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The Group Cohesion Scale-Revised: Reliability and Validity

THOMAS TREADWELL
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VENKATESH VEERARAGHAVAN

ABSTRACT. The authors revised the Group Cohesion Scale (V. Veeraraghavan, H. Kellar, T. W. Treadwell, & V. K. Kumar, 1996) by dropping 1 item, rewording one item; reducing the number of anchor points from 5 to 4 by dropping the *not applicable* response category; and changing the anchor points from *low, moderately low, moderately high,* and *not applicable* to the more familiar *strongly disagree, disagree, agree,* and *strongly agree* response categories. They tested the revised scale, consisting of 25 items, in 8 psychodrama group classes. The Group Cohesion Scale-Revised (V. Veeraraghavan et al., 1999) showed acceptably high reliability for use in research and seemed to be sensitive to detecting changes in cohesiveness as a function of group development. Consistent with their previous investigation, the authors found that summer classes were more likely to show increases in cohesiveness than regular semester classes, probably because of the increased frequency and sustained interactions demanded by a 1-week course that met for 8 hr each day.

Key words: cohesiveness, group cohesion, group process

BECAUSE OF THE WORK OF MORENO AND JENNINGS (1937), Newcomb (1943), Thibaut (1950), Festinger and Kelly (1951), and Cartwright and Zanders (1960), the concept of group cohesion has become a key notion in many theories of group processes (see Forsyth, 1999). The concept of group cohesion, which has been around for decades and has been investigated by many researchers, has many definitions.

Langfred (1998) defined *cohesiveness* as how much members of a group like each other or as the amount of friendship between group members.

Nevertheless, although mutual liking tends to be a strong source of cohesion, members of a group do not have to like each other to form a cohesive group. Rempel and Fisher (1997) explained group cohesion as the primary motivation to remain in a group. Frank (1997) described it in terms of a member's sense of belongingness to a group or the attractiveness of a group for its members. Frank suggested that "the greater the cohesion of a group, the more influence its standards exert on its members" (p. 63).

Forsyth (1999) regarded cohesion as analogous to the "glue" that holds a group together or as the strength of the bonds linking group members to the group. He observed that cohesive groups share some common characteristics: (a) enjoyment and satisfaction, (b) a cooperative and friendly atmosphere (see also Secord & Blackman, 1964), (c) exchange of praise for accomplishments, (d) higher self-esteem and less anxiety among group members, and (e) greater member retention. Additionally, Secord and Backman (1964) stated that members of highly cohesive groups mutually accept each other's ideas, contribute equally to problem solving, and are not likely to be adversely affected by the power and status structures within the group.

Group cohesion usually has salubrious effects on group behavior and functioning. Those effects include reduction of, or even elimination of, social loafing (Karau & Hart, 1998; Karau & Williams, 1997), drop out rate (Robinson & Carron, 1982), and absenteeism (Carron, Widmeyer, & Brawley, 1988); improvement in communication among group members (Wech, Mossholder, Steel, & Bennett, 1998); greater conformity to group norms among sports team members (Prapavessis & Carron, 1997b); enhanced problem solving (Rempel & Fisher, 1997); and increased work output (Langfred, 1998; Prapavessis & Carron, 1997a). Frank (1997) claimed that group cohesion is important in therapy groups because it enables members not only to risk change but also to maintain the change.

On the negative side, Janis (1972) pointed out that when groups become too cohesive, they isolate themselves, resist outside influences, and engage in "groupthink." Mondy, Sharplin, and Premeaux (1991) argued that a highly cohesive group whose goals are incongruous with the organizational objectives is likely to sabotage management efforts toward increased productivity. In view of this possibility, many managers deliberately reduce cohesiveness to maintain control.

Group cohesion has been assessed by observations (Homans, 1950), sociometry, and self-report questionnaires (Festinger, Schacter, & Back, 1950; see also Wood, Kumar, Treadwell, & Leach, 1998). Several questionnaires for assessing cohesion in specific types of groups exist. Carron, Widmeyer, and Brawley (1985) designed the Group Environment Questionnaire to assess attraction of sports team members to their groups. Podsakoff, Mackenzie, and Ahearne (1997) designed a scale to measure drive, cohesiveness, and produc-

tivity in work groups. Hurley (1989) developed a scale to measure "affiliativeness" (the interpersonal behavior within groups that promotes helpfulness and emotional support) in psychotherapy groups. Hurley regarded cohesion and affiliativeness as overlapping concepts.

Budman et al. (1987) made a significant development in the area of measuring cohesion as a single construct with the construction of the Harvard Community Health Plan Group Cohesion Scale. It is an observer-rating scale; its use, however, is limited to measuring cohesion in psychotherapy groups. Additional measures of cohesion exist in the form of self-report scales, such as the Group Atmosphere Scale (Silbergeld, Koenig, Manderscheid, Meeker, & Hornung, 1975), the Group Climate Scale (Mackenzie, 1981), and the Group Environment Scale (Moos & Humphrey, 1973). The latter three instruments were designed to assess the overall psychological environment of psychotherapy groups with cohesion as one of the deciding components.

Veeraraghavan, Kellar, Treadwell, and Kumar (1996) created the Group Cohesion Scale (GCS) to assess cohesion among group members in terms of the diverse dimensions usually noted in the literature as interaction and communication (including domination and subordination), member retention, decision making, vulnerability among group members, and consistency between group and individual goals. The following are examples of the items included in the assessment:

- Group members usually feel free to share information.
- There are feelings of unity and togetherness among the group members.
- Group members are receptive to feedback and criticism.
- Many members engage in "back-biting" in this group.

In two previous studies, Veeraraghavan, Kellar, Gawlick, and Morein (1996) and Wood et al. (1998) found the GCS to be reliable for research purposes. In the latter study, the researchers also found that the GCS was sensitive to the idiosyncratic group dynamics in different classes inasmuch as some classes showed a decrease, others showed an increase, and still others showed no change as a result of group development. Specifically, the two classes that showed significant increases in cohesiveness were the summer classes that met for an entire week for approximately 8 hr each day. Wood et al. attributed the increases in cohesiveness to the sustained interactions demanded by being together for 8 hr each day (the group members were also together during lunch). Although the GCS showed adequate reliability and validity, Wood et al. suggested that the GCS might be improved by dropping the response category *not applicable* because it made scoring the items difficult. (The original GSC used a 4-point scale: *low, moderately low, moderately high,* and *high,* along with a *not applicable* response.) Specifically, they noted that the *not*

applicable response had no clear meaning in reference to two particular items: "I personally do not like to go to group meetings" and "If a group with the same goals were formed, I would prefer to be a member of that group." Furthermore, it was felt that the more general anchor points—*strongly disagree, disagree, agree,* and *strongly agree*—might fit better with the items than the ordinal wording used before (i.e., *low* to *high*). The above two changes were implemented in developing a revision of the instrument, along with two other changes. The item "I do not like to go to group meeting" was simplified to "I dislike going to group meetings," and 1 item that appeared ambiguous was dropped.

Hereafter, we refer to the revised 25-item GSC as the GCS-R (Veeraraghavan, Kellar, Treadwell, & Kumar, 1999). The main purpose of this study was to test the GCS-R for its reliability and validity in terms of its ability to be sensitive to particular group dynamics in ongoing groups.

Method

Participants

Participants in the study were students enrolled in eight experiential training courses in the use of cognitive and psychodramatic techniques. The classes, being taught in different semesters, were experiential inasmuch as students, with the assistance of the instructor, worked on real-life issues experienced by the students in an effort to learn about various cognitive, psychodrama, and sociometry techniques. One instructor taught seven of the classes (see Table 1; PD1, PD2, PD3, PD4, PD6, PD7, and PD8), and a different instructor taught one class (PD5). There were two spring, three fall, and

TABLE 1
Coefficient Alphas for the Group Cohesion Scale-Revised

Group	*N*	Coefficient alpha	
		Pretest	Posttest
PD1 (Summer)	19	.67	.90
PD2 (Spring)	15	.48	.82
PD3 (Spring)	9	.75	.79
PD4 (Fall)	17	.78	.85
PD5 (Summer)	8	.89	.77
PD6 (Summer)	15	.79	.81
PD7 (Fall)	14	.85	.89
PD8 (Fall)	13	.83	.87

three summer classes. The fall and spring classes met once per week for 2 hr and 30 min for 14 weeks, and the summer classes met for 8 hr each day over a 1-week period.

Most of the students in those classes were undergraduates, majoring in psychology. In each class, there were one or two graduate students, majoring in clinical psychology. A few students were majoring in nursing, education, or business.

Procedures

On the first day of class, the students received course outlines and signed informed consent forms to allow continuous videotaping of the classes and the administration of the GCS-R for research purposes. The instructor assured the students that the data were being gathered for research purposes and that once the data were coded, all identifying information would be removed. The informed consent form also required students to maintain confidentiality concerning all group activities and discussions. The instructors administered the questionnaire twice during the semester—once during the third week of classes and then again in the final week of classes for the regular semester classes. For the summer sessions, the questionnaire was administered during the afternoon session on the first day of classes and then again in the afternoon of the last day of classes.

Results and Discussion

Reliability of the GSC-R

Internal consistency reliability estimates, using Cronbach alpha coefficients, were computed for both pre- and posttest assessments for the eight classes. The Cronbach alpha estimates for the instrument were acceptably high for use in research (Table 1). Those results replicate our earlier work (Veerargahavan, Kellar, Gawlick, & Morein, 1996; Wood et al., 1998), and the estimated reliability values are similar to those generally found for self-report type rating instruments (see Borg & Gall, 1973).

Validity: Change in Cohesiveness as a Function of Group Experiences

The two naturally occurring interventions in the study were (a) attendance and participation in class and (b) regular semester or summer session classes. As in the previous study (Wood et al., 1998), there was no specific intervention to increase cohesiveness. Furthermore, even though we used the same psychodramatic (e.g., warm-up, doubling, auxiliary egos, role playing) and

sociometric techniques in all classes, the dynamics in each class were idiosyncratic (see Table 2). Paired *t* tests were used to evaluate the differences between means. Given the small sample sizes, we used $\alpha = .10$ to establish significance. Additionally, we computed *d*—a measure of effect size (Cohen, 1988).

