anything just to get out of there, right?

Burt: Right! Definitely right.

One of Fritz Perls' (Perls, Hefferline, & Goodman, 1973) frequent interventions in his workshops was to use a sentence from a dialogue with a member of the client's family of origin to address a person in the client's present social atom. The therapist now repeated what Burt had said to his mother as a way to address his wife.

Therapist: Could you say that to Ethel, "When I feel blamed, I'd be willing to do anything to get out of there?"

Burt: To Ethel? Oh, yeah. Oh, that fits. When I feel blamed, I'd do anything to get away.

With that insight, the couple could return to the conversation about the dinner party with some understanding and a sense of humor. Ethel expressed her surprise at discovering Burt's fear of blame, because she had always seen him as a pillar of self-confidence. Burt ruefully acknowledged having forgotten Ethel's shyness and showed appreciation for her meeting the challenge of the party. More important, perhaps, was his realization that he had not expressed any appreciation in a long time.

When the therapist talked with the couple about what they had experienced, each credited doubling with their changed views. They developed greater awareness and with that, an ability to comment on the process. As they became aware of how often they lapsed into blame, they were able to stop themselves rather than look to the therapist. Both began to identify the roots of blaming and were able to communicate with greater empathy. More secure with each other after this intervention, Ethel and Burt were able to express fears of abandonment and sadness at missed opportunities.

Doubling is a technique with great range. In this instance, the therapist chose to double because Burt had been using intellectual defenses to distance himself from emotion while his wife Ethel expressed it, a common division of psychological chores that proves unworkable in times of stress. In this instance, the trust established in previous sessions enabled the therapist to use the doubling technique without much preparation. The therapist's self-knowledge, confidence, and sensitivity to the couple's responses are what determines this therapist's timing and particuar choices of action techniques. Another therapist or the same therapist with another couple may not have chosen to risk being perceived as intrusive or presumptive (Leveton, 2000) and would have introduced such work by asking permission in a more formal way (Fisher, 2002).

Without straying far from the role of therapist and by using perceptions of the client to time comments and participation, a therapist can use doubling as

a way to access action techniques. As the client experiences the double in a supportive—if at times challenging—role, it is not unusual for the therapist to change back and forth between double and therapist roles. When the therapist takes on the role of someone not in the room, distance from the accustomed role creates a greater risk.

The therapist's role flexibility (Leveton, 2000) can vary for the same therapist and among therapists as a group. Not all therapists feel comfortable with role shifts, nor do all clients. Individuals vary in the amount of structure, direction, and support they need to role play. Although many are able to be flexible, others need to play one role in a setting in which the therapist's role never varies. The therapist must assess each couple's ability to shift as the therapist tries different action techniques. A look of confusion, a question about the process, or an inappropriate response is a sign that more support is needed.

Burt (to the therapist as therapist): I wish I hadn't come home yet. I'd rather be any place else.

Therapist: Ok, let's stop the role play for a moment. I'm not mom now. OK?

Burt: Yes, that's right.

Therapist: So this is hard for you when Mom starts to challenge you.

Burt: Sure. I know I'm not going to have the right answer.

Therapist: Maybe you can let mom know that. Let's go back to the role play. I'm still Mom.

When necessary, the therapist injects added structure, which clarifies the process and avoids ambiguity.

In this case example, the use of doubling was augmented by role reversal and the interview. I have found that one advantage of beginning with the double is that it needs little explanation and can quickly transform a talk session into an action experience. From there, a couple that is inexperienced in experiential work can be introduced to a wider variety of psychodramatic techniques. For the clinician who is comfortable with doubling, its advantage is its range. Doubling can be quiet and close to the therapeutic voice or provide a dramatic, emotional contrast to it. The technique can further inner work, or it can be used to augment an interpersonal dialogue. Although it is a powerful technique that can quickly bring a client to an unanticipated emotional expression, this method can also be used to de-escalate an emotional situation with quiet reflection (Leveton, 2000).

One of the issues often raised in applying psychodramatic techniques with individual and couples therapy is the question of the therapist's taking on a role while working with a couple. In psychodramatic groups, the director does not take a role in an enactment. Although couples therapy is different from a psychodramatic group, relevant criticisms of the therapist's role playing cen-

ter around therapeutic boundaries, transference complications, creating dependency, and the possible perception that the therapist is taking sides. Kipper (1986) suggested that the therapist leaves the scene without a director. These are all valid points for discussion and consideration.

Because a search of the literature has produced very little about these topics, the following is a summation of my own clinical experience and that of my students. In the hands of an experienced, well-trained professional with experience in a wide variety of roles, taking on a role can be an effective intervention devoid of the obvious dangers or pitfalls cited earlier. In my view—and I am aware that this will stimulate controversy—the issue of therapeutic boundaries is resolved not only by following the observable, established roles of therapist and client, of director and protagonist, but also by taking the personality and individual style of therapist and client into account. The therapist's taking a role in an enactment depends on such characteristics as role flexibility, expressiveness, tolerance of expressiveness, and the trust residing in both participants. The dangers, of course, are always there, just as they are with any other form of therapeutic intervention. The therapist must take care to separate personal agendas from the client's material (Hayden-Seman, 1998). The therapist must follow, rather than lead, the client (Moreno, Blomkvist, & Ruetzel, 2000). The therapist must check the intervention against the client's response in order to judge its effectiveness.

In one of the first family interviews in which I tried doubling, I was worried about the possibility of taking sides when I doubled for an adolescent who had been silent during the initial three sessions. Doubling for her for a good part of the hour, I was afraid that other family members would feel left out or unattended. I was surprised to learn that the opposite was true: The others expressed relief at hearing the adolescent's concerns, first in my voice, then in her own. Further role plays encouraged my joining in the enactments of families and couples when I thought it appropriate.

All therapeutic techniques that deal with surplus reality require flexibility. Perhaps the challenge to the director's role as the expert or the authority figure is most difficult to accept. It flies in the face of convention. A patient without a doctor? A protagonist without a director? But a director who takes a role is still a director, as theater and film, where the shift is also debated, have proven on many occasions. It is possible, with many clients, to shift between directing and participating, just as it is possible, in family therapy, to join the family part of the time and remain outside the family in the role of the observing expert authority part of the time. The question becomes one of ability. Can the director shift back and forth? Can the client tolerate and benefit from the shift? Leaving the couple without a therapist, in the sense of a person who remains obviously in charge of the session and its direction, is definitely a concern. A client who has developed strong

dependency feelings for the therapist may not be able to tolerate a shift in roles. Clients may indeed feel abandoned by a therapist who leaves the expected situation and enters a role play. If the therapist senses that one or both members of the couple need to be working with someone who takes a strong and consistent role, role taking is not advised.

The client's needs must determine the use of any therapeutic technique. There are clients who need the therapist to remain impersonal and in the background; it is unlikely that they would tolerate a therapist's taking a role in a personal enactment. Others look for any signs that reveal their therapist's personality: the greater range of expression allowed to the therapist who takes a role can provide enrichment and relief for such a client. Flexibility is a requirement; clients who have not achieved role flexibility themselves are seldom able to tolerate it in a therapist. Both therapist and client need the ability to play. The therapist must be capable of assessing the client's ability to tolerate a role shift and of understanding the subtle cues that signal trouble. Any sign of disorientation or anxiety when a new technique is introdued should alert the therapist to question its appropriateness. Confusion and anxiety are often related to the amount of ambiguity in a situation. In order avoid confusing the client, the therapist must make a clear shift between behavior as a talk therapist and director, and joining in an enactment. The therapist must be able to vary behavior and language enough for the client to experience a new and different role. There must be a clear signal, however subtle, that tells the client when the role-playing begins and when it ends.

Transference issues may arise. A therapist playing an antagonistic mother like Burt's, for example, may fear that the role will affect the client's view and consequent relationship. Any role taken by the therapist offers the possibility for new transference projections. Countertransference is equally important. In identifying with husband or wife, the therapist must work for awareness of personal agendas. Because role playing provides an avenue of direct, feeling-ful expression, the therapist must take care to express feelings appropriate for the client instead of using the opportunity to express personal needs.

Like any clinician, I have learned over time to track several levels of the client's experience simultaneously, and have trained my students to do the same. When role playing in couples or individual therapy, the therapist must assess the effects of the role play, much as the actor assesses the audience's reaction. The couples' sense of security, any signs of confusion, irritation, anger, or sadness that fall outside the dimensions of the role play must be noted and filed for later discussion.