The results show that in three of the eight classes, the group cohesiveness scores increased significantly with effect sizes of .46 (PD1), 1.10 (PD2), and 0.84 (PD4). Cohen's (1988) criteria suggest a low effect size (0.2 to 0.5) in PD1 and high effect sizes (0.8 and above) in PD4 and PD6. In one other class (PD5), the results were marginally significant ($p = .117$) with a medium effect size of 0.63. It is worth noting that the three summer classes showed significant increases (including PD5 with a marginal significance), whereas only one of the five regular semester classes showed a significant increase. Those results support our earlier observation (Wood et al., 1998) that it was the sustained interactions among group members (almost 8 hr each day) in the summer class that probably promoted cohesiveness. During the regular semester, classes meet only once per week, making it difficult for group members to see each other during the week.

How then does one account for the one regular semester class (PD4) that showed a significant increase in cohesion, with the largest effect size of 1.10? That finding is not easy to explain in view of the previous comment about the greater possibility of sustained interactions in summer sessions promoting cohesiveness. The finding suggests, however, that increases in cohesiveness may be a function of several factors, including how much time students spend

TABLE 2
Mean Pre- and Posttest Group Cohesion Scores and Results of *t* Tests

Group	*N*	Group Cohesion Mean Scores		*t*	*p* <	*d*
		Pretest	Posttest			
PD1 (Summer)	19	73.16	78.00	2.00	.060	0.46
PD 2 (Spring)	15	72.17	68.33	–.1.95	.311	0.27
PD3 (Spring)	9	75.00	78.56	0.68	.519	0.22
PD4 (Fall)	17	69.47	78.18	4.54	.000	1.10
PD5 (Summer)	8	72.75	83.25	1.79	.117	0.63
PD6 (Summer)	15	75.75	83.25	3.24	.006	0.84
PD7 (Fall)	14	73.71	72.14	–0.74	.472	0.20
PD8 (Fall)	13	75.46	79.00	1.37	.197	0.38

Note. *d* = effect size.

with each other during the day. Other potential factors that affect the extent of cohesiveness include the unique interactions that develop in a class, the personality types of students, their prior experience with group classes, and friendships possibly begun before enrolling in class.

Conclusions

The results of this study suggest that the GCS-R has acceptably high reliability for use in research, at least with interactive classroom groups. Because the items are stated quite generally, we question its use with therapy groups, industrial organizations, or management training groups and suggest that its usefulness with those groups needs to be empirically evaluated.

The instrument's validity is supported by its ability to detect changes in cohesion. The GCS-R should be regarded as a state, as opposed to a trait, instrument, and thus, it can be appropriately used to assess fluctuations in cohesion within a group's development. As the instrument is currently designed, however, it can be used to measure group cohesiveness at a given point.

As Wood et al. (1998) found, summer classes that met 8 hr each day were more likely than the regular semester classes to show an increase in cohesion, suggesting that sustained interactions in the former may have promoted cohesiveness. That a large effect size was associated with a regular semester class suggests that several factors may influence a group's development.

Although cohesiveness is generally regarded as beneficial to group functioning, it is sometimes desirable to decrease cohesiveness in order to promote productivity. In a highly cohesive group, members may avoid conflict or promote overwhelming social pressure, contributing to a decrease in productivity (see Mondy, Sharplin, & Premeaux, 1991). Therapists can use the GCS-R as a barometer to assess cohesiveness at different stages of group development. That information can be used to bring about changes in the way the group members interact with each other, with a view to improving team work and morale.

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Integrating Psychodrama and Cognitive Therapy—An Exploratory Study

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ABSTRACT. The authors evaluated the effects of participating in a group course, using integrated psychodramatic and cognitive-behavioral techniques, on participants' ($N = 40$) changes in the number of core beliefs, number of automatic thoughts, moods, and alleviation of depression. The results of the study showed that the average Beck Depression Inventory (BDI-II) scores from the first 3 and last 3 weeks of the course did not differ significantly. That lack of difference may be attributed to the use of students as participants in the study; their BDI-II scores, already low in the first 3 weeks of the course, had little, if any, room for improvement. The average mood ratings, before and after writing balanced thoughts, differed significantly ($p < .05$) for each time period of analysis (i.e., separately for the first and last 3 weeks). Thus, there were immediate positive effects from writing balanced thoughts but no significant differences between the average mood ratings across the 2 time periods, whether the ratings were obtained before or following the writing of the balanced thoughts. The lack of generalization during the initial practice (first 3 weeks) of writing balanced thoughts across new situations was evident later in the course. The BDI-II scores significantly correlated with the number of automatic thoughts, core beliefs, and different types of core beliefs. That finding suggests Beck's assumption that negative thought content characterizes depression (see D. A. Clark, A. T. Beck, & B. A. Alford, 1999).

Key words: behavioral therapy, cognitive therapy, depression treatment, psychodrama

THE COGNITIVE MODEL IS BASED ON THE ASSUMPTION that thoughts influence emotions and behaviors and assumes that dysfunctional thoughts are frequently associated with psychological distress. The dysfunctional thoughts are provoked by the individual's core belief or beliefs acquired during early childhood experiences (A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 1995). Core beliefs (see J. S. Beck, 1995) consist of

28 beliefs that are divided into two categories, helpless and unlovable. The following are the helpless core beliefs: helpless, powerless, out-of-control, weak, vulnerable, needy, trapped, inadequate, ineffective, incompetent, failure, disrespected, defective (i.e., I do not measure up to others), and not good enough (in terms of achievement). The following are the unlovable core beliefs: unlovable, unlikable, undesirable, unattractive, unwanted, uncared for, bad, unworthy, different, defective (i.e., so others will not love me), not good enough (to be loved by others), bound to be rejected, bound to be abandoned, and alone.

Some authors use the terms *schemas* and *core beliefs* interchangeably, as if they were the same concept. A. T. Beck (1964), however, makes a distinction between the two constructs. He states that core beliefs are the actual content of the cognitive structures within the mind. Thus, the cognitive structures are the schemas, and the content represents the core beliefs. Young (1990, p. 9) referred to Early Maladaptive Schemas (EMSs) as "stable and enduring themes that develop during childhood and are elaborated upon throughout an individual's lifetime." EMSs are composed of many characteristics, which are self-perpetuating and tend to be more difficult to change. EMSs may cause psychological distress because they are known to be dysfunctional. When EMSs are activated, usually by some environmental stimuli, they tend to provoke high affect levels. EMSs are beliefs about oneself that are unconditional and are usually the result of encounters with important individuals (parents, siblings, peers) within the first few years of one's life (Schmidt, Joiner, Young, & Telch, 1995; Young, 1990).

A prominent hypothesis of the cognitive theory of depression (A. T. Beck, 1987) is the cognitive triad (Figure 1), which specifies that depressed individuals have negative thoughts revolving around themselves, the world (their experiences), and the future. Individuals who are depressed misinterpret facts and experiences in a negative fashion, limiting their focus to the negative aspects of situations, thus feeling hopeless about the future. A direct relationship is postulated between negative thoughts and severity of depressive symptoms. Specifically, the more frequently that negative thinking occurs, the greater severity of other depressive symptoms (Haaga, Dyck, & Ernst, 1991). In a study of women, Dent and Teasdale (1988) found that persistence of depression 5 months later was predicted by the severity of the initial depression and the frequency of the global negative trait adjectives that the women used to describe themselves at initial assessment. Women with equal depression, but with more global evaluative thinking, were slower to recover.

Kumari and Blackburn (1992) had normal and depressed participants record their negative automatic thoughts over a 2-week period, using the Daily Record of Dysfunctional Thoughts Form (A. T. Beck et al., 1979). A thought-content analysis showed that the "affective state associated with negative

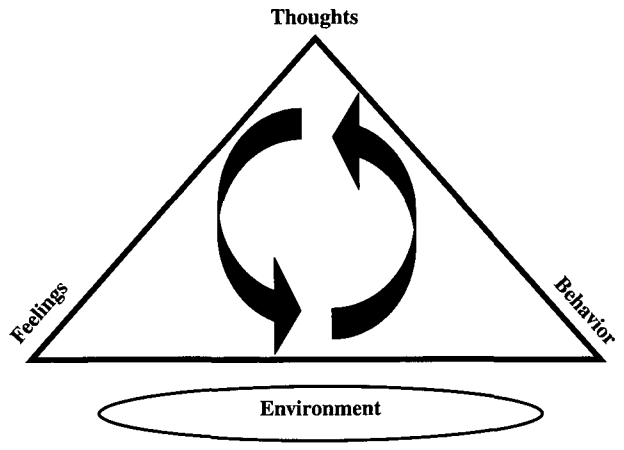

FIGURE 1. The Cognitive Triad.

thought is different in normal and depressives. The two main emotions registered were anger and anxiety by normal subjects, and depression and anxiety by depressed individuals" (p. 173). They found the themes related to self-deprecation, hopelessness, rejection, and illness more prominent in the depressed than in normal individuals. Madonna and Philpot (1996) found the ratio of positive to negative self-statements (as reported on the Automatic Thought Questionnaire-Revised of Kendall, 1989) to differentiate the low, medium, and high depression groups of undergraduate students, as determined by their scores on the Beck Depression Inventory (BDI), developed by A. T. Beck, Brown, and Steer (1987).

The cognitive model specifies that depression is maintained by negative thoughts. Thus, to reduce depression, one needs to reduce the frequency or intensity of such thoughts. In other words, to create a positive change in one's mood and behavior, one needs to evaluate and modify dysfunctional thoughts. Cognitive–behavioral therapy (CBT) focuses on evoking change in a person's thinking and underlying beliefs to bring about lasting emotional and behavioral change (A. T. Beck et al., 1979; J. S. Beck, 1995).

Research on the Effectiveness of Cognitive–Behavioral Therapy

Considerable research dedicated to testing the effectiveness of CBT, supports the use of CBT as an effective treatment for clinical depression (A. T. Beck et al., 1979; Dobson, 1989; Haaga et al., 1991). At the least, CBT has been found to be as effective as other major treatments for depression, includ-

ing pharmacotherapy, behavior therapy, and interpersonal therapy. Dobson (1989) conducted a meta-analysis of published research to evaluate the effectiveness of Beck's cognitive therapy for depression. The analysis included 28 studies in which cognitive therapy had been used on depressed individuals and the BDI (A. T. Beck et al., 1979) was used as an outcome measure. Ten of the studies compared a group treated with cognitive therapy and a wait-listed or no-treatment control group. From the findings, Dobson concluded that the cognitive therapy group, on average, did better than 98% of those in the control group. Recognizing that there is much support for the effectiveness of CBT, we present the following section in which we review in more detail the aspects of the meta-analysis that are most relevant to our study.

Wierzbicki and Bartlett (1987) compared the effects of group and individual cognitive therapy with the outcome of an untreated wait-listed control group. Eighteen individuals were assigned to either group or individual therapy, whereas 20 people were assigned to the control group. Six weekly group sessions lasted 90 min each, and there were six weekly individual sessions that lasted 60 min each. Both the individual and the group therapy sessions had the same structure, consisting of homework assignments to be discussed with the therapist. The outcome measures used in the study to measure depression were the BDI and BDI-II Depression Scales (Dempsey, 1964). Those in individual therapy showed a greater reduction in depressive symptoms than those in the group therapy and the control groups. Although the results from the latter two did not differ significantly, those who attended group therapy tended to show greater improvement.

Reynolds and Coats (1986) compared CBT with a relaxation-training group and a wait-listed control group. Thirty adolescents were assigned to one of the groups. Treatment for both groups consisted of ten 50-min sessions that met twice weekly. Techniques used with the CBT group included self-monitoring, positive mood and activity log, an explanation of the cognitive triad, self-evaluation, homework assignments, and self-reinforcement. During the relaxation sessions, the participants learned specific relaxation exercises to relax numerous muscle groups and how to generalize those learned skills to tension-producing situations. Both the CBT and relaxation groups had a greater improvement in the BDI scores, when compared with that of the control group; however, there was no significant difference between the two treatment groups.

In eight studies, cognitive therapy and pharmacotherapy were compared. On average, the participants who received cognitive therapy had a better outcome than 70% of the individuals who received the drug therapy (Dobson, 1989). Rush, Beck, Kovacs, and Hollon (1977) compared cognitive therapy with pharmacotherapy in 41 depressed individuals. Participants in the cognitive therapy group attended a maximum of 20 individual sessions over a 12-

week period, whereas individuals assigned to the pharmacotherapy condition had a maximum of 12 sessions over a 12-week period. The measures used in the study were the BDI, the Raskin Depression Scale (Raskin, Schulterbrandt, Reatig, & McKeon, 1970), and the Hamilton Rating Scale for Depression (HRS-D), devised by Hamilton (1960). Participants in the cognitive therapy group were given homework assignments and were taught how to recognize the connection between feelings, thoughts, and behaviors; regulate negative thoughts; explore evidence for and against those negative automatic thoughts; replace the negative cognitions with reality-oriented interpretations; and identify, dispute, and change dysfunctional beliefs. Patients in the pharmacotherapy condition attended 20-min weekly sessions in which the side effects of the medication were monitored and supportive therapy was provided. Results showed a reduction in depressive symptoms in both treatment groups. The cognitive therapy group showed a significantly greater reduction in HRS-D and BDI scores than the pharmacotherapy group did.

Finally, there were seven studies that contrasted cognitive therapy with a number of different therapies not previously mentioned. Those findings showed that on average, the individuals who received cognitive therapy did better than those in the alternative therapy groups: psychodynamic, interpersonal, assertion training, and relaxation (Dobson, 1989). Steuer et al. (1984) examined whether depressed geriatric patients would be responsive to CBT and psychodynamic group therapy. Twenty-six participants were divided into four groups: two cognitive–behavioral and two psychodynamic. The groups met for 46 sessions over a period of 9 months. The cognitive–behavioral techniques involved the participants in keeping weekly activity schedules, maintaining a pleasure log, completing task assignments, keeping a record of negative automatic thoughts, using empirical reality testing of those thoughts, examining distortions, and creating different ways to view one's life. The psychodynamic techniques used were support, direction, confrontation, and interpretation. Specifically, the leaders aimed to develop cohesion within the group and to encourage the development of insight into patterns of socially maladaptive behaviors in order to alleviate depression and to prevent a relapse. The instruments used were as follows: The Hamilton (1967) Rating Scale for Depression (HRS-D), which concentrates on the vegetative symptoms of depression; the Zung (1965) Self-Rating Depression Scale (SDS), which has been used extensively with the elderly population; and the Beck Depression Inventory (BDI). Results showed significant decreases in measures of depression for both groups. On the BDI, however, the cognitive–behavioral group showed a greater improvement than the psychodynamic group.

Researchers have found cognitive–behavioral therapy to be an effective form of treatment for other disorders and problems as well as for depression. Baucom, Sayers, and Scher (1990) found cognitive–behavioral techniques, specifi-

cally cognitive restructuring, to be effective in marital therapy. Sixty couples were assigned to one of the following five groups: behavioral marital therapy (BMT), BMT plus cognitive restructuring (CR), BMT plus emotional expressiveness training (EET), cognitive restructuring, and emotional expressiveness training, or a wait-listed control group. Before treatment, each couple completed self-report measures, including the Relationship Beliefs Inventory (RBI) of Epstein and Eidelson (1981) and the Irrational Beliefs Test (IBT) of Jones (1968). Although both the RBI and IBT measure unrealistic standards held by individuals, the RBI measures dysfunctional cognitions toward marital relationships, and the IBT focuses on unrealistic standards held for individuals instead of relationships. Couples in the treatment groups were then provided therapy for 12 weekly sessions. The BMT group used problem-solving techniques, along with communication skills, to aid in the problem solving and contracting. The CR group focused on identifying each individual's concerns within the marriage and assisting the couples in developing more realistic views of their mutual perceptions. In addition, the CR group concentrated on the unrealistic standards held by each person toward the relationship and how those standards might contribute to marital distress. The EET group focused on the expression of emotions and being empathetic. The couples were also taught how to switch back and forth from the role of the speaker to that of the listener. Results showed that the treatment groups that included cognitive restructuring were as effective in increasing marital adjustment as the other two groups.

CBT has been effective in the treatment of bulimia nervosa. The therapy consists of changing the participants' negative beliefs concerning their weight and body shape and of helping them to develop normal eating habits and coping skills that can be used to prevent binge eating and purging (Wilson & Fairburn, 1993).

Cognitive–Behavioral Therapy in Groups

Group therapy has been shown to be not only be an effective form of treatment but also a cost-effective therapy. A meta-analysis conducted by McRoberts, Burlingame, and Hoag (1998) examined 23 studies that compared group and individual therapies. In the studies included in the meta-analysis no difference was found between the outcomes of the group and individual formats.

Oei and Sullivan (1998) evaluated whether changes in cognitions led to a reduction of depressive symptoms in recovered and nonrecovered mood-disordered patients. Cognitive–behavioral procedures were implemented in 12 weekly group sessions, each lasting 2 hr. Outcome measures used in the study were the BDI, the Automatic Thoughts Questionnaire (ATQ) of Hollon and Kendall (1980), the Dysfunctional Attitudes Scale (DAS) of Weissman and

Beck (1978), and the Beck Hopelessness Scale (BHS) of A. T. Beck, Weissman, Lester, and Trexler (1974). They found several results "consistent with the proposition of cognitive theory (i.e., the remediation of negative cognition plays a significant role in recovery from depression during CBT)" (p. 407). Their results were as follows: (a) The mean BDI score showed a faster improvement in recovered mood disordered group than in the nonrecovered group, (b) the mean ATQ scores showed an increase in differences between the two groups as the treatment progressed, (c) the mean DAS scores revealed an increase in difference between the two groups as the treatment progressed, and (d) although there was no significant difference in the rate of change in the BHS scores between the two groups, a significant difference was found between the two groups as a function of the treatment.

Leung, Waller, and Thomas (2000) evaluated the effectiveness of group CBT on 20 women diagnosed with bulimia nervosa. Another focus of their study was the role of core beliefs in changing eating attitudes and behaviors. Specifically, they had predicted that the women having fewer healthy core beliefs would show less improvement from treatment. They used the Young (1994) Schema Questionnaire (YSQ) to measure the women's core beliefs and the Mizes Anorectic Cognition scale (MAC) of Mizes and Klesges (1989) to measure cognitions related to typical anorexic and bulimic behaviors. The women attended 12 group sessions of CBT, in which they learned about their disorder and received support and understanding from the other group members. They were also trained in behavioral techniques to control their bingeing and purging behaviors and were taught cognitive skills to contradict their dysfunctional thoughts surrounding food, weight, and size. The results showed a 59% reduction in the frequency of bingeing and a 53% reduction in vomiting. The results supported the researchers' assertion that the frequency and intensity of negative core beliefs will be related to the extent of improvement as a function of the treatment. They found that women who showed a lack of improvement in bulimic attitudes demonstrated a stronger belief in 10 of the 16 negative core beliefs–schemas (abandonment, dependence–incompetence, defectiveness–shame, enmeshment, failure to achieve, subjugation, self-sacrifice, social undesirability, unrelenting standards, and vulnerability to harm). Women with stronger social undesirability belief tended to have less reduction in the frequency of bingeing. They also found that the greater the defectiveness–shame and social undesirability beliefs, the less improvement in vomiting behaviors.

Nixon and Singer (1993) examined the effects of group CBT in reducing self-blame and guilt in parents of children with severe disabilities. Both the BDI and ATQ were used in that study. Thirty-four mothers were randomly assigned to either group therapy treatment or to a wait-listed control group. The participants in the treatment group attended five 2-hr sessions focusing on

techniques to help them deal with cognitive distortions that provoke self-blame and guilt. During the sessions, the women learned how to conceptualize automatic thoughts and cognitive distortions by becoming aware of them through daily monitoring. The therapists then contradicted those thoughts and distortions by providing evidence that refuted those beliefs. The therapists explained to the group that their beliefs allowed them to continue feeling blame and guilt. They taught the women strategies to change their cognitive distortions and automatic thoughts and told them that modifying their thinking could help change how they felt about themselves. Following the treatment, the therapists found a significant difference between the treatment group and control group in reduction of guilt, self-blame, negative automatic thoughts, and depression.

Researchers have also examined whether group CBT is effective in the treatment of panic disorders. Otto, Pollack, Penava, and Zucker (1999) found that CBT is an effective, alternative treatment for those individuals who are not responding well to pharmacotherapy. They taught participants about the CBT model of panic disorder and its treatment. Then, the individuals attended 12 group sessions that focused on cognitive restructuring, exposure intervention, and relaxation training.