One of the advantages of couples therapy is that psychodramatic sharing can be augmented with an ongoing, complex discussion of the role-play. On the therapist's part, openness to discussing process and possible transference and dependency issues is of primary importance in helping to resolve such issues as they

arise. The client's feelings about the therapist's taking on a role can be addressed when appropriate. In addressing the process and helping to bring conflictual issues to conscious awareness, the therapist who works with couples and individuals for an extended time frame has an advantage over the group psychodramatist who often sees clients only once or a few times. Working for longer periods of time also makes consultation possible, an invaluable aid to assessment of the process and, especially, to awareness of the countertransference.

Further investigation of role flexibility on the part of the director is necessary and advisable if therapists want to continue the creative process of developing psychodramatic techniques in the realm of psychotherapy. I chose Doubling and Sculpture to illustrate the effectiveness of using role play to interrupt pathological blaming and promote more productive work on the couple's communication. The question of the therapist's entering the role play is addressed with some of the safeguards that might inform such a move. Because of the sparsity of reports about this possibility in the literature, I propose that therapists participate in further discussion.

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The Integration of Psychodrama With Bowen's Theories in Couples Therapy

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ABSTRACT. In this article, the authors describe a method in which cotherapists work with those in relationships, mainly couples, using psychodrama methods and Bowen therapy. They include vignettes taken from 5 sessions and discuss the context of each problem, the process of the therapy session, the insights gained, and the theory for the interventions. The authors integrate Bowen's theory of the differentiated person as one who is able to operate from a place of "I," as distinct from "we" in a relationship, and use psychodrama techniques to demonstrate this functioning. The authors believe that their attention to their own differentiation in their work affects clients directly. They use their synthesis of theory, experience, and practice to help client couples to become more differentiated.

Key words: couples therapy, differentiation, doubling, families, psychodrama and Bowen's theory

THE APPLICATION OF PSYCHODRAMA WITH COUPLES, as described in this article, is based on four of the main theoretical principles of Bowen's (1978) theory. The four principles are the profiles of triangles, the nuclear family emotional process, the family projection process, and the differentiation of self.

The *triad* is considered the most basic stable element of human relationships. Members of the dyad, like parents, cannot alone persistently regulate their emotional climate without an outside, third, reference point. When two partners become either too close or distant, to the extent that there is discomfort, the more distressed member will involve a third party in the relationship as a point of reference to regulate the emotional climate between the pair. That is normal human functioning. If, however, the pull on the third party is too strong, the triad becomes a "triangle." When the emotional stress of the

dyad is highly escalated, there are interlocking triangles established, for example, the police, schools, social services, and the courts. The third drawn-in person is termed "triangulated." The position is maintained at a price, not only for the third, triangulated party but also for the other two members. One basic aim of Bowen's therapy is to assist in the dissolution of the dysfunctional triangulation process by enabling the clients to become consciously aware of these emotional processes. It encourages them to act on their thinking, rather than to follow an automatic instinct.

The second profile, the *nuclear family emotional process*, occurs when there is a strong tendency in a family to triangulate. Then the extrication of one member of a triangle will result in the two remaining members co-opting another member to form a new triangle. Such a pattern is fluid and tends to fluctuate. When the degree of fusion between the selves of the family members becomes too concentrated, it is manifested in symptoms that can present to a therapist in the following three ways: physical or psychological dysfunction in one or both spouses, for example, alcoholism and depression; marital conflict; or emotional, physical, or behavioral problems in a child.

The child, most vulnerable to be triangulated by either partner, is a potential casualty of the third profile, the *family projection process.* In that profile, the child is "chosen" by reason of some particular resemblance to a parent or other close family member (e.g., a grandparent). The resemblance may involve physical characteristics, a distinguishing temperament, a physical or mental incapacity, or a special context in which the child was born (e.g., a period closely following the death of a close family member). Once chosen, the child is subject to the "projections" of the parents and is less able to be seen as a relatively distinct person in his or her own right. He or she is likely to have a relatively low sense of self and tends to have a "we" experience, a sense of togetherness (family) rather than of individuality, (an "I" experience). The profile is called the *differentiation of self.* A child grows up with that characteristic. Bowen regarded such a person as having a relatively undifferentiated sense of self. We use the term "relatively" because no one is entirely differentiated. Bowen maintained that people tend to find partners of the same level of differentiation because they each wish to share the same proportion of self with the other. One partner, however, often functions on a higher level. If two undifferentiated partners have children, then one of them is likely, in turn, to be a recipient of the parents' projections, with an even lower level of differentiation. In that way, the process is transmitted through generations to cause even further dysfunctional families.

In his method of treatment, Bowen aimed to educate and coach the clients to differentiate themselves from each other and from their respective family of origin by *de-triangulating*. The method focuses on the couple (the parents) with the purpose of freeing the child from the parents' emotional

involvement with each other. If the couple were unwilling to attend therapy sessions together, Bowen would choose, if possible, to work with the more differentiated partner. The expectation is that an increased level of differentiation in one member will result in a faster change for all concerned. It increases the probability for a greater level of differentiation among the remaining family members. Very often, the therapeutic intervention is to coach the over-functioning spouse to be less over-functioning, enabling the under-functioning spouse to function at a higher level.

All five case studies (vignettes) described in this article involved two therapists. Farmer occupied the principle part of the director role, but the part was delegated to Geller from time to time. Although equal cotherapists, Geller delegated part of her therapist role to Farmer, leaving him to direct while she played the auxiliary roles, especially the double. It has been our experience that the cotherapist format facilitates a quicker pace to the therapeutic process and enhances the effectiveness of the sessions. The flexibility and relative autonomy within the framework of the cotherapy team proved to be an advantage.

We believe that there are nine ways in which psychodrama procedures, particularly those conducted with two therapists, enhance Bowen's therapy. Those are as follows:

1. Replication in the here-and-now. Psychodrama replicates everyday experiences in the therapist's office, thus focusing the couple on the here and now. It enables closer emotional contact between the couple.
2. Emotional transparency. Psychodrama explores emotional processes through action, thereby making the psychological and behavioral patterns visible and, therefore, more comprehensible.
3. Detachment and multiple triangles. When psychodrama is conducted with two therapists, it allows the director to resume a detached, observer stance while the cotherapist is in charge of interacting more closely with the couple. So, one of the therapists need not be involved immediately in the action and can learn from a more detached position. Therapist detachment is important in the Bowen approach. He would not become functionally entangled or triangulated with a couple. His aim is to avoid triangulation so that the couple has to address their own emotional processes and issues with each other. Moreover, with the presence of two therapists, there are four people in the session, thus allowing for four possible triangles rather than the one triangle possible with only one therapist. When there are five people in a session (e.g., the parents, a child, and two therapists), there are nine potential triangles. The more triangles there are in the session, the greater the opportunity to detect and address attempts to triangulate.
4. Thoughtfulness. Bowen's theory, and hence, his practice, emphasizes a thoughtful, cognitive experience, rather than an emotional one. The discus-

sion and open conferring by the two therapists using psychodrama can allow for both thoughtfulness and emotionality, playfulness and spontaneity.

5. Modeling. The availability of the cotherapists provides ample opportunities for modeling, through role playing, a healthy dialogue between them. That is a definite advantage for the coaching process. There is often an "ah-ha" experience reported that is not observed in more traditional talk therapy.
6. Slow examination of past experiences. Psychodrama explores scenes concerning family-of-origin issues. Those can be relived with powerful consequences. At any point during such unraveling of the past, the action can be stopped, commented on, and revised, if necessary. The drama can be stage-managed, with an opportunity for all participants to comment on his or her individual observations and experiences during the drama.
7. Experiencing surplus reality. Psychodrama enables the enactment of scenes that did not occur but which should have happened. Through spontaneity, the flexibility of the method allows for exploration of new ways of relating with significant others, thus raising the level of differentiation of self.
8. Rehearsal for living. Psychodrama provides opportunities to rehearse past or future encounters among the clients. This is an important part the coaching process.
9. Differentiation and spontaneity. The experience of the session through psychodrama enactment can have a profound emotional impact. Using their spontaneity, clients experience themselves and their partners in different roles. Their spontaneity encourages them to explore new ways of relating with each other and with the therapists. This aspect is congruent with Hollander (1992), who compared Moreno's theory with that of Bowen and equated spontaneity with an aspect of differentiation of self.

Case Studies

In the following vignettes, the cotherapists are referred to by their real first names, that is, Chris and Marcia. That is also how the clients addressed them and how the therapists refer to each other during the sessions. We sought to be authentic in regard to the case histories and the sessions that we describe. The names of the clients, however, are fictitious, as are other identifying features, to protect their privacy. Dysfunctional people are often seen as individuals, but with a Bowen systems approach.