The Present Study

We report on an exploratory study that we designed to examine the effects of completing the Thought Record Forms (TRF) on a weekly basis in a group course, in which we integrated psychodramatic and cognitive–behavioral techniques as a means to alleviate depression. In the group course, the students were specifically trained to complete the TRFs, identify their core beliefs, list and rate their moods, practice writing balanced thoughts, and to re-rate their moods after writing the balanced thoughts. In addition, we examined the relationship among a number of variables derived from the TRFs (e.g., automatic thoughts, core beliefs–schemas, balanced thoughts, moods) and depression.

The study derives its major impetus from A. T. Beck's (1967, 1976, see also Clark, Beck, & Alford, 1999) theorizing that one's negative automatic thoughts reflect a general negativity about oneself and a cynicism, both of which are symptomatic of depression. When depressed (clinical as well as nonclinical), a person has a "significant elevation in negative thought content about the self, future, and possibly to a lesser extent, personal world" (p. 405). Beck later applied his cognitive model to the understanding of anxiety (A. T. Beck, Emery, & Greenberg, 1985) and personality disorders (A. T. Beck, Freeman, & Associates, 1990). If negative automatic thoughts and other cognitive errors in thinking are a type of information processing, then therapy, which brings awareness of negative thought processes, should decrease depression. That notion encom-

passes recognizing various errors of perception and interpretations of one's interaction with oneself and others and learning to develop new ways of thinking (that is balanced thoughts). Beck, however, does not assume in his theory that negative thinking causes depression, but it does "contribute to the pathogenesis of depression" (see Clark et al., 1999, p. 412).

Given that assumption, it seems reasonable to expect that a course integrating psychodramatic procedures with cognitive therapy techniques (primarily a psychoeduational model, see Greenberger & Padesky, 1995) should be helpful in reducing depression. The cognitive therapy model is focused on identifying upsetting situations, automatic negative thoughts, and triggered moods, on writing balanced thoughts to counter negative automatic thoughts, and on recognizing distortions in thinking and interpretations of difficult situations (see for example, J. S. Beck, 1995; Greenberger & Padesky, 1995, for exercises). The psychodramatic procedures of role playing, role reversal, and mirroring should facilitate the process of examining various conflicting situations that individuals experience within the context of a group so that they can understand better the nature of negative thoughts triggered by situations and their effects on moods. In essence, the procedures illustrate the psychodramatic triad (Hollander, 1978; Karp, 1998), as shown in Figure 2.

Furthermore, a group environment provides a supportive climate to practice new thinking and behaviors. Thus, we hypothesized that, as a result of participating in the course, the students would show a lowering of depression scores, as measured by the BDI-II.

The TRF yields a number of variables, such as frequencies of the stressful situations mentioned earlier and of automatic thoughts, the number of dysphoric moods, mood ratings, implied core beliefs, different types of implied core

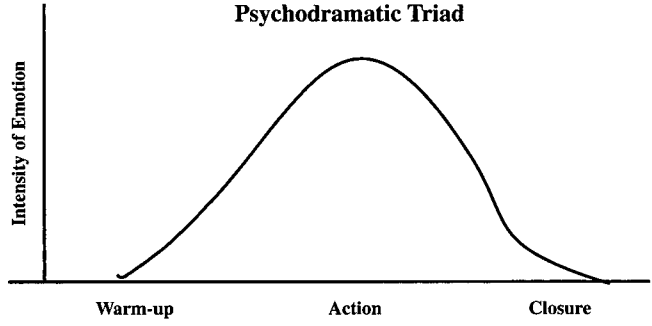

Figure 2. The Psychodramatic Triad.

beliefs–schemas, and the number of balanced thoughts written, and the resultant reduction in moods. Given that negative thought content is symptomatic of depression (Clark et al., 1999), we expected that many of those variables would be significantly correlated with the BDI-II scores and among themselves.

Methods

Participants

The participants were 40 undergraduate and graduate students (24 women and 16 men) enrolled in one of five group psychodrama courses taught at West Chester University between fall 1997 and fall 1999. Each course lasted 14 weeks, and the class sessions were 3 hr in duration. The same professor, who had extensive training in psychodrama, group therapy, and CBT, taught all five psychodrama courses.

The instructor typically began each class session by examining TRFs completed by students for that week and helping them to identify their core beliefs–schemas from their automatic thoughts and cognitive errors in thinking (J. S. Beck, 1995; Greensberger & Padesky, 1995). During the first and second group session, the instructor gave the students an explanation of their automatic thoughts and showed them how to identify them. Once that was accomplished, the instructor focused on the core beliefs that were prominent that week and used those to focus on a specific situation by using psychodramatic (e.g., role playing, role reversal, doubling) and cognitive–behavioral techniques (e.g., downward arrow technique; and specific homework, Socratic questioning, reframing, and advantage–disadvantage analysis; see J. S. Beck, 1995). Our main intent in using psychodrama procedures was to allow a protagonist, identified either by using sociometric methods combined with TRFs or by having someone volunteer, to examine a stressful situation that he or she had faced in the past week. The instructor guided the protagonist to an understanding of the source of his or her automatic thoughts and to ways of coping with both the negative automatic thoughts and comparable situations. Each class ended, following the psychodramatic model, with the sharing phase of personal experiences. Group members, in addition to the protagonist, identified similar tensions and reported how they coped or failed to cope with their situations.

Instruments

The instruments used for the study were the Thought Record Form (TRF) of Greenberger and Padesky (1995) and the Beck Depression Inventory II (BDI-II) of A. T. Beck, Steer, and Brown (1996). The TRF consists of seven columns and is used to identify negative thoughts evoked by a particular situation. To

complete the TRF, the participant identifies a situation, along with recognizing, listing, and rating every mood on a scale of 0 to 100%. Following that, the participants record their automatic thoughts (very often those thoughts can be in the form of images, which can be visual); identify a hot thought; offer evidence that supports the hot thought as well as confirmation that does not support the hot thought; recognize alternative–balanced thoughts; and re-rate their moods on a scale of 0 to 100%. The TRF also lists guidelines (questions, statements, or both) within each column to help in the completion of each column.

The TRF yielded several variables of interest to the present study. We assessed the measures during the first three and the last 3 weeks of each course. The variables of the present study were as follows:

1. Number of distressing situations identified.
2. Number of negative moods identified (initial moods).
3. Average initial mood rating.
4. Number of automatic thoughts.
5. Number of implied core beliefs.
6. Number of implied different types of core beliefs.
7. Number of balanced thoughts.
8. Number of moods reported after completing the balanced thoughts (new moods).
9. Average new mood rating.

Average mood ratings were computed for the periods at the beginning of the TRF (i.e., initial moods, the column after situation) and at the end of the TRF (i.e., new moods, the column after balanced thoughts). We calculated the average mood ratings by adding all the ratings for each reported mood and dividing by the number of identified moods. In the situation in which an individual identified a positive mood (i.e., happy goals = 35%), we calculated the percentage of the opposite of the reported mood (i.e., not happy = 65%) to be consistent with the notion of negative moods, which was the variable of interest to the present study.

The BDI-II is a 21-item self-report measure of state of depression. Each item is followed by four statements that are ranked from 0–3. One determines a total score by adding the ratings corresponding to statements chosen for each item. The clinical cut-off scores for the BDI-II are as follows: Minimal depression = 0–13, mild = 14–19, moderate = 20–28, and severe = 29+. In a recent study with undergraduate psychology students, Dozois, Dobson, and Ahnberg, (1998) suggested new cut-off scores: Nondepressed = 0–12, dysphoric = 13–19, and dysphoric-depressed = 20–63. The BDI-II (and its predecessor instrument the BDI) is popularly used in studies on depression and is used widely in clinical settings. Many studies support its reliability and validity (see Dozois et al., 1998; A. T. Beck, Steer, & Brown, 1996; A. T. Beck, Steer, &

Garbin, 1988). For the purposes of this study, we computed an average BDI-II score for the first 3 weeks and again for the last 3 weeks of the course.

Procedure

The students completed the BDI-II weekly at the beginning of each class. An exception to that routine was the fall 1997 class, which did not complete the BDI-II weekly. The students were introduced to the TRF gradually to ensure proper understanding of the terms involved and how to complete the form. For the first 3 weeks (not including the first day of the course, which was an introduction and explanation of the TRF), the students completed only the first three columns of the TRF in which they identified a potentially negative situation, recorded and rated the intensity of the emotions (moods) that they felt during the situation, and identified the automatic thoughts they experienced. For the remainder of the course, they completed the entire TRFs (all seven columns). Students, instructed to finish as many TRFs as needed, completed them as part of their weekly homework assignment.

Results and Discussion

We had two main purposes in this study. Our first purpose was to evaluate whether the group classes had any impact on changes in the number of core beliefs, automatic thoughts, moods, and the BDI-II scores. Specifically, our aim was to determine whether the group class resulted in a decrease in the previously mentioned variables from the first 3 weeks to the last 3 weeks of the course. The final scores were the averages of the scores in the first and last 3 weeks, rather than just the first and the last week of the course because some students missed a class in the beginning or towards the end. More important, we believed that the average of the first 3 weeks would function as a better baseline period, given that that was the period during which the students received instructions on how to complete the TRFs. Furthermore, we assumed that the average data from the last 3 weeks would provide us with a more realistic assessment of change, especially because the last week of a course during any semester can be a source of stress for many students. Our second purpose in the study was to examine the correlation among the various measures derived from the TRFs and BDI-II scores.

Because the sample sizes from each class were small, we combined data from all classes for data analysis. Given the small sample size, we made no adjustment to control for Type 1 error for the number of tests conducted and we used an alpha of .05 to evaluate significance of each test. Sample sizes varied for different analyses because of the data missing from students who did not complete the TRFs or the BDI-II.