Case Study 1—Julie

Julie, aged 34, had been a star in her teens. She then lost herself in marriage to a man who was distant like her father, and she felt rejected by him. She now needed to differentiate herself.

Chris (speaks to Julie as himself): How were you before your marriage?

Julie: Mother was the rule maker, because father was away at work.

Chris: Can you speak in the role of your mother?

Julie (as her mother): Julie was the center of attention. She was the eldest of five. I had to lay down the law with her care, and we often clashed. As it happened, my own mother lived upstairs and got on very well with Julie.

Chris asked Marcia to play the role of Julie's maternal grandmother. Julie described her grandmother as an easy-going person, the matriarch of the family, who held everything together by using her warmth and status. She did not need to set rules. Instead, she was a role model that Julie wished to emulate, and there was no conflict. Chris asked grandmother and Julie to reverse roles a few times, and that ended up with Julie manicuring her grandmother's nails.

Chris and Marcia, conferring aloud, mentioned that Grandmother seems to replace the often-absent father, preventing too intense a relationship between Julie and her mother. Grandmother becomes particularly close to Julie, perhaps to offset the conflict between Julie and her mother.

Chris (to Julie as herself): Julie, your grandmother is now dead. Can you think of her as a spirit looking down over you? (Julie nodded)

Chris (looking upward, as if to grandmother's spirit): What was to be Julie's role in this female-centered family of origin, especially if she had stayed there and not married?

In that interaction, Chris did not exactly reverse role. Rather, it was a concretization in which the ceiling represented grandmother's spirit. Using focusing techniques (Goldman & Morrison, 1984) is helpful.

Chris (to Julie as herself): What would have been Grandmother's main message to you?

Julie: She would say, "Don't worry; everything will be all right."

Marcia then repeated those words, assuming the role of grandmother. Julie felt warmth and comfort.

Julie (as herself): I had never realized Grandmother's significance for me until now.

Julie gained an insight that was triggered by the warmth and comfort of Marcia as her grandmother. Chris and Marcia then discussed with Julie the implications of her growing up in this female-orientated family. Grandmother's husband had been a gambler, like Julie's husband. The men in Julie's family life had never measured up to her grandmother.

Marcia and Chris (wondering aloud): Perhaps Julie has lost herself in her marriage in seeking to replicate with her husband something of the essence of her family of origin that she has not yet learned to let go of. On the other hand, however, she may not have been able to come to terms with the loss of her grandmother's warmth and reassurance, on which her teenage emotional status had rested.

Byng-Hall (1995) addressed the importance of distinguishing between replication and correction of family scripts. Although speculative, such hypothesising opens up possibilities for later refutation or confirmation.

Julie (in response): I don't want a husband like a father. I want a guy, not a parent.

The therapists ended the session by discussing with Julie how she might rehearse a closure with her husband, if that was what she wanted in the future.

Case Study 2—Raj

Marcia gave a long introduction about this 36-year-old Sri Lankan man before he had arrived and after he had come so that all three could agree on where to focus the session. Raj's long and complex family history was important for the therapists to grasp early in the session so that what later emerged could be placed in context.

At the age of seven, when his actual mother came to take him to her own home, Raj had learned that his paternal grandmother, whom he had addressed as "mother," was not really his mother, but she had raised him because his mother, who was depressed and overwhelmed by parenting, had been advised by her doctor to have another child to overcome her depression, was unable to cope with raising him. At the age of 14, while Raj was still living in Sri Lanka, his mother moved to the United States, leaving the boy once more with his grandmother. At the age of 18, he moved to the United States in a hurry, not remembering to say goodbye to his grandmother, who died a few years later. His paternal grandfather had been very close to him and had been a possible role model. He had died when Raj was 4, and since that time, Raj had had no good men as father figures in his life.

The therapists concluded that through the use of surplus reality, Raj might be able to experience in a session what he was not able to do in life and to express himself to these important figures who have left him alone in the world.

Chris: Raj, talk to your grandfather as if he is over there in that empty chair.

Raj (to the chair representing grandfather): You were a very good man and extremely kind to me.

Marcia: And can I be Grandmother? Raj, tell me about myself.

Raj (to Marcia as grandmother): You are gentle and kind. You have a white scarf around your neck (Marcia found one and wore it).

Chris (to Raj as himself): Did you have any contact with her after you left Sri Lanka?

Raj (as himself): No, and I feel guilty that I did not help her. (He still expe-

riences helplessness, thinking about the responsibility that he had felt toward his grandmother but which he could not exercise).

Chris: Raj, can I speak to you as if you are now your grandmother?

Raj assumes her role.

Chris: Are you still alone, yourself, grandmother? (She [Raj] nods).

Is Raj still the most important person in your life? (She nods again).

Raj (as himself, asking a question to which he has never had an answer): Why did all this happen to me, and how can I get over it?

Chris: Can Marcia be your grandmother? Ask her, and see if she can help you.

Marcia, sometimes spontaneously, and also at the request of Chris, assumed the role of the grandmother, interacting, by instinct, in response to Raj. To share information, Marcia in the role of grandmother answered questions from Chris about Raj's relationships and background. Marcia also used her insight as a therapist to communicate with Raj and, in asides, talked with Chris about the background as it emerged in the psychodrama.

Chris (as himself, to Marcia as grandmother): Is Raj feeling overly responsible for his girl friends because he couldn't take responsibility for his grandmother?

Marcia (grandmother) nodded.

Chris: Grandmother, does Raj feel that, with the significant women in his life, he is helpless and out of control or has little or no influence in the relationship? Does he really need to think that he has to control the women in his life?

Chris used the advantage of his lack of prior contact with Raj to be a naïve and innocent inquirer, having the freedom to ask or to suggest whatever he chose. That was balanced and complemented by Marcia's use of her insight and experience as Raj's therapist to communicate with Raj.

Raj: If I don't get respect shown by women, I'm like a cat whose tail is trodden upon. I smart and then retaliate, sometimes physically. Actually, I employ 60 women, and they do in fact look up to me.

(Raj looked to Marcia, seeking concern and guidance. With his emptiness, helplessness, and insecurity, he had to keep taking himself in hand and try all the harder to be master of his fate.)

Chris (to Raj): It's like you're lacking something, such as a sense of your grandmother inside you?

(The three participants gain further insight in the session into Raj's loneliness, emptiness, and sense of failure with women. Raj said that he thinks of his grandmother being in heaven, looking down and knowing what is happening to him. To another question, however, he added that he did not feel her in his heart.)

Chris (to Raj): It is time to finish, but first, what would you like to say by way of goodbye to your grandmother (Marcia)? Maybe now that you have got in touch with her you will be able, in time, to let her go properly and feel a part of her inside you that has always been there.

At the closure, Raj was grateful and able to see the importance and relevance of the therapeutic work.

Case Study 3: Marco and Kate

Marco and Kate have been attending Marcia's sessions for marital issues, having returned after several years for premarital therapy. Both are lawyers. With two children, Kate wanted her husband to help more in the home, but he preferred to play sports. Kate was critical and parental, yet Marco was good for his wife and encouraged her to have more fun, such as going skiing. Each was insightful and interactive. They began one session by reporting a conflict they had in their car as they were coming to the session.

Chris (as himself, to the couple): Show us what happened! Be in the car.

Marco, assuming the role of the driver, sat on the left side of the car, actually the sofa. Kate, on the right side, told him to watch the traffic. Marco turned up the radio and cut his wife out, without realizing it. In response, Kate looked out of the window, becoming silent and distant. The tension between the two rose, leading to an escalation of this pattern of interaction.

Marco (an aside): She is like my mother, who had a road traffic injury as a child and is always fussing about possible accidents.

Kate (an aside): He makes a lot of noise, much like my father's shouting when drunk. I react to it the same way.

Kate (to Marco): You will do to our children what your father did to you!

They explained to Marcia and Chris that Marco was highly successful, yet still needed to prove himself by defiance and rebellion.

Marco (role playing his father, Paulo, who came from Italy): I am not educated and cannot write in English.

Marco (as father, Paulo, in an aside): My son, Marco, is very accomplished, but I would not say this to him.

Marco (as himself): That's right. You never express any appreciation to me. (in an aside): Father needs respect, not love.

Kate (to Marco): But your father does speak well of you to other people.

Marco: I'll never get any praise from my father. He is too fixed in his ways, and getting old.

Kate: And your mother is the same.

Kate (role-playing Marco's mother): I tell others that he's really, really clever, but I never say this to Marco.

Marco (as his father, Paulo): I am proud, and I cannot take any criticism.

Marco (as himself, in an aside): I'll never get acknowledgment from Father. He is too fixed in his ways and getting old.

Chris (to Marco, who was back in the role of Paulo): What would it cost you, Paulo, to say to Marco that you are proud of him?

Marco (as Paulo): It would hurt my own pride to admit this to Marco. He has done so well relative to me.

That was a revelation to Marco, as he experienced in-role his father's self-disclosure.

The session ended with a discussion about how Marco, with this new understanding of his father, might now get acknowledgment from him, or perhaps, instead, Marco could give it to himself. Marco saw the point. If there had been time, Marcia might have been able to enact a scene in which she, in the role of Paulo, could use surplus reality to enable Marco to have a dialogue with his father. That could be either one that he could never have had in life, or one as a rehearsal to finding a way of achieving his father's acknowledgment.

In a later session, the couple reported to Marcia that they had been moved by the session and that Marco was able to see that, just as his father was critical of him, so Marco was critical of his own son. This couple was so spontaneously interactive that Marcia did not need to double or to play other auxiliary roles as she usually did. Her very presence in the session, with her experience and considerable rapport with the participants, enabled them to proceed with confidence. Before this session, she had prepared them for psychodrama methods and had given Chris details of the background and the current issues. During the session, there were frequent periods of dialogue between the therapists, usually including the couple, to reflect on the previous action and to suggest where to proceed. In the session, Marcia was a codirector, and she also shared her impressions and memories about the couple. With that, we were able to condense a large amount of complicated material into one hour.

Case Study 4: Dorothy

Dorothy, aged 55, presented problems with her third husband, who is 12 years younger. She feels "invisible." She has reached a fork in her life and, although a creative and philosophical survivor, she did not feel "entitled," that is, not "permitted," to be successful. Her mother died when she was 3 years old, leaving her with an alcoholic father and, eventually, a controlling, non-nurturing stepmother who was pleased to send Dorothy off to an aunt. Dorothy had an illegitimate child while she was still at college, a fact that forced her to leave school to rear her son. Her adult life had been a series of marital problems, including abuse.

Dorothy (as herself): I have just written a letter to myself (a task set by Marcia). I wrote much more than I thought possible.

This statement referred to an ongoing struggle with herself. Dorothy remarked that this reflected the mixed feelings that she has had about her stepmother. She had taught her to love books and took her to church, but then she

would too readily send her out into the yard, excluding her from the house, or pack her off to see an aunt.

Dorothy: My father would not acknowledge me. He tore my Bible up in front of me.

Marcia spontaneously played the role of Dorothy's father, tearing up the Bible. Dorothy informed Marcia that her father had accused her of sexual promiscuity and alcoholism, projecting his own problems on to her. Marcia, in the role of the father, stood up and gesticulated at Dorothy, making accusations, thus warming the session up to further action. Dorothy decided to play the role of the stepmother.

Dorothy (as stepmother): My name is "Jean," and so do not call me "mother." Your father married me to be a mother to his children. I was angry with him for drinking and going with other women, but I did not challenge him. Instead, I took my anger out on you, Dorothy.

Chris suggested to Marcia that Dorothy might address her issues with both her father and stepmother. He proposed that Dorothy play the role of her father and asked about father's attitude to Dorothy.

Dorothy (as her father): I have trouble with my feelings toward Dorothy. I cannot look at her. She reminds me too much of her mother, who died so young. She was a unique person—and Dorothy is a good mother, too—just like her own mother. (A possible link to Dorothy's sense of "invisibility.")

Chris (to Dorothy as her father): Father, what would it cost you to tell her you're proud of her?

Dorothy (as father): A lot of pain, because it relates too closely to the loss of her mother. Also, I would feel anger that Dorothy enjoyed what I never had in the way of good, mothering love, both from her real mother, and then from my second wife.

Chris (to Dorothy, as herself): Dorothy, is it possible that, in spite of everything, there is love for your mother and feelings for your father that cannot be expressed? What about bringing your father into a session with Marcia?

Unknown to Chris, Dorothy had done that 30 years earlier with Marcia, when her father was able to hear her needs and to help her financially. This was rehearsed when Marcia again role-played Dorothy's father. Dorothy, now in the role of herself, expressed her apprehension about any kind of re-encounter with her father, but she realized its importance and agreed to try it again.

Dorothy (as herself): I used to feel that my anger would kill him.

While Chris functioned mainly as the director in the session, Dorothy's trust of Marcia allowed Marcia to be spontaneous and decisive, quickly adopting the roles of both the stepmother and the father in the same session. Dorothy role-reversed with each of them to address the issues of the struggle within herself. These involved the relationship between stepmother and father, in addition to the conflicting individual relationships between Dorothy and,

respectively, her stepmother and her father. The issues between the parents, on the one hand, led to Dorothy's feeling distanced from them, but, on the other hand, they also impinged on Dorothy's sense of self.

It was not only the separate parents that were represented internally by Dorothy; it was also the relationship between the parents that was internalized, leading to a sense of dissociation or depersonalization (feeling invisible). The internalized drama was externalized on the stage, as in Internal Family Systems Therapy (Schwartz, 1995), so that one-to-one dialogues were enacted, as in Bowen's approach to de-triangulation.

Case Study 5: Carol and Steve

This is a narrative description of a session with Carol and Steve, a couple very familiar with the process of the psychodrama therapy. They had several annual sessions with Marcia and Chris. When they arrived for the present therapy session, they had their delightful child, Jenny, aged 15 months, with them. Carol complained at the beginning of the session, when the child ran across the room and started fiddling with office papers, and Steve paused before getting up to check on Jenny. Marcia and Chris asked if they could explore this with Steve; working with one person of the couple often helps the other as well. Carol and Steve readily agreed.

Steve said that his mother still denounced his deceased father. She was also inclined to reproach Steve, and yet wanted credit for being his mother. Steve's father, a lawyer, was known, although it was unspoken, to have wanted Steve also to be a lawyer with its high pay. These high expectations and his father's apparent disappointment in him left Steve with a poor self-image, professional immobilization, and a sense of continued failure. Actually, Steve was a teacher.

That history seemed to be relevant to Steve's pauses, especially when he said that he feels depersonalized when doing things at Carol's behest. Marcia and Chris made a link between two sets of suspended communications with a father: Jenny with Steve and Steve with his father. There also seemed to be a parallel between some pressure that Steve had from his mother and father and what he sometimes experienced with Carol.

In the role of his mother, Steve showed how she ranted against her patronizing husband. The mother was a rural, European, non-English-speaking woman who was brought to the United States by her husband.

Marcia then role-played Steve's mother, and Steve assumed the role of his father. There was a fast-moving series of interactions and reversals of roles.

Finally, while Marcia was in the role of Steve's father, Steve role-played himself. He suffered his father's disappointment, was unable to go along with his father's requests, and passively resisted his father through alcohol, drugs, and ambivalence in pursuing a career. Carol then reported that the very same

pattern of interaction takes place between her and her own mentally ill, dominating mother.

From an object-relations perspective (Dicks, 1967), the couple may have a problem arising from a "shared internal object;" that is, a dominating parent. In this case, one party may have passively resisted the parent, while the other identified with the parent.

Steve could have internalized the struggle itself to become "frozen" when "pausing," as in dissociating. Bowen's theory would suggest that in life, Steve should detriangulate (Kerr & Bowen, 1988; Fogarty, 1978) from his parents' conflict by encountering each one separately. In the psychodrama session, Steve addressed each parent, role-played by Marcia. His encounter with his mother, however, was from the role of his father and not of himself.

In the sharing, the couple expressed their gratitude to Chris and Marcia, saying that without their help, they would not have had Jenny. Could Chris and Marcia represent the "good" parents that neither of the couple had?

Carol and Steve were seen a year later. The follow-up session dealt with some sleep disorder and sexual problems. After that session, Marcia reminded Chris that Steve's mother would sleep with him when there was conflict between her and his father.

Discussion

The aim of Bowen therapy is to help family members change their behavior so that the family system functions at a less emotionally reactive level. Through teaching, coaching, educating, and orchestrating, it presents to the couple an image of a higher-functioning relationship. Most couples seek help because their relationship is not functioning adequately, usually because there is too much emotional reactivity, which stems from a degree of discension, leading perhaps to violence, between them. We recognize that some degree of conflict within a couple is a fairly inevitable part of life and that when it is tolerable, it does not of itself indicate pathology. However, resolution of incessant or protracted conflict sometimes may require skilled assistance to prevent avoidance of conflict altogether by distancing, rather than resolution, and to forestall an escalation in the degree of dissension, perhaps to violence. The skilled assistance includes good listening, making "I" statements, validating the other person's feelings, and displaying empathy with compassion. In the process of teaching such skills, the therapists serve as a model of interaction by taking responsibility for themselves over issues in the therapy relationship, making neutral statements, avoiding blame, and generally responding rather than reacting.