Effects of the Group Course

Table 1 contains the means, standard deviations, and results of the *t* test of the first 3 weeks and last 3 weeks of a group course on the BDI-II and the various TRF variables: number of negative situations, number of automatic thoughts, number of core beliefs, BDI scores, number of moods reported at the beginning of the TRFs, number of moods reported after the balanced thoughts, and the average rating of the moods at the beginning of the TRF and after their balanced thoughts. From the results in Table 1, we concluded that students significantly mentioned more situations in the beginning (first 3 weeks) of the course than at the end (last 3 weeks). The decrease in the number of situations mentioned by the students in their TRFs might have resulted from the various activities that the students participated in during the semester (including completing the TRFs). An explanation for those results could be that the students

TABLE 1
Means, Standard Deviations, and Results of the *t* Tests of the First and Last 3 Weeks of the Course

		First 3 weeks		Last 3 weeks			
Variable	*n*	*M*	*SD*	*M*	*SD*	*t*	*p*
Situations	40	5.40	4.50	3.85	1.42	2.34	.024
Automatic thoughts	40	6.93	4.62	6.50	4.58	.510	.613
Core beliefs	40	4.70	4.27	4.30	2.88	.616	.541
BDI-II	33	5.11	6.32	5.02	7.83	.104	.918
Number of moods reported at the beginning of TRF	40	11.08	10.66	8.30	3.42	1.77	.085
Number of moods reported at the end of the TRF	15	4.13	2.53	8.20	4.50	–3.16	.007
Average mood rating at the beginning of TRF	40	70.13	14.74	72.17	17.81	–.718	.477
Average mood rating at the end of the TRF	15	38.24	20.67	45.35	14.01	–1.62	.127

Note. TRF = Thought Record Form. BDI-II = Beck Depression Inventory-II.

were able to cope with difficult situations in their life and were less likely to mention them as affecting them emotionally. An alternative explanation for the finding could be that students were busier at the end of the semester and spent less time and effort in completing their TRFs.

There were no significant differences in the number of automatic thoughts and in core beliefs from the first 3 weeks to last 3 weeks of the course (see Table 1). On the one hand, those results seem contrary to the extent that one would expect that a decrease in the number of situations should be concomitant with a decrease in automatic thoughts and core beliefs. Furthermore, one would also expect that completing the TRFs every week would result in decreases in the frequency of automatic thoughts and implied core beliefs, because such activities bring about greater awareness of the nature of one's maladaptive thinking. On the other hand, it is possible that the situations from the first 3 weeks were so qualitatively different, from those of the last 3 weeks that there was no generalization possible from the first to the last 3 weeks. Perhaps it was unreasonable to expect that the frequency of the automatic thoughts and implied core beliefs would decrease as a result of completing the TRFs over an extended period of time. It is possible that habitual patterns of thinking may not change but that what changes is the way one deals with them.

Another finding that was contrary to our expectations was that the BDI–II scores from the first 3 weeks did not differ from those of the last 3 weeks of the course (see Table 1). Those results might be thought of as somewhat disappointing given that the exercises pertaining to completing the TRFs (identifying situations, moods, automatic thoughts, becoming aware of core beliefs, completing balanced thoughts, re-rating moods) are specifically designed to facilitate a decrease in depression. The results might be better understood if we consider the nature of the sample used in this study—a group of university students, not a clinical patient group. More specifically, the BDI-II scores in the first 3 weeks were already quite low, leaving little, if any, room for improvement in those scores. We do not imply that the students did not benefit at all from completing the TRFs. They might, in fact, have learned a valuable strategy for coping with difficult situations. From the personal observations of the course instructor (personal communication), we know that many students made informal comments to him about the value of becoming aware of their moods, automatic thoughts, and their core beliefs, and of learning how to modify them in similar negative situations.

The number of moods reported at the beginning of the TRFs, the average mood rating at the beginning of the TRFs, and the average mood rating after writing balanced thoughts did not differ significantly from the first 3 weeks to the last 3 weeks of the course. Results shown in Table 1 suggest that there might have been less change in moods as a function of writing balanced thoughts in the last 3 weeks, relative to the first 3 weeks. To evaluate that possibility, we

computed the percentage change in mood as a result of writing balanced thoughts for each of the data sets (i.e., the first 3 and the last 3 weeks), using the formula suggested by Persons and Burns (1985). The formula is as follows:

$$\text{Percentage in change of mood} = \frac{\text{Initial Mood–New Mood}}{\text{Initial Mood}} \times 100.$$

A paired t test done on the percentage change in mood was significant, $t(14) = 3.40$, $p < .004$; mean percentage change week 1 = 94.18, $SD = 3.31$; mean percentage change week 2 = 88.51, $SD = 5.48$. The smaller reduction in negative mood at the end of the course, relative to the beginning of the course, might have to do with novelty effects and expectation effects. In the beginning of the semester, the exercises are new, and students may exaggerate the effects of writing balanced thoughts, given that the main reason for writing them was to obtain a reduction in their negative mood. An 88% reduction, however, in negative moods as a result of writing negative thoughts could still be considered impressive, if one can assume that the ratings are valid.

The number of moods reported at the end of the TRFs, after writing balanced thoughts (column 7), was significantly lower during the beginning of the course than in the last 3 weeks (see Table 1). The number of moods reported in the beginning of TRFs was significantly greater than the number of moods reported after writing balanced thoughts (see Table 2). Although this was true for both the first and the last 3 weeks of the course, the difference was more dramatic in the former than in the latter. It is possible that in the beginning of the course, the students did not fully understand or follow the instructions on how to complete the TRFs. After they had written the balanced thoughts, students often failed to rate again every mood they had listed at the beginning of the TRFs. That may explain the decrease in the number of moods from the beginning to the end of the TRFs. A possibility exists that the moods that they mentioned at the beginning of the TRFs but did not repeat after writ-

TABLE 2
Frequency of Moods Reported at the Beginning and End of the Thought Record Form (TRF)

Mood frequency	n	Beginning of TRF		End of TRF		t	p
		M	SD	M	SD		
First 3 weeks	15	9.80	4.43	4.13	2.53	4.36	.001
Last 3 weeks	40	8.30	3.42	7.19	3.57	2.76	.009

ing balanced thoughts had dissipated, and consequently they did not list them again. That possibility suggests that writing balanced thoughts had a positive and immediate effect on the students in improving their moods.

Table 3 contains the means, standard deviations, and results of the *t* tests for the average mood rating at the beginning of the TRFs and at the end, after writing balanced thoughts. Students were instructed to complete only the first three columns of the TRF in the beginning of the semester, but 15 students did complete all seven columns in the first 3 weeks of classes. In both the first and the last 3 weeks of the class, the average mood rating improved as a function of writing balanced thoughts, which was true for both the TRFs completed in the first 3 weeks and those completed in the last 3 weeks of the course (see Table 3). The results suggest the positive and immediate impact of writing balanced thoughts on improving students' moods. It is interesting, however, that the average mood rating did not change from the first 3 weeks to the last 3 weeks of the course, whether one looked at the average mood rating at the beginning or at the end of the TRFs. In other words, although there were immediate effects from writing balanced thoughts, there were no long-term effects in improving mood ratings as a function of participating in the course activities. It is possible that the duration of the course was not long enough to have an impact on improving students' overall mood.

Correlation Among the Various TRF Measures and the BDI-II Scores

Given that we specifically designed the TRF to bring about improvement and thereby decrease depression, we wanted to determine if there was a relationship between each of the TRF variables and the BDI-II scores. Furthermore, because some of the variables derived from the TRFs have not been used in prior studies, we decided to examine how they correlated with each other. The variables intercorrelated were as follows: Number of situations

TABLE 3
Average Mood Rating in the Beginning and End of the Thought Record Form (TRF)

		Beginning of TRF		End of TRF			
Average mood	*n*	*M*	*SD*	*M*	*SD*	*t*	*p*
First 3 weeks	15	70.90	14.55	38.24	20.67	5.23	.000
Last 3 weeks	40	72.17	17.81	47.19	19.45	7.32	.000

mentioned, number of initial moods (i.e., listed in the beginning of the TRF), average initial mood rating, number of automatic thoughts mentioned, number of implied core beliefs (regardless of type), number of implied different types of core beliefs, number of balanced thoughts written, number of new moods (i.e., reported after the balanced thoughts), new mood average, and BDI-II scores. The intercorrelations, computed separately for the first 3 weeks and the last 3 weeks of the course, appear in Tables 4 and 5, respectively.

TRF and the BDI-II

The BDI-II correlated with four out the nine TRF variables in the analysis of the first 3 weeks data (see Table 4) and six out of the nine variables in the analysis of the last 3 weeks data (see Table 5). In the first 3 weeks data, the BDI-II was correlated significantly ($p < .05$) with the number of moods listed, the number of automatic thoughts listed, the number of implied core beliefs, and the number of different implied core beliefs. However, in the last 3 weeks of the course, the BDI-II correlated significantly with the number of situations mentioned, number of moods listed, number of implied core beliefs, number of automatic thoughts listed, and the number of new moods, resulting from writing of balanced thoughts; and with the new mood average, resulting from writing of balanced thoughts. In evaluating the correlations, one must keep in mind that some of the correlations might not have been significant either because of small sample sizes or the restricted range of the BDI-II scores, or both.

As expected, the number of automatic thoughts listed and the number of implied core beliefs in those thoughts were correlated significantly with the BDI-II scores in the first three and the last 3 weeks of the course, supporting Beck's theory of depression that a greater number of negative thoughts and core beliefs is likely to occur in more depressed individuals.

An unexpected finding was that although the BDI-II was significantly correlated with number of initial moods mentioned, it was not correlated significantly with the average initial mood rating, either in the first three or in the last 3 weeks. One would expect that higher depression scores should be associated with higher negative moods. More than likely, the lack of significance was a function of restriction of range effects on the BDI-II. Nevertheless, the BDI-II scores positively and significantly correlated with the number of new moods and the average new mood rating, suggesting that students with higher depression scores reported a higher frequency of negative moods and also that their average negative mood tended to be higher. Why the BDI-II scores did not correlate significantly with the initial average mood but did correlate with the average new mood is not clear. That difference in results could be attributed to chance.