Several authors have discussed the relationship between psychodrama and forms of family therapy. Moreno (1946) referred to the treatment of a matri-

monial triangle in 1937. We are indebted to Williams (1989) for putting the concepts of Moreno into the language of current systemic family therapy practice. Zerka Moreno (1991) gave a detailed account of cotherapy, given with J. L. Moreno, to a complex family. Hollander (1992) made a specific comparison of Moreno's concept of spontaneity with Bowen's differentiation of self.

The Bowen Family Systems model became the framework for our use of cotherapy with psychodrama (Farmer & Geller, 2003). In the process of therapy, we attended to our own differentiation—being, as therapists, both team players and individuals, by our own choice, according to the needs of the moment. That flexibility was maintained on the stage, not only in regard to the relationship between ourselves as therapists but also in relation to the client(s), to avoid becoming triangulated into the family system or distancing ourselves from it. As in an enmeshed or undifferentiated family, if one party differentiated itself, this frees up the other members.

By aiming to be nonreactive to each other, we encourage the couple also to be nonreactive, helping the emotional climate to remain calm. We assist the couple to be more directed by self (neither drawn in nor pulled apart from the therapists or from each other). The use of "I" statements and of mirroring emphasizes the importance of maintaining a clear boundary between subjectivity and objectivity. Having a cotherapist enables the director to be more flexible. The cotherapist acts as an auxiliary, mostly in the role of the double, thus fulfilling two functions: an agent of the director and a voice of the protagonist. The director serves as the formal leader of the session.

We engage each other in explicit dialogues or employ potential dialogues (such as playful, subjective, fantasy "as if" conversations for rhetorical purposes). We could also be employed in direct dialogue with the client(s), making suggestions about possible courses of action, changes of scenes and so forth. This sometimes ambiguous approach might resemble that of a preacher or a politician who directs the sermon/speech to the audience/congregation at large. The message might be one ostensibly for all to hear, but it might also appear to be addressed to just one of the listeners. With everyone hearing it, but in a different way, it can still be a personal, if disguised, message.

That approach, known as the "reflecting team," has been described elsewhere by Andersen (1990). In these therapeutic dialogues, the reflecting team is free to agree, raise questions, question each other, and express different points of view without undermining the other party. Another therapeutic benefit of such a procedure is that the issue raised can become internalized through a positive introjective identification (Hinshelwood, 1994) of a well-functioning therapy couple by the client couple.

We frequently engaged each other, reflecting aloud for the benefit of couple/family. We felt free to agree, question ourselves or the other one, and express different points of view with respect and interest and without under-

mining the other party. This model, we believe, can become internalized, through positive introjection and identification by the client couple and through what they learn in terms of the content.

There are some important technical questions to consider, related to classic psychodrama. Kipper (1986) addressed the use of doubles and advocated that doubles only be used for the original players, except in the Dialogue Technique, in which the protagonist and auxiliary role play themselves. Geller, however, readily doubles for someone who has reversed roles with an auxiliary ego. Moreover, we do not usually ask to double and only sometimes explain the purpose of the double. Because it is necessary to work quickly, we would, at the most, say: "Can I be your double?" We often use doubling to quicken the process, allowing the purpose of the intervention to speak for itself.

Furthermore, in addition to Kipper's five indicators for employing the double technique, we offer two more. Geller as the double may give the director additional information that she has already gleaned from previous sessions with her own clients. The double might also make a suggestion about how a particular scene or the session in general might progress.

In classical psychodrama, the function of the director is threefold: a therapist, a producer, and a catalyst. (Kipper, 1986; Moreno, 1946). We propose further subdivision of the therapist's function, specifically the role of the observer, assessor, planner, and container. The director and the cotherapist share these subroles of the therapist's function. The cotherapist function of the producer, taking charge of the warming up, identifying cues, selecting scenes, and making closure, is carried out mainly by the director, in this case Chris Farmer. His cotherapist, Marcia Geller, however, assumes many of the functions of the catalyst, such as the use of the auxiliaries, observer participation, modeling, and coaching.

Kipper (1986) regards the participator subsection of catalyst as having direct and indirect applications. Direct participation involves playing the role of an auxiliary, which is rare and leaves the group without a leader. In one-to-one therapy, direct participation is unavoidable. In our work, however, the director might sometimes act as a double.

Indirect participation involves care, empathy, understanding, and support, especially through tone of voice. That is something that we undertake, both individually and as a couple, when our styles complement each other. The director provides a structure—a container—that is safe. The cotherapist encourages the emotional flow. In our case, the cotherapist (Geller) is able to do so effectively because of the knowledge that, while she frequently makes suggestions, she can rely on the director (Farmer) to make the decisions, lead, and move the action.

That flexibility and relative autonomy of roles of a therapy team may lead to concerns about the blurring of boundaries that can occur when a director

or cotherapist spontaneously takes on an auxiliary role. It can be confusing to all the other participants: Should it not be clear who, if anyone, is directing, then the drama may be experienced as a ship without a captain. We avoid this possible situation by explaining our actions as we proceed. Furthermore, we attend to our own application of Bowen's differentiation of self by learning to operate as team players, or as individuals, as the situation demands.

We are termed cotherapists because we work together in a collaborative fashion. Our psychodrama therapy roles, however, are complementary and require different descriptions. Chris Farmer is therefore termed the director because, ultimately, there can be only one director, although both Farmer and Geller remain cotherapists.

The use of quick role reversals, the reflecting team approach, and the education-didactic parts might suggest that our procedures are basically a cognitive, rather than an emotional therapy. However, Goldman and Morrison (1984) have shown that when their focusing technique is adopted, people can rapidly get deep into role, especially when they are playing the role of someone already familiar to the subject.

We emphasize that neither Bowen nor we advocate emoting for its own sake. Moreno's (1946) notion of catharsis of integration is precisely a means of finding a new understanding or meaning for the protagonist. Bowen emphasized the importance of being aware of emotions and of feelings in order to distinguish them from the thoughts to which they may be linked. In that way, a process of assimilation, rather than fusion, may separate a client's thinking processes from feelings and emotions. It also provides room for the client to reflect on the meaning of such feelings and to make decisions and take actions with a conscious intention, rather than to be led by a near automatic "gut response."

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Action Methods in Marriage and Family Therapy: A Review

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ABSTRACT. Action methods, the therapist-initiated tasks that engage clients in physical activity and in taking on dramatic roles, are used in a number of marriage and family therapy approaches. In this review article, the authors present a wide range of important and representative action methods and occasionally offer brief descriptions of how the methods are implemented. They distinguish psychodrama-influenced techniques from those differing in their underlying premises, structure, design, and implementation. They classify action methods by whether they are dramatic, that is, when the activity is understood by the participants as involving some intentional pretense.

Key words: action methods, family therapy, marriage, psychodrama, review of action methods

ACTION METHODS (AM) ARE THERAPIST-INITIATED TASKS that engage clients in physical activity or in taking on dramatic roles. Although there are psychotherapeutic approaches that make use of action methods as central techniques in clinical treatment, such as psychodrama, play therapy, and drama therapy, their use in marriage and family therapy (MFT) has been more peripheral, with mainstream approaches typically using action methods only as a supplement to verbal discourse. Nonetheless, there exist numerous action methods that contribute to MFT praxis. In this article, we provide an overview of action–based approaches and techniques used within MFT for assessment and as interventions.

Advantages of Action Methods

The advantages to the inclusion of AM in MFT are many. Contemporary MFT is rooted in Family Systems Theory (Nichols & Schwartz, 2001, p.104),

according to which problems or symptoms manifested in individuals are best understood in the context of those larger social systems dynamics (most important, families) in which those individuals participate. Accordingly, MFT practitioners work to alter patterns of interaction and attend to observable social behavior in families more than to reports of internal experiences. Wiener and Oxford (2003, pp. 5–6) enumerate 10 advantages of AM in comparison with exclusively verbal techniques, nine of which apply particularly well to conjoint therapy. AM (1) better engage clients who process in visual and kinesthetic modes; (2) equalize participation for children and adults; (3) heighten awareness outside of prior verbal representations; (4) create new experiences that go beyond verbal description; (5) illustrate abstractions concretely; (6) dramatize familial role relationships; (7) effect relationship changes through role expansion; (8) offer safe ways to explore and practice new behaviors; and (9) facilitate life transitions.

Scope of This Review

The AM of psychodrama and sociodrama, which include role play, role reversal, mirroring, doubling, auxiliary ego, and multiple ego techniques (Blatner, 2000), are well known to the majority of readers of this journal and will not be described further. What is relevant about those AM is that, collectively, they have contributed significantly to the underlying rationale of using action techniques and constitute a proportion of AM that have been adapted by others to MFT praxis. In this review, we describe AM used in psychodrama-influenced MFT approaches and AM used in approaches that differ from psychodrama in their underlying premises, structure, design, and implementation. Except for citing Moreno's contribution, we give little attention to who influenced whom or first devised any particular AM.

The majority of AM included are intended primarily for purposes of assessment rather than as interventions. It should be noted, however, that assessment and intervention are often reciprocal; each purpose may be advanced by, or even comprise the process of, the other.

AM can be usefully classified as either dramatic or nondramatic. Johnson (1992) has coined the term "play space" to denote "an interpersonal space within an imaginal realm, consciously set off from the real world by the participants, in which any image, interaction and physical manifestation has a meaning within the drama" (pp. 112–113). Enactments are dramatic when they occur in the play space; note that psychodramatic AM are inherently dramatic. In general, evoking the play space in therapy facilitates role expansion, because in a dramatic situation, clients are often freer to explore uncharacteristic and new behaviors and reactions than in nondramatic enactment. AM classified as dramatic are marked with an asterisk when first cited.

In light of the sheer number of AM that have been used in MFT and their still more numerous variations, we aim in this review to present a wide range of important and representative AM, occasionally offering brief descriptions of how they are implemented. We include specific techniques (in which explicit instructions are available) and broader classes of a technique (in which a principle or example is given). Where named as distinct techniques, AM are italicized in the text. The reader is referred to the sources cited for more detailed information about the rationale and pragmatics of their application.

The Contributions of J. L. Moreno

Many of the AM in contemporary MFT praxis are derived from the techniques of psychodrama, a psychotherapeutic method developed by J. L. Moreno between 1936 and the early 1940s (Blatner, 2000). Moreno was one of the first psychiatrists to venture beyond individual psychotherapy to contribute to the foundations of interpersonal therapy. In a number of his writings, Moreno noted that intergroup and interindividual processes are at the core of all social phenomena and that mental illness can exist solely within a system rather than within any one individual (Blatner, 2000; Moreno, 1934). Not only did his work influence many subsequent approaches that use AM, Moreno himself made significant early contributions to the theory and application of couple and family therapy (Compernolle, 1981), documenting his relational work with couples and families and the beginnings of a systems theory. Williams (1998) similarly points out that Moreno's concepts and techniques integrate well with contemporary MFT praxis. Blatner (1999) suggests how psychodramatic concepts contribute to furthering the aims of family therapy.

Considerations for Using AM in Systemic Couple and Family Therapy

The format and techniques of classical psychodrama, modified in application to accommodate differences in group sociometry, have been used to conduct individual family therapy (Guldner, 1990; Hollander, 1983; Leveton, 1991; Oxford & Wiener, 2004; Perrott, 1986) and multiple family therapy (Guldner, 1982). Several authors (Guldner, 1983; Kipper, 1986; Seeman & Wiener, 1985; Wiener & Oxford, 2003) have noted important limitations of and differences in applying psychodrama (which was primarily developed for groups of nonaffiliated persons) to affiliated groups such as couples and families. For example, instead of full [psychodramatic] role reversal, a therapist working with a conflictual couple might use *double-bonding role reversal** (Hale, 1985), in which the husband takes the wife's role from the position of her chair, addressing a projection of himself in the facing empty chair that he

just vacated. At the same time, the wife stands at the side of and slightly behind her own chair, thus doubling for herself.

Action Methods Derived From Psychodrama

In this section, we include AM that are distinct from psychodramatic work. The methods, however, make use of psychodramatic techniques or recognizable modifications.

For several AM, Satir adapted role play and action sociometric techniques that Moreno originated (Satir, Banmen, Gerber, and Gomori, 1991). One well-known example of action sociometry, popularized by Satir and often used by experiential MFTs, is *family sculpting**, which Duhl, Kantor, and Duhl (1973) developed. In family sculpting, Satir supervised the positioning of all family members in turn, according to each individual member's perception of his or her experience of the family. Such a sculpture—a static, spatial representation of the felt experience of one member—was then adjusted by changing all members' positions in the tableau to conform to every other member's perception, so that all family members present could experience nonverbally the similarities and differences across their experiences of the family system. Other sculpting variants include kinetic family sculpture to represent change processes over time (McKelvie, 1987); using stand-ins so that family members can be replaced in the sculpt, permitting them to walk around the tableau and experience it from an "outside" perspective (Constantine, 1978); and sculpting in which members, starting from a silent, static tableau, then added brief, repetitive phrases or movements (Jefferson, 1978).

Satir was also well known for her creation of *family reconstruction**, a technique in which clients are able first to recreate and then alter troubling scenes in their family. In this method, the client, named the "Explorer," reenacts scenes from his or her childhood past, reexperiencing relationships in ways that may affirm or alter his or her present perspective. Unlike family sculpting but akin to psychodrama's use of auxiliaries, nonfamily group members (called "players") represent actual family members in the Explorer's scenes (Nerin, 1986). Although based on one individual's perspective, a family reconstruction witnessed by other family members profoundly shifts the family's present process.

Teachworth (2002), a Gestalt therapist, uses two *three-chair enactments** to help clients to re-experience their own relationships with their partners and their parents' union. In one, clients first role-play themselves as children witnessing their parents' interactions from one chair and then reverse roles to embody each parent interacting with the other in the third empty chair. In the other enactment, the client takes the role of a counselor engaged in a couples therapy session scene, working to resolve a core conflict between his or her parents in the other two empty chairs.

For action modality psychotherapy (Hayden-Seman, 1998), when applied to couples therapy, the therapist uses guided dramatic action within the psychodramatic structure of warm up, enactment, and closure. Moving from the warm-up phase to enactment, one client, as protagonist, recreates his or her experience of the relationship, alternately directing and enacting a realistic scene relevant to a central issue. The client's partner assists by taking other roles in the scene. From this goal-directed scene, the couple moves on to enacting a painful scene set in the partner's childhood that is connected to the first enactment. In this painful scene, the therapist plays any roles that are seen as hurtful or negative to avoid a conflicting transference. Next, a *reconstructed scene** is enacted as healing or positive, with the protagonist's mate playing a healthy, nurturing role in the place of the previous negative one. During closure, the therapist models the sharing that is expected from each partner, emphasizing process feedback.

In another approach, similar to Hayden-Seman's, of orchestrating *"reformed past" scenes** (Chasin, Roth, & Bograd, 1989), clients experience their pasts as mutable constructions, rather than unchangeable givens. After inviting each partner to name his or her own strengths in the presence of the other, the therapist asks each partner for a verbal description of future wishes for their relationship. Then, both clients enact a first scene incorporating both partner's future vision, concretizing their future wishes together. The partners now enact a second, painful scene from one of their pasts (usually from childhood) in which their desired wishes were thwarted. Then they stage a third, culminating "reformed past" enactment as a revision of the second scene in which the partner plays a healing figure that transforms the remembered defeat into fulfillment.

Other Action Methods

The remaining AM in this review are not based on Moreno's work. Although some of the themes, forms, and concepts appear similar, the manner in which these AM are constructed and processed is fundamentally different.

Action Methods Used for Concretization and Representation

Action metaphors are a class of AM that serve to concretize interactional processes in MFT. One example is *boundary sculpture** (Duhl, 1999) with couples, which begins with each partner visualizing his or her ideal personal space. One partner paces off personal space in the room, describing it and adding details in response to the therapist's questions that focus on the nature of boundaries and entrances to the space. Then the other partner approaches

the space and seeks to enter. The reactions of both partners to the enactment are processed immediately afterward.

Satir employed many AM to externalize psychological processes and functions and staged formatted enactments for family discovery and learning, such as her *parts party** and the *four interpersonal styles** (Satir et al., 1991). Her followers (McLendon, 1999) went further in using physical props charged with symbolic or metaphorical meanings (e.g., a piece of rope to represent a boundary or a bond between family members, or a *self-esteem tool kit** that included plush hearts, stuffed toy animals, and a detective hat).