TABLE 4
Correlations Among Measures in the First 3 Weeks

Measure	1	2	3	4	5	6	7	8	9	10
1. Number of situations	—									
2. Number of moods	.946**	—								
3. Mood average	−.333*	−.408**	—							
4. Number of automatic thoughts	.838**	.839**	−.131	—						
5. Number of core beliefs	.874**	.878**	−.195	.959**	—					
6. Number of different core beliefs	.656**	.680**	−.115	.827**	.876**	—				
7. Number of balanced thoughts (n = 17)	.458	.467	.514*	.530*	.590*	.592*	—			
8. Number of new moods (n = 15)	−.038	.028	.381	.081	.276	.281	.763*	—		
9. New mood average (n = 15)	.256	.359	.090	.085	.225	.427[a]	.499[a]	.372	—	
10. BDI-II (n = 33)	.095	.390*	.253	.426*	.476**	.496**	.455[b]	.161[a]	−.022[a]	—

Note. BDI-II = Beck Depression Inventory-II. n = 40, unless noted otherwise.
[a]n = 14. [b]n = 16.
*p = .05 (2-tailed). **p = .01 (2-tailed).

TABLE 5
Correlations Among Measures in the Last 3 Weeks

Measure	1	2	3	4	5	6	7	8	9	10
1. Number of situations	—									
2. Number of moods	.657**	—								
3. Mood average	.005	−.137	—							
4. Number of automatic thoughts	.845**	.610**	.143	—						
5. Number of core beliefs	.754**	.630**	.258	.895**	—					
6. Number of different core beliefs	.610**	.434**	.254	.705**	.831**	—				
7. Number of balanced thoughts (n = 17)	.702**	.361*	.157	.759**	.719**	.601**	—			
8. Number of new moods (n = 15)	.542**	.771**	.195	.648**	.669**	.391*	.554**	—		
9. New mood average (n = 15)	.097	.220	.331*	.133	.244	.119	.008	.225	—	
10. BDI-II (n = 33)	.397*	.430*	.290	.531**	.642**	.339	.312	.514**	.436*	—

Note. BDI-II = Beck Depression Inventory-II. n = 40, unless noted otherwise.
*p = .05 (2-tailed). **p = .01 (2-tailed).

Correlations Among the TRF Variables

The number of situations identified was positively and significantly ($p < .05$) correlated with the number of moods, automatic thoughts, core beliefs, and implied different types of core beliefs mentioned in those same weeks. The number of automatic thoughts, the number of core beliefs, and the number of different types of core beliefs mentioned were positively and significantly correlated with each other. We expected that result because the more negative situations one identifies, the greater is the opportunity for automatic thoughts to occur and core beliefs to surface.

Two correlations were unexpected. The number of situations identified was negatively and significantly correlated with the number of moods listed and with the average negative mood in the data of the first 3 weeks, but it was not correlated in the data of last 3 weeks (see Table 4 and 5). In examining the data carefully, we found three extreme scores on the situations identified in the first 3 weeks. When those outliers were dropped from the analysis, the correlations became nonsignificant.

The number of moods was significantly correlated with the frequency of automatic thoughts, implied core beliefs, and number of implied different core beliefs. The average mood ratings for the two time periods (see also Table 6) were significantly correlated. Other than that, the mood ratings were uncorrelated with any of the other TRF variables. It is possible that mood ratings given by the students are not valid, in the sense that the students might not actually know how they felt in regards to the situations they mentioned. Possibly we need to consider a new way of assessing mood ratings.

TABLE 6
Correlation Between First 3 Weeks and Last 3 Weeks Measures

Measure	*n*	*r*	*p*
Number of situations	40	.374	.018
Number of automatic thoughts	40	.481	.002
Number of core beliefs	40	.393	.012
Number of different types of core beliefs	40	.408	.009
BDI-II scores	33	.750	.000
Number of moods reported at the beginning of the Thought Record	40	.364	.021
Average mood rating at the beginning of the Thought Record	40	.504	.001
Average mood rating at the end of the Thought Record	15	.534	.040

Note. BDI-II = Beck Depression Inventory-II.

We found positive and significant relationships between the number of balanced thoughts and the number of automatic thoughts, and between the number of core beliefs and the number of different types of core beliefs. That is understandable because the number of alternative or balanced thoughts produced was in response to the number of negative automatic thoughts and core beliefs mentioned in the beginning of the TRF.

Correlations of Variables Between the First and Last 3 Weeks

We did one last analysis to see if the TRF-based variables and the BDI-II scores from the first to the last 3 weeks were correlated. In Table 6, the number of situations, automatic thoughts, core beliefs, and different types of core beliefs in the first 3 weeks of the class has a significant positive correlation with the corresponding measures in the last 3 weeks of the class. The students had a tendency to respond similarly in the first 3 weeks and the last 3 weeks.

Summary and Conclusions

Contrary to expectations, the average BDI-II scores from the first 3 weeks of the course to the last 3 weeks did not differ significantly. That nonsignificant difference might be attributable to our use of a group whose BDI-II scores were low to begin with (i.e., before they participated in the course) leaving little room, if any, for improvement. Students did report a lowering of negative moods, on the average, as result of writing balanced thoughts in each time period. The students reported no reduction of negative moods, on the average, at the end of the course as a function of completing TRFs every week. In other words, the students' average initial mood ratings before they wrote the balanced thoughts in the first 3 weeks and those of the last 3 weeks did not differ significantly, despite the fact that the students reported fewer stressful situations in the last 3 weeks than during the first 3 weeks (see Table 1). We concluded that, although the immediate positive effects of writing balanced thoughts did not transfer or generalize to situations reported in the last 3 weeks, possibly much longer-term interventions, longer than 14 weeks, are needed to see transfer effects. A clinically depressed group might achieve better results. The greater reduction in negative mood (about 94%) in the first 3 weeks, as a function of writing balanced thoughts, than in the last 3 weeks (about 86%), suggested to us that there might be both novelty and expectancy effects operative here. In the first 3 weeks, students learned a new technique; they knew that its purpose was to reduce the intensity of their negative mood. That is what they reported. But they failed to generalize that effect over many weeks in response to new situations. That explanation is also suggested by the similarity of responding to the TRFs, as indicated by the correlations

between the first and the last 3 weeks on the different variables (see Table 6). Those results, however, are not to be construed to suggest that the activity of writing balanced thoughts was not helpful. Students often indicated to the course instructor that they were more aware of their negative thoughts and how to combat them as a result of completing TRFs.

We did not expect that the intensity of moods would not be significantly correlated with such variables as the BDI-II or the frequency of automatic thoughts and core beliefs, in either time period (the first and last 3 weeks). Low sample sizes and the restriction of range effects might have caused the result. It is possible that the mood ratings might not be fully valid indicators of students' actual mood. In this study, the students listed a mood and then used a 0 to 100 scale to rate each mood. We observed that students did not often list the same moods before and after completing balanced thoughts. That response might mean either that they experienced fewer moods after writing balanced thoughts or simply forgot to include all of the same moods (see Table 1, particularly in the first 3 weeks). Therefore, modification in the way mood ratings are assessed might be needed. Perhaps a listing of moods should be provided, with clear instructions that each mood is connected to the situation and to their automatic thought. Using the Likert-type scale of 0 to 100 to assess moods is crucial in completing the TRF.

The result—that BDI-II scores significantly correlated with the number of automatic thoughts, number of core beliefs, and different types of core beliefs in both time periods—supports Beck's assumptions that negative thought content characterizes depression (see A. T. Beck, 1976; Clark et al., 1999).

We conclude that the results of this exploratory study must be regarded with caution because the sample size was small and was characterized by students with low initial BDI-II scores. We believe it would be helpful to gather additional data about how helpful students find the various exercises pertaining to the TRFs in coping with everyday situations in life, rather than to rely just on responses given to the TRFs. Researchers may find that completing the TRFs might not reduce BDI-II scores, participants might find it practicable to complete the TRFs as a useful coping strategy for dealing with upsetting situations.

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BOOK REVIEWS

Sociodrama: Who's in Your Shoes? by Patricia Sternberg and Antonina Garcia. 2000. Westport, CT: Praeger.

The publication of the revised and expanded second edition of *Sociodrama: Who's in Your Shoes?* admirably furthers the work of Jacob L. Moreno, the originator of sociodrama. Theory and practice are never far apart in this thoroughgoing account of the historical precedents and the tenor of the times that led to Moreno's development of sociodrama. In it, professors Sternberg and Garcia are careful to integrate historical and theoretical information about sociodrama with descriptions of how it is conducted. In doing so, they have provided an excellent book that serves both as a guidebook for the practice of sociodrama and as a source book for study and research. In it, we find a strong confirmation of Moreno's early belief in sociodrama's promise for solving problems of human relations.

To introduce the origins and fundamentals of sociodrama, the authors describe Moreno's early theatrical experimentation and the exploration of social issues that he conducted while he was a medical student in Vienna. We learn about his spontaneity theory, in which spontaneity serves as the impetus to bring creative ideas to fruition. We also learn that before he came to America in 1925, he had established the Theater of Spontaneity, the basic concept of which was that the actors were considered to be social researchers who, totally unrehearsed and without scripts, sought to create spontaneous interactions among themselves and the audience. In that kind of theater, the audiences could suggest topics from current events to be dramatized by the professional actors whom Moreno had trained in his method of spontaneity and social research. Moreno later called that new form of theater "The Living Newspaper."

Sociodrama, which emerged from it, continues to be focused exclusively

on social and cultural issues. There were times, however, when, in the spontaneous treatment of the public aspects of the issues, the actors revealed their personal thoughts and feelings. That shift from the public to the private focus opened up areas of investigation that, in their own right, proved to be significant and in need of clarification. Eventually that shift led to Moreno's development of psychodrama. To this day, it is the focus on personal rather than public issues that sharply differentiates psychodrama from sociodrama. Those are but two of the far-ranging interests and activities that prompted Moreno's thinking as a writer and theorist. His theories of role and personality development and his theory of interpersonal relations, with spontaneity and creativity as their cornerstones, were developed in relation to the psychodrama and sociodrama experiments and serve as the substructure of sociodrama. Sternberg and Garcia have impressively distilled these theories and interpreted them in their chapter "Examining Sociodrama Underpinnings."

The additions and revisions that have been made in the second edition of *Sociodrama: Who's in Your Shoes?* bring changes that have greatly enhanced its usefulness. The large number of new index and bibliography entries will aid those using the text for study and research. Those endeavoring to spark a sociodrama group's spontaneity and move it into enactment can find new scripted dialogues and suggestions for improvisational situations. Of special importance, however, are the new chapters and essays. Among the new chapters are "Focusing on the Stages of Group Development," "Sociodrama in Religion, Ethics, and Spiritual Growth," and "Marketing of Sociodrama," which contribute strongly to the book's usefulness and timeliness. Equally important are the essays in the book's final chapter that pull together the great variety of information throughout the book. In those essays, leading practitioners of sociodrama, both here and abroad, discuss their insights about sociodrama, its effectiveness, and their particular ways of using it.

The authors discuss the essential components of sociodrama—the warm-up, the enactment, and the sharing—when they examine sociodrama's structure and its goals and benefits. The issues that are of concern to the group, its "open tension systems," emerge during the warm-up discussion that precedes the enactment. It is the group leader's function to listen for the open tension systems and identify the one major issue that seems to excite the group's interest the most. That is the shared central issue that provides the theme to be explored in the sociodrama. During the warm-up, the group members may express such needs or drives as the need to be assertive or the need to be playful. It is through the director's help in fulfilling those needs or "act hungers" that the goals of sociodrama are achieved. Those are the goals of the expression of feeling (catharsis), gaining new perception (insight), and obtaining behavioral practice (role training). The authors point out that those actions and reactions are lifelong considerations for all of us and that sociodrama provides

the opportunity for people to express a wide range of emotions, from tears to laughter and from agitation to serenity. In that regard, they see sociodrama as "one of the most efficient yet safe methods available for obtaining information in the area of psychic emotional experience without undergoing the actual experience."

At the outset of the book, the authors identify both the similarities and the differences between sociodrama and psychodrama. The two are similar in that they both explore thoughts, feelings, and roles through enactment. In doing so, they share the use of specialized techniques that Moreno developed to deepen the enactment and bring out what he called the "invisible dimensions of living" that are "not fully experienced or expressed." They are what he called the "surplus reality" dimensions of dreams and daydreams, thought fragments and unacknowledged feelings. To bring them out, he developed the surplus reality techniques of role reversal, which the authors refer to as "one of the most profound techniques that Moreno developed," doubling, the aside, and future projection, all of which are used in both sociodrama and psychodrama.

As the authors point out, there are, however, fundamental differences in the way that the methods are used. As a therapeutic modality, psychodrama focuses on the personal problems of a particular member of the psychodrama group, the protagonist. By using the surplus reality techniques developed by Moreno in the psychodramatic reenactment of the protagonist's real-life experiences, the psychotherapist seeks to work through the protagonist's problems and restore his or her well-being.

That is in sharp contrast to sociodrama, which never acts out any one person's situation or emotional problem. Its focus, instead, is exclusively on hypothetical situations that illustrate the issues that the group is interested in examining. As an educational modality, sociodrama informs people about the nature of the problem that is enacted and serves to clarify the values that are involved. Through its enactment, a sociodrama provides group members with an action setting in which to learn the complexities of the problem and the best ways of dealing with them. Sociodrama focuses on the way the group relates to the social issue that is being examined. In that way, the group is the subject, whereas in a psychodrama, the individual is the subject.

It is the authors' hope that by reading their book and experimenting with its contents readers will share the joy and enthusiasm they had in writing it. The complete compatibility they have with sociodrama's goals and methods becomes clear very soon. So too does their strong belief that sociodrama has the ability to transform the way we look at problem solving. Like Moreno, they see a wide range of settings in which sociodrama's unique contribution to problem solving can be used, such settings as schools, churches, businesses, and theaters, as well as psychotherapy sessions and social action groups.

Sternberg and Garcia have provided a finely drawn account of the historical and theoretical background that gave rise to sociodrama, the fundamentals of its theory and practice, and the specifics of its application. In doing so, they champion the high hopes of J. L. Moreno for sociodrama's continuing role in the exploration of social issues and the resolution of conflicts—and serve his cause well.

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Theory and Practice of Action and Drama Techniques, by Leni Verhofstadt-Denève. 2000. London: Jessica Kingsley Publishers.

The subtitle for this philosophical tome is *Developmental Psychotherapy From an Existential–Dialectical Viewpoint.* The book might have been more accurately titled "A Foundation in Existential–Dialectical Developmental Psychology," or "A Phenomenological–Dialectical Approach to Personality and Its Application to Action–Based Therapies." Most likely, the publisher did not want a title that would intimidate readers, especially practitioners of action techniques. Actually, this book, or something like it, is exactly what practitioners of psychodrama and other action-based therapeutic techniques need most. Clearly, one of the most glaring deficits in the training and professional development of action-focused therapists is a coherent philosophical foundation out of which technique can develop and be guided. Verhofstadt-Denève provides a well-grounded and philosophically sound approach to human psychology. Unfortunately, many drama therapists and psychodramatists may find it difficult to interpret, especially if they do not read French. The author religiously preserves the French language of many important and seminal quotations and fails to include any translation to accompany them.

Pick up any scholarly philosophy journal or significant philosophy work, and you will find that French, Latin, and German are standard vehicles for imparting the wisdom of the ages. No one wants to miss the most intimate linguistic nuance of philosophical meaning. Among philosophy scholars, it may be felt that to translate those quotations would take from their meaning and diminish their power. Like Hebrew to the Torah, Arabic to the Quran, or Latin to the Catholic canon, there is a perception of magical power in the word as given in its original form. Language is the voice of the soul. To translate it is to lose the connection to the heart of the meaning itself. Transformed into another language, it may make sense, but it will not carry the power or the author's heart and soul. The reader will not *feel* what the author meant originally. But how will the average psychodramatist feel about so much "in-your-

face" French that comes without any accompanying translation? Bored? Turned off? Those who read both English (the language in which the book is written) and French will have the advantage. The focus of the book is the word, not the action, and action-oriented therapists may need to adjust their orientation somewhat to benefit from it.

Part of the reason some of us prefer action-based therapeutic techniques is because *the word* is not as easy for us to relate to. Moreno himself scoffed at Freudian "talk therapy" and revealed the healing power of dramatized emotions in the hands of a trained therapist. Freud was a writer and may have spent more time writing about his patients than listening to them, much to the benefit of human understanding. But psychodramatists are not known as writers. The word is not their strength, and they are not philosophers. The application of psychodramatic techniques may be guided to a degree by the principles expounded by Moreno himself, and those who are well trained are aware of these concepts; but in practice, one usually observes practitioners guided by such popular psychotherapeutic orientations as cognitive behavioral psychology, ego psychology, self-psychology, and so forth. Their focus, however, is not in those schools. They are primarily practitioners of the art of psychodrama. It would be unfair to expect to find a great interest in complex existential metapsychology among psychodramatists. Leni Verhofstadt-Denève boldly ignores this reality and presents to her audience a depth of philosophical and psychological understanding that is unparalleled in the world of psychodrama. Perhaps this is what is needed most among practitioners, a solid philosophical foundation for practice technique.

So much of what is done in the circle of the psychodrama group is left unexplained and even misunderstood. Rarely do we have a context in which to define what is happening. Some may argue that it is not necessary to understand but that simply by *doing*, we work through our unresolved pasts. Verhofstadt-Denève attempts to give some meaning and structure to the psychological phenomena that can occur in psychodrama. Her approach requires a willingness to expand one's thinking into the realms of existential philosophy and from there into a phenomenological–dialectical personality model (Phe-Di P Model). We must become comfortable with exploring the subjective and objective self and learn to differentiate between "I" and "ME," between self-observation and the observations of others, and answer the central questions of "Who am I" (*Self-Image*),"Who would I like to be" (*Ideal-Self*), "What are others like" (*Alter-Image*), "What should others be like" (*Ideal-Alter*), "How do others perceive me?" (*Meta-Self*), and "How should others perceive me?" (*Ideal-Meta-Self*)—all ideas common to the psychodrama.

Verhofstadt-Denève gives a special position to the character of "the other." By using Hegelian dialectics, she develops an understanding of self-reflection in the interaction between self and other, allowing a critical assessment of the

Ego by the Alter that expands perceptions beyond the egocentric tendencies so common to us all. As she moves into the therapeutic process, we see how philosophical concepts begin to take shape in the context of therapeutic action. We can see how personality change can occur in ever so small increments as the protagonist encounters his counterpart as an antagonist and an interaction ensues in which the developmental dialectic of frustration and resolution progressively brings insight to the participants in the drama.

Verhofstadt-Denève refers to her book as a "manual." It would be difficult to refer quickly to this text to find a solution to a specific problem, and it does not give us a step-by-step formula for addressing any particular impasse common to psychodrama. The "practicable frame of reference" she attempts to establish must truly be built in the mind of the reader through long and contemplative study. That is a much-needed exercise, today more than ever. Her attempt to deal with not only the "*content* of development but also with the motivating *dynamics* of the developmental process" is to be applauded.

We often address traumas or chronic traumatta experienced by our clients as though they were the source of infinitely penetrating negative influences permeating every fiber of the human personality. Verhofstadt-Denève views the recurring existential themes of anxiety, guilt, loneliness, and the self-perception of finiteness as essential content of the developmental process out of which enduring strength and positive self-esteem can arise through critical reflection on the self, others, and the object world.

After providing us with a grounding in basic existential psychology and the principles of the existential–dialectical personality development model, Verhofstadt-Denève presents methods and practical applications using these concepts. The chapter on psychodrama may seem a bit elementary to the experienced practitioner, but it is valuable to explore with an open mind, suspending one's former perspectives and training and remembering that she is coming from an existentialist perspective. As she clarifies in the following chapters, she sees psychodrama as "intrinsically dialectical in nature." She then moves to another practical application, that of a psychodramatic approach to dreams in a developmental therapy for adolescents. That is an especially enlightening application with easy-to-follow directions. An additional chapter on the use of action and drama techniques in educational settings is disappointingly short. That is an area that warrants the attention of an entire book.

Four chapters by contributing authors follow and elucidate action techniques for specific populations. Braet's focuses primarily on enhancing self-image and boosting self-esteem in obese children. Unfortunately, a gross printing error in figure 10.2 leaves one frustrated when trying to understand the accompanying text. In spite of that, there is real and applicable value in that chapter that applies to the dialectical concepts of Verhofstadt-Denève in a very easy-to-replicate manner. The remaining chapters are interesting, each

in their own application of the Phe–Di P model, but they are unfortunately brief and lack the depth of discourse and explanation of Verhofstadt-Denève's work. As more practitioners make Verhofstadt-Denève's approach their own, perhaps other works will come forth with more detailed examples and with greater depth of explication.