Wiener (1998b) uses the *feeding exercise* to concretize struggles over autonomy and nurturance in couples therapy. Partners in this AM take turns feeding one another small pieces of hand-held food (e.g., grapes or small cubes of cheese); the eater remains physically passive, moving only his or her mouth. There are three variations to the exercise: Both may speak during the enactment; only the feeder may speak; and neither may speak. In the variations in which the eater may not speak, the feeder is instructed nonspecifically to attend to the eater's nonverbal cues. This enactment frequently produces vivid associations; the eater may feel helplessly dependent while the feeder may experience intense responsibility for the eater.

In *staged metaphors** (Papp, 1982), the therapist first has both partners create a visual fantasy about self and their partner in which both take on a symbolic animal form. The therapist then instructs them to imagine what kind of interaction occurs between these animals in the fantasy. Once the fantasies are visualized completely, each spouse in turn enacts his or her choreographed fantasy with the other spouse. The therapist asks questions to supply a plot for the action of the scene and helps the couple bring postural and gestural details into the scene.

*Therapeutic rituals** constitute a class of AM that are useful in addressing a variety of situations arising in MFT practice. These scripted AM use recognized symbols for processes, events, places, people, and objects and are typically devised to lift constraints on the family system arising from the absence of adequate cultural rituals, such as religious ceremonies, celebrations, or rites of passage. They function in a number of ways: to signify and celebrate healing and completion; to acknowledge changes of membership, status or identity; to affirm a change in expression of belief. Through family rituals, members are able to integrate multiple meanings of behavior and safely express strong emotions through the manipulation of symbolic objects and by taking symbolic action. (Imber-Black, Roberts, & Whiting, 1988; Winek & Craven, 2003).

Social ceremonies are rituals used to conform and normalize changes made to established relationships within the social order. *Therapeutic ceremonies** are intentionally designed to enhance the self-esteem of the participants and thus provide occasions for processing distressing emotions and spontaneous

actions. Lubin and Johnson (2003) have devised a number of therapeutic ceremonies for multiple family groups dealing with such shared traumata as foster families struggling to integrate foster children or families of military veterans dealing with PTSD. The ceremonies reduce such families' marginalized social status, internalized shame, denial, and distress.

Family constellations (Hellinger, Weber, & Beaumont, 1998) is a unique approach used to repair intergenerational damages to love in families. Family constellations are tools for discovery that make use of nonfamily members (called "representatives") who stand in for other family members, living and dead, and are selected by the client from a larger group.

The first phase of constellations work is a personal, subjective, spatial representation of the ways that the family system influences the client's feelings and actions, in which the representatives' reactions supplement the client's reports. A crucial difference between family constellations and family sculpting or family reconstruction is that the representatives are not in role; that is, they report what they experience as themselves, not as what the client's family member whom they represent might or would experience. The second phase involves a trial-and-error search for an image of systemic balance and loving resolution, obtained by the therapist moving representatives and using feedback from changes reported in their experience. The third, final phase is the creation of a constellation embodying an image of what the family can be, in which every represented family member has an appropriate place and function.

Action Methods Used in Mainstream Marriage and Family Therapy Approaches

Structural family therapy *enactments* are "techniques by which the therapist asks the family to dance in his presence" (Minuchin & Fishman, 1981, p. 79). The therapist using enactments invites scenes of everyday transactions through which families reveal both to the therapist and themselves their often-dysfunctional interactional sequences. The therapist may follow enactments with *restructuring**, which is changing the previously enacted scene by giving directives for alternative behaviors. "In restructuring, the therapist creates scenarios, choreographs, highlights themes, and leads family members to improvise within the constraints of the family drama." Minuchin, 1974, p. 138). These AM contrast with psychodramatic enactment, in which scenes emerge out of the perceived reality or the desires of the protagonist, not those of the therapist.

Strategic family therapists, who focus solely on changing patterns of behavior and communication within family systems, use both direct (straightforward) and indirect (paradoxical) interventions to resolve clients' presenting problems. Both types of interventions become AM when assigned as out-of-

session homework tasks. By design, direct interventions work when they produce compliance with instructions that alter roles and interactive sequences of behavior, whereas indirect interventions work when clients fail to comply or even defy the therapist's instructions.

There are numerous subtypes of paradoxical interventions. In a *restraining paradox*, the therapist informs his clients that he will help them change, while simultaneously asking them not to change (Weeks & L'Abate, 1982). In *prescribing the symptom**, the therapist directs clients to either heighten or maintain their problems, based on the rationale that interpersonal problems persist precisely because of family members' specific attempts to solve them (Fisch, Weakland, & Segal, 1982). In the paradoxical *pretend technique* of Madanes (1981), the therapist prescribes the pretending of a symptom that is a problematic focus for the family. This practice undermines the family's belief that the "real" symptom is still needed. Weeks and L'Abate (ch. 7) describe a number of tasks that are assigned to families as homework and that use pretense or have a paradoxical component.

Other strategic AM are designed to defeat the family's usual homeostatic pattern. In the *invariant prescription* (Palazzoli, Cecchin, Prata, & Boscoso, 1978), the parents of a living-at-home young adult, whose crises kept the family in turmoil, were instructed to announce their departure for a weekend, expressing confidence that the young person would do fine. By being conspicuously unavailable to be called or to return home, the parents were forced to keep from intervening in any crisis while the young person was compelled to deal with life circumstances without assistance from the parents. In *ordeal therapy*, families who had previously failed to make changes in therapy are asked to agree in advance to whatever task the therapist assigns them. The assigned task is designed to be more disagreeable than the symptom, so that changing by avoiding the symptom is preferable to undertaking the ordeal (Haley, 1984). The ordeal itself may be a straightforward or paradoxical task, or even be the ordeal of continuing the relationship with the therapist.

Although symbolic-experiential family therapists evoke play space as a central feature of their work (Keith & Whitaker, 1999), the only AM that they use consist of therapist-initiated, playful in-session behavior, such as tossing a frisbee to the children during conversation or even wrestling physically with an adolescent.

Cognitive and behavioral family therapies make considerable use of AM. Cognitive behavioral couple therapists use *guided behavior change*, which involves specific, out-of-session behavioral changes to enhance couples' relationships, and *skills-based interventions*, in which clients participate in behavioral rehearsal within the psychotherapeutic setting (Baucom, Epstein, & LaTaillade, 2002). In *behavior exchange* (Jacobson & Margolin, 1979), part-

ners first bring to the therapy session their independently prepared lists of positive behaviors that they believe their partner desires; next, they commit to doing some of the behaviors on their lists; and then they schedule a "caring day" to perform some of the listed items.

During sessions, therapists practicing integrative behavioral couple therapy may evoke the play space in the manner of narrative therapy by using the empty chair. In a session, the couple's problem is imagined as sitting in the chair; and at home, during arguments, the therapist is imagined as sitting. (Christiansen & Jacobson, 2000). Two other AM are interventions to improve mutual tolerance: *practicing negative behavior** in the therapy session, used to desensitize each partner to the other's negative behaviors; and *faking negative behaviors** at home between sessions, that is, intentionally doing what has been previously identified as negative behavior. That is recommended for use only when one is not emotionally aroused and used for only a few minutes before disclosing the deception.

Action Methods Used in Working With Families Having Young Children

Family play therapy uses AM individual child play therapy and family therapy to offset the marginalizing of children in talk-only therapy. Play, at which children excel, allows children and adults to participate together. Family play therapy makes use of media that include: toys, pillows, sand trays with figurines, hand puppets, art supplies, photos, and video cameras.

The use of dolls and puppets in family therapy as *displacement doll figures** has a lengthy history. Levy (1937), working with the case of a four-year-old boy's jealousy of his infant sister, brought dolls representing the mother and both children to the session, and he and the child fashioned clay breasts for the mother doll. The infant doll was put to the breast, permitting the enactment of jealousy by the boy through the doll representing him. Roberts (1999) describes a family in which a child's psychosomatic pain was passed into her least-favorite stuffed animal through a displacement ritual that brought the child and her parents into close contact.

Two contemporary, fairly similar examples of family puppet play technique are the *family puppet interview** (Irwin & Malloy, 1999) and the *family puppet technique** (Ross, 1999). For these techniques, one needs an assortment of hand puppets. For the interview, the array of puppets should include fantasy characters such as a dragon, king, and queen, as well as realistic people puppets for both. The therapist introduces either technique as a way to get to know the family by observing them performing an activity together. After family members choose a puppet, each introduces his or her puppet by giving it a name and making a brief statement about its character and circumstances. At this point, the techniques diverge; in the inter-

view, the clinician assigns the family the task of inventing a fictional story with the puppets, whereas in the technique, the therapist directs the family members to reenact a real (usually problematic) interaction. Once a story or event has been selected, the therapist takes the audience role as the family enacts their story. After the interview enactment, the therapist will likely draw some parallels between the story, the puppets' interaction, and the family's own conflicts and themes of concern.