It is truly refreshing and encouraging to find that someone who understands psychodrama and the basic concepts first presented by Moreno has tackled the monumental task of grounding techniques in a theoretical perspective that can inspire creative applications in clinical practice. Although others have focused on theory before, Verhofstadt-Denève provides a philosophical basis that informs theory in a way that can inspire practitioners.

Too often practitioners of psychodrama are inspired by their own inner feelings and intuition, without an organized conceptual framework. That can lead to shallowness and can seriously limit the effectiveness of practice. There is an abundance of spiritual and scientific perspectives that permeate the therapeutic mind-sets of action-based therapists. We believe in many things, from the mystical to the concrete. Our faith is formed in our developmental experience, and that inevitably colors our view of human nature. Most of us are, by virtue of our professional ethics, accepting and open to our clients' positions and interpretations of the powers in their universe. We can usually sense when a client's interpretation of events or feelings begins to enter the realm of the irrational. We can usually distinguish between magical denials of reality and positions of faith-based perspectives. But a methodological approach to the theoretical underpinnings of human self-concept change through psychodramatic technique is rarely a time-consuming focus of practitioners who devote their energies moving from client to client or group to group.

Verhofstadt-Denève prompts us to slow down and take the time to work through the development of our own view of the human self. The truth is in the client. Regardless of how we may feel, what we may observe, or what interpretation, counsel, or direction we may give, the outcome lies in the being of the client.

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What I Heard in the Silence: Role Reversal, Trauma, and Creativity in the Lives of Women, by Maria V. Bergmann. 2000. Madison, CT: International Universities Press.

Readers who notice this book in the bookstore will probably be attracted by its title and by the cover photo of George Segal's "Three People on Four

Benches." The latter seems to link with the title by suggesting silence, perhaps also resignation or loneliness. Is this a group or three strangers lost in private thought? The positioning of each figure suggests emotional distance. The subtitle is slightly misleading; its topics turn out to be linked additively, rather than by strong connective theoretical tissue. This is not a feminist book or even a book about what are often called, albeit vaguely, "women's issues." Trauma does not appear until the third part of the book; much of it is Holocaust-related. It ignores, but is far from inconsistent with, current burgeoning work on the effects of trauma on cognitive processes, memory, and the dynamics of transference/countertransference. The last section on creativity is, although adequate in its own terms, only superficially related to the other parts. I shall return to this last chapter in a moment. Meanwhile, practitioners who use role reversal as a therapeutic action method—psychodramatists, sociodramatists, and so forth—should be alerted that by role reversal Bergmann means children who feel turned into caretakers by inadequate parents with whom they are reversing roles. That is not a technique but pathology. On the whole, I believe that is Bergmann's strongest and most developed clinical issue.

Women and Role Reversal

Despite the French analyst Jacques Lacan's provocative comment, "*la femme n'existe pas,*" Bergmann follows other (now) mainstream psychoanalysts who argued that the little girl is aware that her body is female and that she intuitively knows she has a vagina before the hypothesized comparison with boys, before the Freudian experience of "lack." Her knowledge may therefore be presumed to temper that envy the Victorian founding father of psychoanalysis had wished on her. True, some feminists see a paradoxical value in this difference as a launching pad for rebellion, for questioning binary role definitions, and, sometimes, for indulging eternal paranoia. Bergmann, however, treads a safer middle of the road, where identification with mother is the basis for a stable body, and thus psychological female identity. So we are not talking about girls who are disappointed not to be boys or reject the notions of girl–boy difference but about girls who are glad they are girls and want something else only if there is trouble. One form of such trouble is a family constellation in which mother is needy or rejecting and daughter is used as a maternal substitute. What the little girl normatively does with her dolls is what she then has to do for real: play mother but also lose out on a precious aspect of childhood. "Symbolically, by reversing roles, these little girls became the mothers they never had" (p. 16). As a corollary to that, the girl may seek in the father a maternal substitute and also become a pseudo-erotic partner. So what looks like easy Oedipal victory over the weak mother

ensues, generating serious guilt and conflict when it is time for adult sexuality, to say nothing of parenthood. To quote a Bergmann patient, "I can't have a baby because then I would have to lose my mother. . . . It is as if I had kept her alive by letting *her* be my baby" (p. 26, emphasis in original). Implied here, among other things, is the longing to hold out for a real mother, one with a positive attitude toward the female aspects of her young daughter's body. In the same way, the urge to find a mother substitute in the father may result in the following:

> When I think of getting married, I have the image of a little girl holding the hand of a big man . . . I obviously don't want to have a baby. It seems as though I had always been waiting for Daddy.

To contemporary ears, such a statement may have an aura of Freudian cliché, of a patient trying a bit too hard to reinforce stock patient–analyst roles. However, we should recall that "waiting for Daddy" also means feeling cruelly trapped in a father–daughter fandango in which each must serve as fantasy gratifier of the other's needs. So daughter may feel she lacks the right to express her own differentiated erotic wishes. In the pseudo-democratic, role-blurred family constellation of today, that lamentable result may not be uncommon. As a result of such dynamics, adult sexual expression can remain unconsciously linked with guilt about incestuous tangles, in which the daughter feels like father's partner and mother is their joint project. I believe psychotherapists whose work explores role complementarity, whereby one set of roles implies another reinforcing set, will find Bergmann's ideas here compatible with theirs.

Creativity

Bergmann's discussion of creative block hinges, like her formulations in other chapters, on object relations (relationships) rather than drives. We therefore hear less of Freud's original notion of art as wish fulfillment and as fantasy that may be a culturally influenced modification of drive and more of Winnicott's transitional space or Sandler's internal objects. In Bergmann's view, the artist is unconsciously addressing an "other" who is an internalized parent representation. "If a creative person suffers from work inhibition, . . . it is often the result of an unconscious hostile dialog with internalized parental images perceived as punitive and as disregarding of that person's creative efforts" (p. 195). Ultimately, that may be laid at the door of failure to separate internally from parents. Meanwhile, the analyst may have to intervene as a benign new object "who can be trusted to remain . . . invested and support their creative efforts until an artistic product is completed" (p. 196).

Therapists who use a more interventionist approach than typical psychoan-

alysts may be interested in the fact that Bergmann attended a performance of one of her actress-patients. "I slipped into the darkened theater and recognized immediately that Ellen's affect became flat and unconvincing when she had to express the hostility of an evil and powerful female character" (p. 203). Readers who know J. L. Moreno's ideas about spontaneity training may see points of similarity here. The problem was not Ellen's training as an actress. Rather, her energy in the role was sapped by anxiety about her relationship with her real mother, so she was not adequately present in the new theatrical role until that had been worked through.

One of the interesting issues that Bergmann raises in her discussion of creativity is bisexuality; she seems *almost* to say that the two are linked, but it is hard to tell if she really means it. Her statement, "I believe that successful creative endeavor is achieved by the utilization of integrated bisexual wishes" (p. 85), could mean that someone in touch with bisexual wishes may thereby be creatively empowered, thus perhaps writing books such as this one. Or it could mean that we should all master our Oedipal conflicts, opposite sex *and* same sex, before stepping out on to the high wire. Sometimes *bisexuality* is used to indicate pathology, as in "Emma's bisexuality reflected [internalization of] her mother's lack of feminine sexual identity" (p. 62). At other moments, it seems that bisexuality fosters creative talent—for example, "She knew how to appeal to the homosexual component in fashion-conscious heterosexual men. . . . Her bisexuality and fluctuating gender identity were used in the service of creativity and original artistic self-expression" (p. 56). Is "fluctuating gender identity" a deviation to be straightened or the grain of sand that stimulates the oyster to produce a pearl? Perhaps we will never know for sure, but I think it fair to say that Bergmann has not quite made up her mind. Indeed, psychoanalysts generally, although interested in creativity and working productively with creative patients, have never entirely decided whether such evidently disturbed individuals as Vincent Van Gogh and Edgar Allan Poe were creative in spite of manifest personal suffering or whether manifest personal suffering spurred them to find solutions in art not required of the better adjusted. Again, perhaps we will never know. But maybe, when it comes to creativity, one serious drawback may be too much sanity.

Psychoanalysis and Other Modalities

Overall, the book contains more theoretical discussion than case material. Although the writing is excellent stylistically, a more critical editing of the narrative thrust of its ideas would have helped its flow. At times, Bergmann seems to be going over the same ground yet again or even theorizing a patient's problems from a point of view not consistent with one she had just used. The therapist oriented to experiential techniques may find some of the

text rather dense, and, there are, unfortunately, those "archaic narcissistic fantasies," "deaggressivization of objects," "cumulative traumata," "super-ego lacunae," and "libidinal cathexis" that can cause eyes to glaze over. Analysts write to each other more often than not, so the influence of their insights may be curtailed when clogged with jargon. That is a pity because much of what analysts now publish, which stresses how human beings are invested with multiple states of mind and multiple roles, is compatible with work outside their field. In that sense, the therapeutic encounter can be seen as potentially breaking old roles and the therapist as one who facilitates that as a participant rather than as a remote observer. Although psychoanalysis is edging toward the social, psychodrama seems to be moving into a mystical phase in which change is alleged to occur through an individual's will to assert his or her own higher truth. So, just as analysts are adopting a less authoritarian, more interactive stance, psychodrama may be turning away from the relational world. What a shame!

All therapists could profit from this book, especially if they concentrate on the clinical sections. To oversimplify, Bergmann is writing about the unconscious exploitation by family members of each other, often with good intentions, so that even if the children feel loved, they internalize roles that are damaging. This is as true of the girl seduced into being her mother's mother or father's minder as it is of the child of a Holocaust-surviving family that insists, while maintaining silence about the catastrophic events, that the child's role is to restore, through some exceptional achievement in life, all that has been lost to the parents. To prosper, the child may have to disappoint the family. As Bergmann aptly puts it, only "an intrapsychic act of separation from an imposed fate can free the child" (p. 138). I believe female therapists are sometimes more sensitive to this poignant entrapment than their male counterparts, and I also believe, on the basis of this book, that adults whose struggles can be thus described would find in Maria Bergmann a therapist equipped with skill, empathy, and a dogged ability to "hang in there" with her patient over the long haul. If so, she occupies a worthy place among psychotherapists of whatever persuasion, orientation, or notion of therapeutic effectiveness, who try, day in and day out, to help their patients renegotiate their imposed fate.

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