Family art therapy makes use of art tasks—drawing, painting, collage-making, and clay sculpting—to enable families to depict aspects of their lives previously undisclosed or undetected. The choice of an art directive, the manner in which it is employed, and the interpretation of its content are all governed by the clinician's theoretical frame of reference (Landgarten, 1999). Therapists also use family art-making to assess roles, rules, and hierarchical organization by way of the manifest process, the manner in which families organize themselves when they work together (Linesch, 1999).

There are many variations of family drawing. In *conjoint family drawing* (Bing, 1970), members draw a picture of their family as they see themselves, and then they compare and discuss the pictures in a way similar to family sculpting. The *subjective genogram** (Wiener, 1998a) consists of an impressionistic drawing of the family in either representational or symbolic form and is another visual analogue of family sculpting. Using color, size, shape, and spatial positioning, family members first depict their experience of the family and then present their drawings to each other. The therapist then invites each presenter to explain his or her idiosyncratic choices to facilitate comparisons between family members' experiences, particularly of perceived emotional qualities within and between members.

In the *collaborative drawing technique* (Smith, 1999), family members, each using a different color, work together in silence to create a drawing. In turn, each member draws for a specified time; the allotted time starts at 30 seconds and is reduced with each round until it is three seconds in the final round. Because of these time constraints, members are impelled to react to the composite drawing because they do not have the time to draw their own pictures. The relative ease or difficulty that the family has in following this process informs the therapist about the family's dynamics and structure. Gil (1994) describes additional related family art therapy tasks.

*Sandplay therapy**, a staple of individual child play therapy, has been adapted to use in family therapy (Carey, 1999). Typically, there are two sandboxes, along with numerous figurines of people, animals, mythical figures, and objects. In one application, the sandbox is divided and each member simultaneously places figurines in his or her own area. Compared to family art therapy, the process of art-making in sand play work is less important than is the interpretation of the resulting final product.

Kinetic psychotherapy (Schachter, 1999), adapted to working with families, involves games that serve to catalyze the expression of feelings. Therapy takes place in a playroom with ample space, toys, and expressive media. Games include *bombardment** (evoking competitiveness and anger), in which two teams of family members standing on opposite sides of the room throw soft plastic balls at the opposite team (any member hit three times is out of the game) and *freeze tag** (evoking joy and sharing), in which a family member is frozen in position when tagged by a soft plastic ball but can be freed when another family team member tags him or her.

Many commercially available games are available, such as Gardner's the *Talking, Feeling, Doing Game** and Foley & Rebens' (1966) *Twister**, that are structured activities intended to warm families up to verbal participation or heighten their interest in therapy by facilitating the exchange of new information about one another (see McManus & Jennings, 1996). In such games, clients' habits and expectations of unselfconscious game-playing behaviors in outside situations transfer well to therapy, disarming suspicion and defensiveness arising from the unfamiliar or challenging mode of conventional therapeutic verbal discourse. As with so many of the AM described here, therapists can also use such games or tasks for assessment, descendants of a tradition of situational testing in psychology. In practice, the specific game used by a therapist is less important than that the family is assigned some task that involves them in making decisions and interacting around a set of rules.

The *play-baby** intervention (Wachtel, 1990) is intended for families of children having dependency issues. In that AM, the parents initiate games and other activities through which they let the child know that he or she will always remain their baby, even though they continue to expect age-appropriate behavior. In that way, they address the child's unarticulated anxiety that in growing up, he or she will lose the gratifications of being a baby. Leguijt and van der Wiel (1989) used a series of dramatic enactments involving dressing up and performing *fantasy enactments** with a family having preverbal children. Through role projections in this loosely structured play activity, the family uncovered previously unarticulated conflicts and was able to resolve them though improvised scenes. Similarly, the free-form fantasy story enactments used by Ariel, Carel, and Tyano (1985) allow children to explore nonverbalized fears and conflicts in family therapy sessions.

Dynamic family play (Harvey, 2003) is a multimodal play therapy approach for families with preadolescent children. Activity progresses in stages with increasing spontaneity, creativity, and motivation, from beginning verbal and play-based evaluation to the family's successful generation of its own play activities. AM include *follow the leader**, which offers each family member a chance to lead others in imitating him or her in actions such as crawling through a pile of pillows or making faces, and *monster**, in which the therapist, holding a

stuffed animal, slowly approaches the family while coaching a parent to protect a child from the monster. The main benefit of such play activity is that parent and child enrich their bonding through shared dramatic action. A further extension of "monster" is having the parent and child collaborate in making an illustrated book of their adventures with the monster that they read together at home.

Drama Therapy Action Approaches

Rehearsals for growth (Wiener, 1994) is a drama therapy of relationships that uses, in a playful spirit, over 100 adapted improvisational theater AM to facilitate change. Interpersonal improvisation in itself is viewed as therapeutic, in that the rules for good improvising closely map the rules for successful relationship functioning. In these AM, clients may enact unusual activities or observe unusual rules as themselves ("exercises") or become characters in improvised scenes ("games"). An example of each follows. *Tug-of-war** is an exercise in which two family members simulate a realistic contest with an imaginary rope, requiring them to cooperate in cocreating the illusion. Because actual skill, size, and strength are irrelevant in such a nonphysical contest, participants choose outcomes by physicalizing their intentions (winning, letting the opponent win, electing to lose, refusing to lose, etc.). *Slo-mo commentator** (Wiener, 2003) is a game structured as a scene of a televised sports event. Two family members play the roles of sports commentators who, seated together at one side of the stage, comment to one another and an imaginary broadcast audience on the onstage performance of a third family member (the athlete), engaged in some nonsensical athletic act (e.g., "Olympic chair-sitting") in ultra-slow motion. The commentator roles are offered to oppositional or withdrawn family members, who are more likely to participate because they see themselves as safely removed from the spotlighted, action role of the athlete.

Narradrama (P. Dunne, personal communication, 2005) is an approach to conducting ordinarily verbal narrative therapy by means of a number of creative arts-adapted AM. As did Oxford and Wiener (2004), who worked within a psychodramatic frame of reference, Dunne concretizes the narrative technique of externalization (treating a problem as an oppressive entity apart from the person conventionally said to have the problem). By combining various family art-making projects with verbal narration, Dunne opens possibilities for families to redefine, enlarge or protest their relationships to important social issues, family practices, and societal constraints.

In the *pictorial history scroll**, a large scroll created by the family, depicting significant family scenes, transitions, turning points, and special moments, members are invited to interview and answer as objects, people, and characters in the scenes on the scroll to bring out alternative stories and to reenact past

scenes with new descriptions. In the *TV talk show panel** technique, a controversial belief is first identified by the family (for example, women should put the needs of their families ahead of their careers). That belief becomes the topic of a panel discussion on a staged TV talk show. Each family panel member, in a fictional role, talks about his or her preferences in continuing to be restrained by the belief, ignoring the belief, or taking a stand of protest against the belief.

Conclusion

AM are valuable, tested techniques that, when conducted properly, frequently promote rapid and significant clinical change, reaching many client populations that are not responsive to talk-only therapy. For all their advantages, however, AM currently are not widely employed by MFTs or by the vast majority of psychotherapy practitioners. Because few therapists have any exposure to AM in their preprofessional training, this state of affairs appears to be self-perpetuating. Another plausible reason is that the competent use of AM is believed, by those who know something of them, to require more specific, intensive training than do verbal techniques. As a result, therapists avoid attempting AM from the outset, because of their self-acknowledged lack of sufficient proper training. However, in the current, rapidly-changing climate of mental health delivery, where there is an increasing incentive to demonstrate briefer, more effective treatment, AM generically may yet fulfill their great potential in contributing to such improved treatment.

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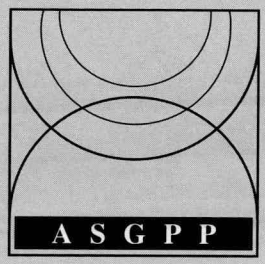

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The pioneering membership organization in group psychotherapy, the American Society of Group Psychotherapy and Psychodrama, founded by J. L. Moreno, MD, in April 1942, has been the source and inspiration of the later developments in this field. It 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 *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.

THE JOURNAL OF

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